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1. What and how can history and medicine contribute to Medical Humanities?

Let me slightly rephrase this question in order to make it better reflect my approach: "What can teaching and studying past medicine in conjunction with contemporary medicine contribute to medical humanities?

I'll begin by noting that in my medical humanities classes, I always combine the past with the present. Students always read a text in the history of medicine and its cultural contexts together with a "parallel" text from contemporary developments in medicine. This combining reflects my perspective regarding the role of history and medicine in medical humanities.

In terms of history, I attempt to combine three somewhat different perspectives. In the first, I teach the history of medicine "for its own sake"—i.e., in order to inform the students of the history of the development of medicine (but not in order to memorize the historical record). In the second, the historical developments are situated in their historical-cultural contexts. Past medical knowledge and praxis are studied not only in terms of a history of scientific developments, but also in terms of those historical contexts that were relevant for medical science and praxis (e.g., race, gender, competing knowledge-healing systems, etc.). In the third, I combine these two historical perspectives together with cotemporary developments in medicine. Here, history is a reflective tool for analyzing-questioning-critiquing-contemplating present medicine and its contexts. The history of medicine in its cultural-social context is juxtaposed with contemporary medicine in order to help the

students critically reflect on the social-cultural-ethical contexts, dimensions, and assumptions of their-our 21st-century Western medicine.

I present this general approach in class in terms of numerous case studies. These studies encourage a reflective-critical stance vis-à-vis contemporary medicine. Thus, we read contemporary reactions to SARS and to Ebola in light of the historical shift to obligatory reporting of sick individuals to state authorities by medical doctors. We raise numerous questions and issues for discussion: since when did it supposedly become obvious that physicians need--in fact have—to report highly personal and confidential information regarding their patients to the state; how did this obviousness develop; what were the ethical, social, and medical contexts of this shift to "medical police;" and more. Our aim is to reflect on contemporary practices in light of the history of these developments and their underlying assumptions with respect to: the individual vs. the collective in medicine (and beyond), medical ethics, public health ethics, the physician vs. the state, and more.

Another brief example, in order to exemplify this approach, takes off from a succinct historical study of the medical study of pre-menstrual syndrome during the first half of the twentieth century. We discuss this historical study in conjunction with contemporary debates and literatures regarding: the "pathology" of premenstrual syndrome and legal responsibility (or lack thereof), the "fit" between social assumptions and (some) women's menstruating bodies, contraceptive pills that guarantee only 4 menstrual cycles per year, Facebook's censure of a series of pictures posted by a woman of her sister's "stained" pants during menstrual bleeding, the history of the Women's Health Initiative, and the recent Sex as a Biological Variable initiative. The juxtaposition of past and present encourages and enables students to

reflectively-critically, and socially-culturally-ethically, situate our contemporary science and medicine.

(2) **How do your research and other academic activities link to Medical Humanities?**

With respect to my research: My expertise is in the cultural history of modern Western medicine and the life sciences (19^{th}-21^{st} centuries). My specific interest is in the history of the scientific-physiological study of emotions from mid-nineteenth century to the Second World War and the history of post-war neurophysiology of pleasure and reward. Thus, I do not focus specifically on "medical humanities" *per se*. However, my approach and methodology are very pertinent for medical humanities—as I conceive it in teaching medical humanities and in my activities beyond academia. In the most general sense and succinctly put, I attempt in my research to study the history of science and medicine within their cultural-scientific contexts. My focus is on the analysis of scientific-medical knowledge and praxis within a specific cultural milieu.

With respect to teaching: I teach a variety of courses in three different faculties: The Medical Faculty (not limited to the Medical School), the Faculty of the Humanities, and the Veterinary Medical School (Faculty of Agricultural and Environmental Sciences). All of my courses in these three faculties focus on the interrelationships between science/medicine and society. Some of my courses are "pure" ethics classes. In these courses (public health ethics, genetics and ethics, and animal-veterinary ethics), I teach primarily, but never exclusively, different ethical approaches and principles (e.g., utilitarianism, environmental ethics, distributive justice, Telos, relational ethics, etc.). In these ethics courses, I always make a point of presenting the ethics together with an historical-cultural background. There are many reasons for this. One major reason is that the abstract principles embody cultural-scientific-ethical

assumptions. In my classes, I attempt to unpack for the students these often "invisible" assumptions and to read the abstract principles also in terms of their contexts. A second and more practical reason for teaching ethics historically is that I often find that it is easier for science students to understand the ethics when it is presented historically.

The second type of courses that I teach are not "pure" ethics courses. In these latter courses (the values of medicine, historical-cultural approaches to medicine, gender and science, and critical approaches to science), ethics always comes up; or rather, questions that pertain to science/medicine and values and ideologies are always immanently present and discussed.

With respect to other activities: I have been—and still am--a member of a number of ethics committees in the Ministry of Health, The Hebrew University, and the Israel Academy of Sciences and Humanities. As a participant in these committees, which straddle science and ethics, I attempt to bring the perspective of the humanities writ large to these applied science and medicine committees. One of my greatest challenges, which, I believe, also sheds light on a general challenge for medical humanities, is how to present, quickly and succinctly, the humanities' perspectives to an audience, which is not versed in the humanities? The humanities' perspectives and approaches are not only quite (very) distinct from the perspectives of the natural sciences and medicine, but the modes of argumentation, exposition, and narrative structure require (a lot of) time. I find that in the context of "mixed" science-humanities ethics committees, it is often very difficult to present in just a very few minutes a humanities-type argument. This is especially so in comparison to the scientific mode of presentation, which sometimes can be summarized, literally, in a "number," e.g., the statistical significance of a finding. This is one of the challenges

of medical humanities (see below) –its mode of argumentation and exposition are very difficult to convey in a 5-minute PowerPoint presentation.

(3) **How are you dealing with the transdisciplinary challenges of Medical Humanities?**

In addition to the above challenge, I see a number of difficulties for the transdisciplinary field of medical humanities, from the more trivial (or seemingly so) to more major ones. The first seemingly trivial—but in fact quite significant—challenge is the distinct languages—terminologies/"words"--of medicine and the humanities. A lecturer from the humanities, who teaches in a medical faculty, might find it challenging to engage medical students, who will respond in terms of the technical-scientific terms of science. This becomes particularly pertinent when teaching a critical literature, which challenges and disrupts some of the students' basic assumptions with respect to science-medicine. I believe that it is crucial in order to avoid this problem that one be well versed in both languages—so to speak.

Reciprocally, science students and professionals are not well versed in reading humanities texts. The humanities-type of prose may be quite difficult, especially for non-native speakers of English, like my Israeli medical/science students and colleagues. Reading humanities texts requires a higher level of English than reading science. I overcome this—seemingly trivial but high-impact--challenge by being very selective in the texts that I teach in the medical faculty – not only in terms of the language, but also in terms of the sophistication of the arguments. Sometimes, I have to settle for less, in order to achieve more.

This leads me to the third and most difficult challenge: the distinct paradigms—i.e., the underlying assumptions, aims, modes of argumentation and proof, narrative structure, etc.--of the natural sciences and the humanities. First, I note that the humanities-science gap is not necessarily and perforce an issue that will come

up. It depends on one's perspective regarding the different aims and possibilities of teaching and doing medical humanities. It is legitimate and possible to teach-do medical humanities without this being an issue at all.

My specific approach is different, almost the contrary. It is to choose some of the more critical literature and to challenge the students. It is to question their-our assumptions. This specific approach necessarily accentuates and makes more obvious the gap between the humanities and the sciences. In overcoming this gap and challenge, I attempt to select texts that can be read in terms of different registers. They can be read semi-naively, i.e., they make sense to science and medicine readers, because their more challenging assumptions or *underlying* arguments are often invisible to naïve readers. These texts are first discussed in class in terms of their overt and naïve reading. Following this semi-naïve reading, the more radical and challenging aspects, which are very often "invisible" to non-humanities students and teachers, can be introduced.

One example in order to illustrate this approach is a text that I use for discussing with the class the medicalization of homosexuality. We read a nuanced social-historical analysis of the social forces, disciplinary developments, and the individual agencies of particular historical actors, which combined to create the *medical* category of homosexuality in the late-nineteenth century. This same text also presents the History of Sexuality thesis and exemplifies a constructivist paradigm. While the students understand and appreciate the social, disciplinary, and agential motivations and developments discussed in the essay, they are completely oblivious to the constructivist and historicizing perspective that undergirds the analysis as a whole. In class, I always begin by discussing the overt and explicit arguments, which make perfect sense to the students, and only then (and slowly) shift to the more

constructivist argument, which opens up a new set of questions that now become the main focus of our discussions.

(4) **What do you consider to be particularly important for the field? Which chances and pitfalls do you see?**

I'll begin by posing two questions: Is there, and what is, the core that holds the medical humanities together? Is there a core of objectives, values, and assumptions that is shared across the medical humanities; or is it a field that is held together by nothing more than the mere fact that it uses the humanities in/for medicine? It sometimes seems to me that there is no shared core to the field of medical humanities, other than the mere fact that one applies the humanities—in many different ways and many different sub-disciplines of the humanities—to medicine. The humanities in medical humanities, at least as they seem to appear in some of our medical humanities, are a tool-box that one draws on in order to promote-develop-inculcate a variety of different sensibilities, perspectives, values, and competences that are important for medicine writ large—be it empathy, communication skills, cultural or structural competence, or how to be a virtuous physician.

These latter are worthy objectives, but they reflect medical interests and motivations, rather than necessarily the concerns of the humanities themselves. This leads me to the following set of challenges or questions: Do we wish to formulate a set of core objectives-values for the dispersed field of medical humanities? Should we purse a shared vision? Should this vision reflect the medical perspective, whereby the humanities are a tool-box for achieving this latter—medical--perspective; or should our field also incorporate the perspectives-objectives-values of the humanities?

It might already be obvious that I wish to emphasize and push a bit more the perspectives and the agendas of the humanities in medical humanities. In my classes, I

do not use the humanities in order to develop empathy, to improve communicative skills, and so forth. Rather, I use the humanities in terms of one of their core values--critique. One of the challenges that follows on this perspective is how to bring the critique of the humanities into medicine, without taking away the edge of this critique, while at the same time, making the critique actionable and applicable to medicine (rather than just be a form of "criticism"). Some of the more substantial contributions of the humanities are practically more difficult to immediately implement and can-should initiate (sometimes protracted) deliberations with respect to values, assumptions, and ideologies. They do not necessarily proffer a "bottom line" and, as I mentioned above, are not always conveyable via a PowerPoint or PowerPoint-like presentation.

I thus worry that the medical humanities might become overly "medicalized;" that we might exclude the "spirit" of the humanities from medical humanities. The medicalization of the humanities also misinforms our science and medicine students and our medical colleagues regarding what the humanities are all about.

In the face of these challenges, there are numerous possible opportunities for our field. These include: 1. Explicitly exteriorizing these tensions and creating a *real* medicine-humanities "medical humanities." 2. Deliberating the great diversity of perspectives in medical humanities and establishing a more coherent field. 3. Encouraging and enabling more sustained *personal* interactions between the natural sciences and the humanities. The medical humanities are potentially the ideal field for enabling close encounters between scientists and humanists and science and the humanities.