

## Conducting a Voluntary Module – Personal Experiences

P. Ravi Shankar<sup>1\*</sup>

### The Medical Humanities

The Medical Humanities have been defined as the incorporation of humanities- and arts-based teaching materials into medical school and residency curricula [1]. It has been mentioned that medical school manages to beat the storytelling out of medical students and to convince them that the word 'care' means a list of behavioral skills and billable services [2]. In the west, the Medical Humanities movement aims to acknowledge that connection is more effective than detachment, that personal reflection is more important than recall, and that moral imagination and self-understanding are essential attributes of the minimally good physician [2]. Medical Humanities programs are common in medical schools in the United States of America (USA), the United Kingdom (UK), Argentina, many countries of Europe, New Zealand and Israel.

### South Asia

South Asia is a big region and has a large proportion of the world's population. The countries of the region (India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan and Maldives) have formed the South Asian Association for Regional Cooperation (SAARC). In South Asia Medical Humanities programs are not common. Voluntary modules are not common in South Asian medical schools. Students have to attend classes and a minimum percentage of attendance is mandatory before they can appear in the final examinations. Students attend classes for a variety of reasons. However, attendance requirement may be an important one. In South Asia, the undergraduate medical course (MBBS) is of four and half year's duration and is followed by a one-year rotating internship. In Nepal, the basic science subjects are taught during the first four semesters (as described later) while in India, the subjects of Anatomy, Physiology and Biochemistry are taught during the first year of the course after which students attend clinical postings and study other subjects.

### The Medical Humanities and Medical Education

According to the author a certain amount of teaching and learning of the Medical Humanities (MH) is required in South Asian medical schools. The arts can contribute to medical practice in a variety of ways. The arts may stimulate insight into common patterns of responses (shared human experiences), insight into individual differences or uniqueness and enrich the language and thought of the practitioner [3]. Literary narratives depicting medical situations may serve as tes-

timonials of the way in which medicine has been practiced in a variety of social settings, and of the ways patients and their relations and friends experience disease and medical care [4]. A voluntary module on MH may serve as an introduction to the subject and can serve to ease for inclusion of MH in the medical curriculum later. I describe here our efforts to create a voluntary module, the challenges faced in recruiting students, and changes made mid-course to retain those who joined. The paper concludes with lessons learned.

### The author and the institution:

The author is a clinical pharmacologist and work at the Manipal College of Medical Sciences (MCOMS), Pokhara, Nepal. Pokhara is a lakeside resort town at the foot of the magnificent Annapurnas and attracts thousands of tourists every year. The college admits students of different nationalities (Nepalese, Indians, Sri Lankans and others) to the undergraduate medical (MBBS) course. At MCOMS, the basic science subjects of Anatomy, Physiology, Biochemistry, Pharmacology, Pathology, Community Medicine and Microbiology are taught during the first four semesters in an integrated organ-system based manner supplemented with regular hospital visits. The clinical subjects are taught from the fifth semester. The same system is followed in all Nepalese medical schools.

### Voluntary Medical Humanities module:

With the support of the department of Medical Education I decided to start a voluntary module on the Medical Humanities. I identified certain 'core areas' to be emphasized. Among these were empathy, the patient, the care giver, breaking bad news and the doctor-patient relationship among others. I tried to address these issues from a South Asian perspective. I wanted the participation of the three main nationalities for the module. However, the majority of the participants were Nepalese. Indians also participated but only one student of Sri Lankan extraction participated. I was of the opinion that one of the best ways of recruiting participants was to talk personally to all the students about the module. To inform all the students the dean was of the opinion that we have to put up notices announcing the module. Ultimately we followed both approaches.

Initially my main focus was on the fifth semester. These students had just entered the clinical phase of study and were supposedly freer than the other batches. However, the students who were interested in MH were already members of

the Poor Patient Fund (an organization which helps out the poor patients of our hospital monetarily and in other ways). Due to their responsibilities towards the fund they found it impossible to take time out for the module. I soon shifted my focus to the sixth semester.

The third semester basic science students were very interested in MH. A group approached me with a request to organize a module for them. I obliged! I was of the opinion that it was necessary to give something 'concrete' to the participants as reassurance that they were making 'significant' progress. Each participant was given a course description, a student guide and list of suggested reading. Initially a 'concept map' was also given summarizing the major topics covered during the session and their interrelationships. Copies of the literature excerpts and case scenarios were also given to the participants.

### Making the module interesting and informative

Ensuring participation in a voluntary module would be difficult unless the sessions are made interesting and informative. Interactive, activity-based, small group teaching has already been used during the practical sessions in pharmacology. I decided to use the same techniques during the MH module.

### Module objectives

- The specific intended achievements of the module were
- To promote the skill of reflective thinking among the students
- To foster cultural sensitivity and self-awareness
- Introduce students to Medical Humanities
- Model and nurture attitudes important for clinical practice in a social context: tolerance, empathy, altruism, compassion, curiosity and caring
- To foster the 'ethical' practice of medicine by the students
- In addition there were specific objectives for each of the units. For the unit one namely Medicine and the Arts the objectives were defined as follows. At the end of this unit you will be able to:
  - Appreciate the patient perspective of sickness and health
  - Have a knowledge of the effect of disease and sickness of a loved one on the caregiver
  - Be aware of the doctor-patient relationship and recent developments in this vital area
  - Be able to break bad news more gently and humanely
  - Appreciate the importance of deprivation of healthcare on populations and
  - Be 'aware' of death.

### Sources of support

MH modules are common in developed countries. As a result of my literature review I became conversant with many of these modules. A common feature which I found was the use of literature and art excerpts to explore issues in the Humanities. I resolved to use literature in the MCOMS module. A major problem I faced was that the excerpts were generally from western countries. Teachers of MH programs elsewhere were very supportive and offered and gave a considerable amount of help.

Anne Farmakidis of 'Academic Medicine' had sent me a copy of the book 'Ten years of Medicine and the Arts'. I found

this book very useful. On reflection, I reached the conclusion that though the excerpts were from western literature, the themes they covered were universal. These excerpts were used to explore the humanities during the module. The book of photographs with short captions of the violent conflict in Nepal edited by Kunda Dixit was also found useful. Issues like death, separation, destruction of health infrastructure could be explored through the photographs.

Another very useful resource was the Literature, Arts and Medicine database (<http://litmed.med.nyu.edu>). The annotated poems, short story excerpts and paintings were very useful for the module. Occasionally I also used literature by South Asian authors. Two sources of support that I should specially mention are Dr. Rakesh Biswas of the Melaka-Manipal Medical College in Malaysia and Dr. Johanna Shapiro of the University of California, College of Medicine at Irvine.

### Preparing for the module

In the preparation stage I resolved to draw up lesson plans and learning objectives for each of the sessions. The module had three units, Medicine and the Arts, Ethics and Medicine and Cotemporary issues in Medicine. The module was planned to be conducted outside the usual college hours. Each session opened with a short introduction of the topic by the facilitator. Students were divided into small groups of five or six students each and interested faculty members also participated. The groups were allotted a literature/art excerpt which they analyzed with regard to the topic of the session. The groups presented their analysis and this was followed by a discussion. Case scenarios were distributed and the participants had to analyze the issues involved and develop a plan of action. The plan of action and the analysis were presented through the medium of role plays.

### Creating interest, stimulating participation:

The biggest problem I faced was creating interest in the module. Students said they were interested but did not turn up for the session. Some came for a session or came for the initial discussion and then dropped out. I was feeling very frustrated that the module was not taking off despite all the efforts which I had put in. The sessions were held in the afternoon during the lunch break or in the evening after dinner. Initially the participation was poor! Certain sessions had only three or four participants. I decided as far as possible not to cancel a session. My rule of thumb was to conduct the session if we had a minimum of three participants. It was difficult to conduct a session and carry on as if everything was normal when the turnout was poor.

### Flexibility, the key

I initially started by giving a reflective writing assignment to the participants. However, while some liked writing and putting their thoughts on paper, others were petrified of the prospect! Flexibility was the key to success and I waived the requirement of reflective writing for certain participants initially. Later as became more familiar with the module they slowly started putting down their thoughts on paper. There were differences among the participants with regard to their approach to the humanities. Some liked to explore it through literature and art while others were more in favor of case scenarios and role plays.

## Literature excerpts

The literature excerpts employed were 'Madame Bovary' by Gustave Flaubert (in translation), 'What the Doctor Said' by Raymond Carver, 'The English Patient' by Michael Ondaatje, 'Recovering' by May Sarton, 'Uncle Curly's Heart Song' by Ron Moran, and 'Their eyes were watching God' by Zora Neale Hurston among others. The excerpt from Madam Bovary describes a town pharmacist convincing a stable boy to enroll for a new operation for clubfoot. 'What the doctor said' describes how the doctor broke the news to a patient that he is suffering from lung cancer. 'The English Patient' is a famous novel which had been made into a movie and describes Hana, a nurse and her patient who has suffered severe burns and cannot be moved. These are the two persons remaining in a wartime hospital in Tuscany, Italy.

The participants were given the literature excerpt and each session had a particular topic like empathy, the patient, the care giver and the group had to analyze the excerpt from the perspective of the topic.

## Case scenarios and debates

The following scenario was used during the session on 'Rural service for medical students should it be made mandatory?'

'Jasmine is a doctor working with a health NGO in Kathmandu. Recently the organization has decided to transfer Jasmine to their office in Mugu district (a remote district in far western Nepal). She is not keen on forsaking the pleasures of Kathmandu. Her boyfriend runs a dance restaurant in Thamel (a tourist area of Kathmandu) and has never heard of Mugu. He has no intention of leaving the Kathmandu valley. Jasmine's father is an ardent nationalist and wants his daughter to take up the assignment.'

In Nepal, most of the facilities and opportunities are concentrated in the capital, Kathmandu. Most people are reluctant to leave the valley. There are a number of NGOs active in the health sector in Nepal. Mugu is a remote district in the northwestern corner of Nepal and is underserved by the healthcare system.

Dance restaurants are becoming more common in the cities of Nepal. Some of them serve as centers for prostitution and may contribute to the HIV epidemic. It is only recently that women are joining the medical profession in large numbers and family members may be reluctant to send their daughters/sisters far away from home. Jasmine's father is a notable exception. There is a vast difference in healthcare and socioeconomic conditions between the cities and the rural areas. This may have contributed to the violent Maoist uprising.

Debates were organized during the unit on 'Contemporary Issues in Medicine'. The debates were interesting and informative with a group of participants speaking in favor of the topic while another group spoke against the topic.

## The sessions

The facilitator had drawn up lesson plans and learning objectives for each of the sessions and for the unit as a whole. The session was organized according to the lesson plan but a certain amount of flexibility was required. The session started with a short description of the topic by the facilitator. Then the participants were divided into small groups. To promote greater interaction, the groups were changed for each ses-

sion. The groups were given a literature or art excerpt and had to analyze it from the perspective of the topic being discussed. This was followed by presentations and discussion. Each session had a philosophy 'bite' where aspects of the Philosophy of Medicine were discussed for around ten minutes[5]. Then the case scenarios were distributed and the groups had to analyze the issues involved and work out a plan of action using the medium of role-play.

The participants completed a session evaluation form at the end of each session. For certain sessions, the participants were asked to submit a reflective write up on the session. The participants assessed the facilitator on the characteristics of professionalism, ability to facilitate the session, creating a non-threatening and friendly atmosphere, informality, sense of humor and design of the session among others.<sup>5</sup> The extent to which the participants felt the objectives of the session were realized and the relevance of the literature and art excerpts to the subject under discussion were assessed by the participants. The participants felt the session achieved the stated objectives to more than 80%.<sup>5</sup> The author felt that the participants had achieved the stated objectives to more than 80% on an average and they should continue to use the skills learned during the clinical postings, internship training and further practice.

## Assessment

There was no traditional assessment in the module. The participants were assessed through their participation in the group activities and their reflective writing assignments. Some of the students and faculty members turned out to be powerful writers. Others improved significantly as the module progressed.

## Sources of support

My colleague, Subish, In Charge, Pharmaceutical Services was kind enough to allow the use of a conference room adjacent to the Drug Information Centre (DIC) in the hospital for the sessions. He was an enthusiastic participant. The dean of the institution at the time, Dr. S.K.Dham was also supportive. The amount of material to be photocopied for the sessions was beginning to become enormous. The conference room provided a safe, supportive and comfortable environment for the sessions. Certain faculty participants in the module also provided considerable support.

## Feedback, the Google group

The participants were provided with regular assessment reports throughout the module. Assessment was two way and the participants regularly evaluated the facilitator and the sessions. Informal feedback was obtained throughout. Constructive feedback and criticism was valued. The facilitator created a Google group on the web for the participants. The study material, assignments, session reports were all placed on the site. However, the culture of Internet use is not that widespread in South Asia and the group was only moderately successful in terms of participation.

## Thank you notes

Twice during the module 'Thank You' notes were distributed to the participants which had a photograph of a beautiful lo-

cation of Nepal, a very scenic country. These were very much appreciated. Another important thing I resolved was never to raise my voice or lose my temper or appear put out and depressed no matter the provocation. I think that overall I did succeed in this endeavor.

### Spreading the word:

Word about the module spread and more participants started joining. My colleague, Subish was very helpful in talking to participants and interesting them in the module. Our selling point was come and try the module for one or two sessions; if you find it interesting continue otherwise feel free to quit. However, except some of the fifth semester PPF students no one actually quit. They also were very interested in the session but they were seldom free during the evenings. I had to conduct 'catch up' sessions for the participants who had joined the course midway. As mentioned before, flexibility was important. Some participants occasionally missed certain sessions due to pressing reasons and these were covered again. The participants began to enjoy themselves tremendously and the role plays were becoming more creative and reflective of the realities of life.

We served tea during the module. As we had no financial support nothing more could be provided. I decided not to accept sponsorship from a pharmaceutical company as I believe dealing with aggressive pharmaceutical promotion is also important for students to learn. This issue has connections with the Medical Humanities and may be diluted if the module is sponsored by a company.

Debates were used during the unit on Contemporary Issues in Medicine. The debates were interesting and able to reflect various aspects of the topic. Some times we (I and the other faculty participants) had a tough time controlling the debaters! At the end of the module, certificates and a letter detailing the specific skills achieved by the participants were distributed.

Around forty students expressed initial interest but only 24 showed up for the sessions. Of these two dropped out later due to various reasons. Altogether, 28 persons (22 students and six faculty members) participated in the module. Eight students were from the third semester, three were from the fifth semester and eleven were from the sixth semester while six were faculty members. The module was conducted over a seven-week period. Participant feedback on the module was positive and the participants enjoyed being a part of the module [5]. The third semester students were studying the basic science subjects while the sixth semester students were studying the clinical subjects of Medicine, Surgery, Obstetrics and Gynecology, Ophthalmology, Otorhinolaryngology and Community Medicine. All the students who had joined completed the module.

### Future plans and changes required

The participants were of the opinion that the literature and art excerpts mainly reflected a western perspective and may not always be relevant to a South Asian context. In the future modules I am planning to use more literature and art excerpts from South Asia. Also the faculty members who had attended the pioneering module could serve as resource persons for subsequent module. The module duration can be extended by a week to reduce pressure on the participants

I am also planning an familiarizing module of around two and half hours duration for students using case scenarios and role plays and those who find Medical Humanities to their liking can then pursue the eight-week module. Sessions on 'So-

cial issues in use of medicines' are underway for the students.

The case scenarios and the debates were relevant to the module objectives. Participants also suggested certain topics such as euthanasia, medical tourism, or women in medicine could be covered in the module [5].

### Conclusions and lessons learned

The participant opinion regarding the module was positive. Students enjoyed working in groups and analyzing the literature and art excerpts and exploring case scenarios through role plays. It was a different experience. The students enjoyed learning together with the faculty members and the faculty participants also enjoyed learning with the students. Medical Humanities can help to introduce students in Nepal and South Asia to socioeconomic realities and help to orient practice in a sociocultural context. It can emphasize the 'art' of medicine. This pioneering module can help other South Asian medical schools to introduce MH in the curriculum.

I personally believe that creating a safe and supportive environment where the students could be themselves, could make mistakes, could have fun and be creative was crucial to the success of the module. The participants and the facilitator enjoyed being a part of the voluntary Medical Humanities module.

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I. First Author: Dr. P.Ravi Shankar MD  
Department of Pharmacology  
Manipal College of Medical Sciences  
Pokhara, Nepal

\*Corresponding Author:  
P.Ravi Shankar MD  
Manipal College of Medical Sciences  
P.O.Box 155  
Deep Heights  
Pokhara, Nepal.  
Phone: 00977-61-527862  
Fax: 00977-61-440260  
E-mail: ravi.dr.shankar@gmail.com

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