



Incorporation of social sciences and humanities in the training of health professionals and practitioners in other ways of knowing

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Received: 30-JAN-2015

Accepted: 14-AUG-2015

Published Online: 25-SEP-2015

Abstract

It would appear that education in health sciences is currently focused primarily on instilling effective scientific, cognitive and technical competencies in health professionals and practitioners; it is not according the same level of importance to personal, relational, ethical and moral competencies. This review supports the quest for greater balance in biomedical and healthcare education by incorporating social sciences and humanities. It also argues that this is an urgent teaching and training task, especially in the developing world (Africa, Latin America and Asia). It is of critical importance to understand that matters of health and disease/illness are not only about the ‘disease in the body’ but also about the ‘disease in the body of the person suffering’, and that these two ways of knowing (epistemologies) or world-views have different implications in the health sciences education process. Lastly, as an ethics of care, the understandings afforded by these more inclusive approaches of the social sciences and humanities should not be a privilege confined to medical schools.

Keywords: Africa; Asia; Education, Medical; Education, Nursing; Epistemology; Health Sciences; Humanities; Latin America; Social Sciences

Introduction

Currently, education in health sciences is focused primarily on instilling effective scientific, cognitive and technical competencies in health professionals and practitioners; it is not according the same level of importance to personal, relational, ethical and moral value competencies.[1] As

Cite this article as: Moreno-Leguizamon CJ, Patterson JJ, Rivadeneira AG. Incorporation of social sciences and humanities in the training of health professionals and practitioners in other ways of knowing. RHIME. 2015;2:18-23.

the increasingly critical body of literature addressing the limitations of the positivist epistemology, way of knowing or world-view in health sciences suggests, the need for biomedical education to incorporate approaches from the social sciences and humanities is of paramount importance.[2-4] Through the use and incorporation of those disciplines it is expected that health practitioners will amplify the ways of knowing and therefore cover aspects such as the personal, relational, ethical and moral, among others, which are aspects repeatedly observed as lacking in the interaction between health providers and health service users. Certainly, if this incorporation of the social sciences and humanities is considered from an epistemological dimension this will probably mean more than the incorporation of just one or two humanities and social sciences courses, which is what many education programs currently provide. Inasmuch as epistemology underpins how we know what we know and how we validate our knowledge, and therefore shapes our world-view, the contemporary emerging picture is that we know according to differing epistemologies and not just the positivist one with regard to issues of health and illness.[2-4]

Expressed in a metaphorical way, this incorporation might be summarized in the two figures ('disease in the body' and 'disease in the body of the person suffering') used by Ghaemi in his book: "The Rise and fall of the Biopsychosocial Model: Reconciling Art & Science in Psychiatry".[5] According to him, in some cases the emphasis on the scientific side only (the disease) ignores the other side of the issue, which is the person suffering (the moral, personal, relational and ethical). Paraphrasing his work, it seems sensible to ask whether it is the main role of the health sciences to know and understand just the 'disease in the body', or also to know and understand the 'disease in the body of the person suffering'. The epistemological implications of these two ways of knowing even seem to find an echo in the WHO Global Report of 2000, which states that one of the objectives of any health system is to respond equally to the medical and non-medical expectations of its users, implying that ignoring either one is indicative of an ineffective and less compassionate health system.[6] Non-medical issues such as the quality of the communication between health professionals and patients and carers, their gender, their cultural background, age, disability, sexual orientation, caste, and even

the immigration status of the patients, as well as the moral, personal, relational and ethical aspects, could in some cases, if not understood compassionately, add to the suffering of people who are already feeling ill, as interestingly illustrated by Kleinman in his social suffering perspective or theory.[7,8]

Thus, with the aim of offering some arguments from a social sciences and humanities perspective, the main argument of this review is that the lack of serious teaching and exposure of health professionals and practitioners to other epistemologies (besides the positivist one) in health sciences education comes at an increasingly emotional, human and financial cost to all stakeholders involved in issues related to matters of health and disease: sufferers, carers, communities, health services, health professionals and states. The reason why this is still common practice is an important consideration in this review.

World-views as ways of knowing

An increasing and significant trend during the past century has been that of generating a dialogue between fields, disciplines and ways of knowing that appear dissimilar, namely biomedicine, social sciences and humanities. The results of these efforts have been evidenced in the emergence of disciplines such as public health, medical sociology, medical anthropology, health communication, social epidemiology, art and medicine, medicine and literature, and the history of medicine. One implicit or explicit argument emanating from this search for dialogue and interdisciplinarity has been and is the notion that biomedicine as a mere science based on a positivist epistemology is no longer fully sufficient to treat diseases in human beings who are also emotional, relational, social, political, moral, linguistic, ethical and cultural creatures, and who adhere to various identity markers such as ethnic, religious, sexual, gender, class or caste. Yet, despite all efforts to promote dialogue, these world-views remain surprisingly imbalanced in health professionals' and practitioners' education in many cases. In fact, a common feature of the literature remains the tendency to talk in terms of 'two cultures' or a 'great divide' rather than talking in terms of the other 'missing' half of the health sciences: social sciences and humanities.[9,10]

The positivist epistemology, as pointed out by Tovar-Restrepo, is the one mentioned by Castoridis: the one immersed in scientism and rationalism and characterized by a set of

assumptions.[11] First and foremost is the assumption that the knowledge relation between health (the knowers) and the disease and/or the sufferers is objective, empirical and based largely on scientific facts. Second is the supposition that empirical and non-empirical research is built on the premise that physical bodies or diseases can be known universally like any other inanimate object without any emotional implications (the famous metaphor of the body as a machine). Third is the belief that matters of health and disease are guided chiefly by control and prediction as though these were just merely issues of science. Fourth is the assumption that knowledge about the biomedical human body is acquired only through direct observation and experimentation, as well as the view that the body, inasmuch as it is a basic material entity, is primarily orderly and knowable through its systems, organs, cells and genes by a cause-and-effect model of treating diseases, be they individual or public.

In methodological terms, the same positivist epistemology translates to the understanding that matters of health and disease can be fully understood simply through rigorous quantification or by measuring each and every aspect of a disease in human beings. Indeed, because symptoms and diagnoses have been based on statistical occurrence, there are difficulties in recognizing that disease frequently manifests itself differently in different individuals and that disease in a person is rarely a single, isolated diagnosis but is increasingly a complex series of interrelated factors. Finally, another assumption in methodological terms is the idea that health science researchers or practitioners are always objective and rational when they are communicating with patients or carers. This cyclical means of knowing and explaining acts as a self-reinforcing mechanism that propels a medicalised hierarchy of knowledge and power, driving a separation of the body from the person suffering and already disempowered through illness. This is the very same person who has to simultaneously make sense not only of her individual experience of illness, and of a loss of agency, but also of the healthcare system in which she has to negotiate her treatment.

The list of theoretical and methodological assumptions related to the positivist way of knowing described above, which is by no means exhaustive, points out a number of contested areas in which other ways of knowing or world-views might offer both valuable and necessary practical applications

to the relation between health practitioners and health service users and carers because they use objective and neutral research methods that focus only on quantifying. This is exactly the point at which the social sciences and humanities can be incorporated into health sciences. Other epistemologies, such as those deriving from phenomenology, critical theory, social constructionism, post-modernism or post-structuralism, bring interesting arguments at the moment of knowing and understanding. As Alderson, in a classic and very interesting piece of work at the end of the nineties, shows, the human and clinical experience of pain might be enriched were it to be understood from different epistemologies.[2] Likewise, Escobar, in the same direction and in a more general way, problematizes the Western model of science as a logo-centric world-view persuaded of the importance of managing knowable, controllable and predictable objects while despising others, such as indigenous ones. These indigenous systems in some cases are considered inferior because they are seen as failing to strictly organize the knowledge as the dominant model of Western science does, for example, when this model organizes the knowledge relationship between the biophysical, the human and the supernatural, as well as the real and non-real.

A global search for initiatives for a balanced program of education for health professionals and practitioners on epistemologies incorporating biomedical sciences and social sciences and humanities reveals that, in spite of increasing efforts, largely by medical schools, provision is not balanced. Furthermore, it is largely concentrated in medical schools with little trickle-down effect to other health sector stakeholders: nurses, healthcare assistants, technicians and, more importantly, administrators, managers of health systems and policy-makers. Moreover, it is mainly found in Western medical schools, generating an elitist approach commensurate with the origins of the biomedical tradition. Few national education and training systems around the world train health professionals and practitioners in other epistemologies, and they do not encourage them to think critically in a different way in terms of knowing and resolving matters of health and disease/illness. Arguably, however, as this review is seeking to demonstrate, health practitioners urgently need personal, relational, ethical, moral, cultural and linguistic skills in their training in order to help minimize negative global health outcomes.

Education in social sciences and humanities for health professionals and practitioners internationally

Taking a broad view across India, Colombia, the United Kingdom, the United States and Switzerland, and looking at these countries' progress in incorporating social sciences and humanities in the teaching of health sciences, such teaching ranges from the non-existent to the innovative, but it emerges primarily from schools of medicine. There is also an economic correlation. In low- and middle-income countries, unfortunately, it is not as forward-looking as in some high-income countries. In the former, even ministers of health and other regulative health authorities have little understanding of the role the social sciences and humanities might play in the amplification of epistemologies regarding issues of health and illness. In India, for example, the debate is relatively nascent, with a few special interest groups engaged in its incorporation.[12–15] Meanwhile, in Colombia serious efforts are both recent and challenging. Health science students in general, and students of medicine in particular, have traditionally compared social sciences and humanities (and the learning thereof) with 'sewing' (This concept has been reconfirmed in a discussion with medical students in Bogota, Colombia, by one of the authors of this article in February 2013). For these students, studying social sciences and humanities is seen as an engendered inferior task, and not worthy of a peer of science.

In the United Kingdom, efforts to promote incorporation are currently being made in most of the top universities, ranging from courses in Humanities faculties to discrete aspects of Humanities taught within Schools of Medicine. Incorporation ranges from elective courses to an in-built integrated approach in life sciences faculties and interdisciplinary medical research centres.[16] In the United States, there is a suggestion that "liberal education" or humanities was built into the Flexner Report over a hundred years ago.[1] However, the authors suggest that this seems to have been forgotten by most medical schools. Lastly, in Switzerland the effort emanates from a partnership between world organizations, a medical school and a network of health professionals around a growing international network of 'Person-centred Medicine'.[17]

Bringing together humanities scholars, social scientists and clinicians from different countries in 2013, the Centre for the Humanities and Health at King's College

London and the Program in Narrative Medicine of Columbia University, New York, launched an International Network for Narrative Medicine.[18] The network aims to accomplish the following: "to strategize means of influencing mainstream clinical institutions; to situate Narrative Medicine in the context of other clinical and scientific developments such as 'Personalized Medicine'; and to convene broad international interest in the place of narrative knowledge and practices in health care".[19]

Taking recent developments in the field further and thinking nationally and internationally, this paper proposes that the sense of crisis coming from the biomedical educative approach of treating 'the body of an individual' rather than 'the person suffering' can be alleviated by incorporating and integrating epistemological work from the social sciences and humanities. As initially suggested, other epistemologies, relational understandings and flexible world-views taught through the social sciences and humanities can offer ample perspectives to health professionals and practitioners in their daily challenge to handle, contextualize and acknowledge the stories of the sufferers and their relations with other humans and health systems. They might also help to foster an understanding that any issue of health and disease, and, by extension, suffering, exists within political, economic, social and cultural contexts, framed by the state and its unequal distribution of resources and ultimately located within the overarching context of international organizations such as the World Health Organization and the United Nations.

Medicine and health are not de-economized, de-socialized, de-politicized and de-culturalised activities.[20] This view is in need of a balanced critical debate both from within a positivist medical world-view and from emergent narrative approaches to biomedicine. Just as illness means different things in different contexts and is also defined by these, so narrative and experiences are complex and organic interactive systems; however, too great a focus on a humanities-based approach, concentrating on individual stories and experiences of illness or disease, risks devaluing other economic, social, political and cultural aspects of health and illness. Nonetheless, social sciences and humanities might help health workers to act imaginatively and to grasp what many current formal teaching methods do not cover. Lastly, incorporation of various epistemologies would certainly offer practical tools, critical thinking

resources and empowerment for working with conflictual and uncertain policies, and social and cultural phenomena, which are the norm in our contemporary world.

Conclusion

As this review argues, the need to incorporate a more balanced approach in health sciences and healthcare education by bonding the epistemological world-views of social sciences and humanities is an urgent teaching and training task. This is especially true of the developing world (Africa, Latin America and Asia). It is critical to understand that matters of health and disease/illness are not only about the 'disease in the body' but also the 'disease in the body of the person suffering', i.e. her lived reality. Similarly, the pretence of a continuous objectivity and rational communication is an inadequate assumption in a relationship that takes place between two people (i.e. doctor and patient) rather than a person and a perceived object

(i.e. doctor and disease), or between a person who is suffering or in pain and a person who is not. As an ethics of care, the understandings afforded by these more inclusive ways of knowing should not be a privilege confined to medical schools that are, in many cases, the most prestigious and elite educational environments. There is an urgent and hitherto largely ignored need to spread the richness of the world-view(s) presented through the social sciences and humanities more equally rather than as marginal appendices to health professionals and practitioners. This task lies in the hands of supportive, ethically- and morally-oriented policy-makers and qualified educators. Education in general, and medical and health sciences education and training in particular, is responsible for initiating and maintaining the divisions and lack of balance that currently exist within the sector between these differing world-views.

References

1. Rabow MW, Remen RN, Parmelee DX, Inui TS. Professional formation: extending medicine's lineage of service into the next century. *Acad Med.* 2010;85(2):310–7. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20107361>
2. Alderson P. The importance of theories in health care. *BMJ.* 1998;317(7164):1007–10. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1114019&tool=pmcentrez&rendertype=abstract>
3. Moreno-Leguizamon CJ, Spigner C. Theory, Research and Practice in Public Health. In: Stewart J, Cornish Y, editors. *Professional Practice in Public Health.* Devon, UK: Reflect Press Ltd;2009. P.11-37.
4. Jones-Devitt S, Smith L. *Critical Thinking in Health and Social Care.* London: Sage Publications Ltd;2007.
5. Ghaemi SN. The rise and fall of the biopsychosocial model. *Br J Psychiatry.* 2009;195(1):3–4. Available from: <http://bjp.rcpsych.org/content/195/1/3>
6. The world health report 2000 – Health systems: improving performance. Geneva: World Health Organization;2000 [cited 2015 Sep 25]. Available from: <http://www.who.int/whr/2000/en/>
7. Babatunde T, Moreno-Leguizamon CJ. Daily and cultural issues of postnatal depression in African women immigrants in South East London: Tips for health professionals. *Nursing Research and Practice* [Internet]. 2012 [cited 2015 Sep 25]. doi:10.1155/2012/181640
8. Kleinman A. Four social theories for global health. *Lancet.* 2010;375(9725):1518-9. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20440871>
9. Kleinman A. Borderlands: professional life lived precariously but happily in anthropology and medicine. *Med Humanit* [Internet]. 2009 [cited 2015 Sep 25];35(1):6. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23674624>
10. Muncey T. Mixing art and science: A bridge over troubled waters or a bridge too far? *J Res Nurs.* 2006;11(3):223–33. Available from: http://www.researchgate.net/publication/244918995_Mixing_art_and_science_A_bridge_over_troubled_waters_or_a_bridge_too_far
11. Tovar-Restrepo M. Castoriadis, Foucault, and Autonomy: New Approaches to Subjectivity, Society, and Social Change (Bloomsbury Studies in Continental Philosophy). New York: Bloomsbury Academic; 2014.

12. Ramaswamy R. "Medical humanities" for India. *Indian J Med Ethics*. 2012;9(3):144-147. Available from: <http://www.issuesinmedicalethics.org/index.php/ijme/article/view/96>
13. Gupta R, Singh S, Kotru M. Reaching people through medical humanities: An initiative. *J Educ Eval Health Prof* [Internet]. 2011 [cited 2015 Apr 28];8:5. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3110875&tool=pmcentrez&rendertype=abstract>
14. Singh N. Whither medical humanities? *Indian J Med Ethics*. 2012;9(3):166-9. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22864074>
15. Supe A. Medical humanities in the undergraduate medical curriculum. *Indian J Med Ethics*. 2012;9(4):263-5. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23099601>
16. Borsay A. Humanidades médicas: orígenes y destinos. *Ars medica. Revista de humanidades*. 2007;6(1):138-46. Spanish.
17. Mezzich JE. The Geneva Conferences and the emergence of the International Network for Person-centered Medicine. *J Eval Clin Pract* [Internet]. 2011 [cited 2015 Sep 25];17(2):333-6. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21114715>
18. Hurwitz B, Charon R. A narrative future for health care. *Lancet*. 2013;381(9881):1886-7. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23725717>
19. Narrative Medicine Conference [Internet]. London: King's College London;2015 [cited 2015 Sep 25]. Available from: <http://www.kcl.ac.uk/innovation/groups/chh/Narrative-Medicine-Conference-/About-the-Narrative-Medicine-conference.aspx>
20. Moreno-Leguizamon CJ. Ayurveda, Biomedicine, and Indigenous Medicine: Three Medical Discourses, One Critical Discourse Analysis (CDA). Germany: Lambert Academic Publishing;2012.
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