Rejuvenating Medical Education

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Seeking Help from Homer

By

Robert Marshall and Alan Bleakley

Cambridge
Scholars
Publishing

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This book first published 2017

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-4438-9564-4
ISBN (13): 978-1-4438-9564-4

By Way of an Apology

This book is tough on medicine and medical education, but for good reasons – our aim is to encourage constant quality improvement to provide best patient care and safety. We do not set out to engage in "doctor bashing" – we recognise that most doctors are doing an exceptional job under extreme pressures, the foremost being organisational pressure due to lack of resources. We applaud English NHS junior doctors for their widespread resistance in the face of this political situation.

Our concern in this book is another set of pressures on performance that can remain unconscious for many doctors but that need to be unearthed and addressed. These include lingering subscription to the historical and cultural legacy of metaphors and practices of "heroic medicine", no longer fit for a contemporary team-based, patient-centred approach. There are also persistent problems in medical education such as failing to address patient safety issues grounded in poor clinical teamwork. Finally, poor self-care persists amongst some doctors, and this is not good for them, their patients or their colleagues. Such doctors should be offered understanding and support. We hope that our audience, many of whom will be doctors, see our book as encouragement for improvement and not as finger-wagging from a moral high ground!

Figure a-1: The authors as Greek warriors and adventurers, Marshall of the cricket bat and Bleakley of the surfboard.

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ACKNOWLEDGEMENTS

Robert Marshall dedicates this book to his wife Annie, with love and thanks.

Alan Bleakley would like to acknowledge the loving support of his wife Sue and his family, who recognise that writing can turn you by turns into recluse, grump, and unsavoury beast, according to current theme and topic. This is amplified in the case of Homeric epic, where every twist and turn is lived out psychologically and metaphorically, if not literally. Homer has made me bone tired in the best possible way.

The authors have benefitted enormously from conversations with Professor Helen King (Open University), Dr Elton Barker (Open University), and Dr Katherine Harloe (University of Reading).

We are grateful to the following journals, in which earlier versions of some of these chapters appeared: *Medical Humanities* (*BMJ* group), *Performance Research*, and *The Review of Communication*.

Our students at Peninsula Medical School (latterly Peninsula College of Medicine and Dentistry), Universities of Exeter and Plymouth, and then the University of Exeter Medical School and Plymouth University School of Medicine and Dentistry, have afforded inspiration and hope for the future of medicine, medical education and the medical humanities. We are particularly grateful to those medical students who made up our first two cohorts for the 4th year Special Study Unit "Homer and Communication in Medicine".

Special thanks go out to Dr David Levine, Victoria Rodulson, Jacob King, Elin Barham and Kirsten Leslie, who helped with some of the research and writing in three chapters.

Trish Greenhalgh, Professor of Primary Care Health Sciences at the Nuffield Department of Primary Care Health Sciences, University of Oxford, has been very generous in her support of our Homer and medicine project, and kindly agreed to write a Foreword to this book.

Alice Oswald, who read Classics at Oxford and has subsequently become one of the UK's leading poets, generously gave feedback on parts of this book.

Finally, we encourage all readers to keep copies of the *Iliad* and the *Odyssey* at the bedside. You never know when you might need them. They are our desert island books.

Authors' Notes

Translations of the *Iliad* and *Odyssey* are by Robert Marshall, except where stated otherwise. Line numbers for the epics refer to the Oxford University Press editions in the bibliography.

The names of Homer's characters and places, when rendered into English, can be a contentious issue. We have used names that will be familiar to most readers or that are currently widely accepted.

Synopses of the *Iliad* and *Odyssey* are given as an appendix, and readers unfamiliar with Homer may like to start there. We usually repeat those events in the epics that are the subject of each chapter, for the convenience of readers not intimate with them.

FOREWORD

PROFESSOR TRISHA GREENHALGH

In a book chapter called *The Silent Crisis*, philosopher Martha Nussbaum (2010) announces that "We are in the midst of a crisis of massive proportions and grave global significance".[1] Across the Western world – and indeed, much of the non-Western world too – we have abandoned the teaching of the humanities ("useless frills") in favour of a narrow focus on what are commonly known as the STEMM subjects (science, technology, engineering, mathematics and medicine).

The result of this shift, suggests Nussbaum, is not merely that generations of citizens are emerging who are unable to engage at a sophisticated level with literature and the arts. The problem is much more sinister: such citizens (to a greater or lesser extent) lack moral imagination and are unable to make judgements about what is right and reasonable:

> Thirsty for national profit, nations, and their systems of education, are heedlessly discarding skills that are needed to keep democracies alive. If this trend continues, nations all over the world will soon be producing generations of useful machines, rather than complete citizens who can think for themselves, criticize tradition, and understand the significance of another person's sufferings and achievements. The future of the world's democracies hangs in the balance (Nussbaum 2010, p.2).

The humanities, she argues, teach us to reflect, to consider different framings of an issue, to deliberate and to place ourselves imaginatively in the position of others. We gain these skills and qualities most especially through the study of stories as we are drawn into different real or imaginary settings and follow characters who encounter, and try to resolve, different kinds of trouble. We learn that despite the open-ended nature of story, literature – and indeed life itself – follows a small number of basic plots (quest, comedy, tragedy and so on) because humans interact in ways that are both totally unique and highly patterned. Through stories, we learn that the world is not fair; that situations are ambiguous; that no text is self-interpreting; that men and women are not born equal in terms of either their material circumstances or the character traits they can bring to bear

on those circumstances; that hopes and dreams and traditions are important; and that all choices have moral significance and unintended consequences.

In this book, Robert Marshall and Alan Bleakley offer a detailed worked example of how one classic contribution to the humanities – perhaps the greatest adventure-and-homecoming epic in the whole of literature – could inform and enrich the teaching of a subject which, perhaps more than any other in recent years, has fallen prey to the inexorable march of scientific reductionism, abstraction and standardisation with a concomitant devaluing of perspectives that are viewed as subjective, unquantified and relativistic.

The assumption underpinning this shift is that *through* reductionism (pursuing scientific "truth" through bounded rationality and ever-smaller units of analysis), abstraction (distilling a generalisable and analytically neat "essence" from our untidy, idiosyncratic and emotionally-charged real-world experiences, and then exploring and manipulating these essences as if they were reality) and standardisation (establishing a single "correct" and parsimonious way of doing everything, monitoring performance closely against that standard and driving "quality improvement" with reference to it), we will achieve with ever-greater efficiency the time-honoured goals of the medical profession: to heal the sick, to alleviate suffering, to comfort and console, and to support the patient in living well with illness.

This flawed line of reasoning runs increasingly through every medical specialty and also, troublingly, through the generalist fields of family medicine and geriatric medicine. Take heart failure, for example. Randomised controlled trials, accumulated over three decades, have informed a weighty collection of "evidence-based" clinical practice guidelines. According to these, patients should be prescribed the maximum tolerated dose of three different classes of drug (a practice known as "up-titration"), be monitored using an agreed set of biomarkers (such as body weight, blood pressure, blood oxygen level, atrial naturietic peptide and – using novel implantable technologies – variables like pulmonary artery pressure) and given structured education with a view to them learning to adjust the day-to-day dose of their own medication without the need for clinical intervention ("self-management"). All this is directed at a set of predefined outcome measures: improved left ventricular ejection fraction, longer survival, fewer hospital admissions and increased self-efficacy scores (allegedly, a measure of "empowerment").

Any practitioner's (or clinical team's) management of heart failure can be assessed in terms of performance against quantified targets derived

from evidence-based guidelines. What proportion of the denominator population is on the maximum recommended dose of ACE inhibitors, beta-blockers etc (high is good)? What proportion of this denominator population has had a hospital admission in the last year (low is good)? What proportion is self-managing in response to changes in their biomarkers (high is good)? Thus, the rationalist pursuit of defined targets becomes the dominant logic in heart failure management at both an individual and a system level.

Where in this model of heart failure management is the uniqueness of the individual patient? Where are surprise, ambiguity, paradox and uncertainty? Where are suffering, despair, compassion and sensibility? Where are deference, trust, confidence and commitment? Where is the unfolding story of a person-in-context – and where is the witness to this story? Where are the symbolic meanings and moral implications of technologies and practices? Above all, where in the evidence-based algorithm are the unique, case-based judgements that engage with these human, interpersonal and societal dimensions of illness?

Of course, evidence-based guidelines are not inherently inhumane, and their judicious use can be, and often is, a key component of humanistic care rather than its antithesis. But this best-of-both-worlds scenario will happen only if (and to the extent that) both these dimensions of professional practice (and with them, professionals as flawed heroes with characters and virtues) are valued and nurtured. As Martha Feldman (2000) has pointed out, "Routines are performed by people who think and feel and care. Their reactions are situated in institutional, organizational and personal contexts. Their actions are motivated by will and intention."[2] A protocol cannot be meaningfully studied in isolation from the person who follows it (or who chooses not to follow it, or finds themselves unable to follow it) in a particular setting.

The focus of this book is what happens when rational science and the managerial efficiency of healthcare systems is pursued *at the expense* of attention to what it means to be human. It is an attempt, through close analysis of a story (and what a story!) to reclaim such things as "community, the human spirit, manners, character, ethical conduct and learning" (see introduction) in the medical curriculum. It uses the adventure-and-homecoming literary genre to press home the point that travel – both literal and metaphorical – broadens the mind, develops professional virtues and nurtures the moral imagination.

Like many doctors, I have read the detailed and systematic public inquiries that were conducted into "system failures" such as Alder Hey, Bristol and Mid-Staffordshire, hoping to glean transferable lessons on how

to prevent such failures ever occurring again. Marshall and Bleakley offer us a different lens on such tragedies: there are no fixes – but by studying the emplotted fortunes of heroes, villains and victims in such systems, we will enrich our understanding of healthcare systems in general and how to improve them.

For example, on page 159, they say, "The mid-Staffordshire Hospital scandal provided a case study for widespread error and neglect due to poor management, lack of resources, and habitual negligence amongst care staff where ethical concerns were sidelined by subscription to crude managerialism". Notwithstanding these fundamental system flaws, a "Homeric" analysis of the events at Mid-Staffs highlights the heroic efforts of individual staff members and illustrates how honesty, courage, kindness, humility and diligence shone through even in a culture that did *not* value or nurture these virtues, while also illustrating how vices like pride, vengeance and cruelty were allowed to flourish.

Virtues cannot be protocolised, nor can vices be over-ridden by leaving them out of the algorithm. As Martha Nussbaum (2010) so eloquently explained in *Not for Profit*, we hone our understanding of virtue ethics through close reading of stories as well as through a more general engagement with the arts.

I enjoyed revisiting the *Iliad* and the *Odyssey* (two books forgotten since school), though I did not find this book an easy read. Those who would take the advice of Marshall and Bleakley and use Homer (or indeed, other classic narrative texts) to enrich a flagging medical education system will have their work cut out to convert his central message into the kinds of learning objectives and assessable competences that pervade the contemporary curriculum. But if Nussbaum is right, undertaking precisely that task is not merely desirable but essential and urgent.

Notes

1. Nussbaum, M. "The Silent Crisis". Chapter 1 in: *Not for Profit: Why Democracy Needs the Humanities*. Princeton University Press, 2010. http://press.princeton.edu/chapters/s9112.pdf
2. Feldman, M.S. "Organizational routines as a source of continuous change." *Organization Sci* 11 (2000): 611-29.

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INTRODUCTION

"THINKING OTHERWISE" WITH HOMER

Figure b-1: "Sing, Muse"

How we got into this epic mess

Over a decade ago one of us (AB) suggested to the other (RM) that he should revisit his undergraduate classical studies and think what might inform the teaching and learning of medicine. This was also in the context of the exciting development of a new and innovative medical school – Peninsula – in which both of us were involved. Those classical studies began as a four years' undergraduate course at Oxford, studying *Literae Humaniores* – "More Humane Letters", as this course is known there. More humane than what is unstated, but presumably than any other possible course of study. Humanity, at any rate, seemed a good place to look for a connection between classics and medicine.

The return visit to the classics was primarily to Homer's *Iliad*. Progress was initially very slow, with frequent recourse to a Greek lexicon kept from Oxford for over 30 years (Liddell and Scott's lexicon; Liddell the father of the Alice who fell down the rabbit hole). Gradually, I (RM) could read the Greek more fluently, and it became one of the day's highlights to get home and immerse myself in the rhythm of Homeric epic poetry. It was a profoundly moving experience.

My (AB's) route into classics was quite different and profoundly unscholarly, but nevertheless passionate and had been on the boil for around 25 years. After studying zoology and psychology, and prior to a career in medical education, I had trained as a psychotherapist within a post-Jungian, Archetypal Psychology tradition primarily based on the work of James Hillman. My DPhil from the University of Sussex too was in the same field. Central to the architecture of this approach to psychology is the use of classical myth and poetic structures. I had soaked myself in reading such myth in translation, constantly returning to Homer.

Our reading of and around Homer, brought alive through subsequent conversation, made it natural and inevitable that we would bring the content of his work,[1] and his style or poetic sensibility, to bear on the study, research and practice of medical education. We found immediately that "thinking with Homer" bore fruit – a "thinking otherwise" about largely habitual approaches to medicine and medical education. Within the context of a nascent but developing medical humanities culture, we took a leap and started to write collaboratively about key topics in medicine and medical education that could be re-visioned through the lens of key Homeric characters and scenes.

In analysing such scenes and characters from the *Iliad* and *Odyssey* we asked readers in a series of articles to re-think, for example, what is a "communication skill" and what we mean by "empathy"; in what sense

medical practice is formulaic, like a Homeric "song"; what is lyrical about medical practice; how doctors function as translators of the patient's story; and how uninvited anger, bullying and violence appear all too frequently in hospitals and clinics while, paradoxically, medicine still clings to its guiding martial metaphor ("medicine as war"). We used "thinking with Homer" as medium and metaphor for questioning the habitual in contemporary healthcare practice. Homer provided the grit, and we hopefully made some pearls in terms of both insights into, and practice change suggestions for, certain habits – rusted and rutted - crying out for attention, and leading to potential improvements in patient care and safety.

Often, those who reviewed our work asked "Why Homer?" Our answer is the text of this book, but the question has also been answered over and over by others writing about Homer, especially in the modern age.

Paul Cartledge (2002, pp.1-7), for example, starts his account of *The Greeks* with an address by President George Bush to the United Nations in 1991 concerning the violent ethnic division of Yugoslavia and the collapse of the Soviet Union. Caroline Alexander (2009, p.xi) says early in her book that: "Today, headlines from across the world keep Homer close by". One of those headlines was of the bodies of U.S. Rangers dragged behind their killers' jeeps, just as Achilles dragged the dead Hector behind his chariot. Barker and Christensen (2013, pp.1-2) begin their book by showing how Homer is not highbrow, permeating popular culture in its language, product branding, literature and film. Jonathan Shay (1994, 2002) enriches modern understanding by going directly to Homer to shed light on the trauma inflicted on those who fought in the Vietnam War, for example, showing how difficult it is for combat veterans to simply slip back into the skins of civilian identities. Adam Nicolson (2015, pp.1-7) perhaps gives the best personal answer to the question "Why Homer?", describing the effect of his first adult reading after surviving a storm at sea: "Here was a form of consciousness that understood fallibility and self-indulgence and vanity, and despite that knowledge didn't surrender hope of nobility and integrity and doing the right thing."

Medical education is generally interpreted, inside and outside medicine, as the teaching of medicine to undergraduates. It is much more. Graduation creates one of the unnatural and unhelpful barriers in medical education - between undergraduate and postgraduate education; the other is between postgraduate training and education for "junior" doctors, and their appointment to consultant status within hospital medicine or as qualified general practitioners, conferring the status of "expert". We believe that doctors learn, and want to learn, from the first day of medical school until they stop practising medicine and probably beyond. This book is then

written with that large group of learners and teachers in mind. It is not intended purely as an academic study, although we provide the necessary academic apparatus, but to change medical practice. We write this book for the benefit of doctors in particular, who would never dream of turning to Homer faced with an abusive colleague, a dysfunctional health system, or ongoing disaffection and fear of burnout. A classical education used to be regarded as essential for the study of medicine. Perhaps it still is, but, in a postmodern, now "post-truth", age, perhaps it needs to be presented in a way that intrigues as well as informs.

We hope that this book is of interest beyond that group, however. Classicists have always been interested in modern and innovative, even unusual, reception of their areas of study. We have had helpful discussions with some of them and outcomes are woven in to our book. For others, our level of classical expertise has been suspect and we have been asked: "who is this book for? If it is for classics scholars, are we not a little presumptuous, and if it is for doctors and healthcare professionals interested in education, isn't the Homer bit simply ostentatious?" One can only hope that a little learning has seeped in over several decades of study through our collective interest, and besides, much of what we write about is actually pedagogy, common to all disciplines.

There is a fourth potential cohort of readers beyond the medical, classics and education communities. The issues we discuss are, most of them, relevant to everyone – how we speak to each other, and how we speak to the powerful; issues of empathy and compassion; whistleblowing; abuse; exhaustion in the workplace; developing the resilience to cope with work and the world outside. We completed this book at the beginning of 2017, with the new President of the United States issuing a raft of executive orders that will have a profound effect throughout the world, and which disgust many. Homer's *Iliad* starts with a prophet scared to resist an oafish king – or speak truth to power - the latter's petulant anger when the truth is told, and his unreasonable reaction and subsequent demands, leading to a large toll of deaths for his people. We see parallels in all autocracies (including the traditional autocracies of medicine), where potential democracy is masked or distorted.

But for any non-specialist reader we would hope that this book serves as an introduction to the pleasures of reading Homer for the first time, and moving on to read the many generalist books about these two great epics. We hope that, like Adam Nicolson (2015, p.6), they may ask: "Why has no one told me about this before?"[2]

Where does medical education fit in?

Junior doctors are now entering a far different world from their predecessors – there is greater emphasis upon prevention rather than cure; doctors work in collaborative, interprofessional teams; patients' hospital stays have been radically shortened, compromising continuity; patient encounters occur more in the community than in hospitals, yet most medical education for students and juniors occurs on the wards; women will soon constitute the majority of the medical workforce; and junior doctors in England have become overtly politicised, recently striking over conditions of work (unthinkable in previous generations); the patterns of presenting symptoms are changing as mental illness becomes more dominant; and finally, there is a realisation that iatrogenic illness, caused by medical intervention itself, is a major problem, resulting in greater patient safety awareness and action.

As passionate medical educators, we actively resist medical education's habitual forms, established for over a century since the major overhaul resulting from Abraham Flexner's famous 1910 Carnegie Report (on medical education in North America) (Flexner 1910) and 1923 Report on Medical Education in Europe (Flexner and Pritchett 1923). We will continue to agitate for necessary and radical reform, drawing from sources that have been ignored in the past. Despite innovative responses to the established Flexnerian orthodoxy from a new Carnegie Report (Cooke et al 2011) demanding overhaul of North American medical education, and a parallel response from UK medical educators (Bleakley et al 2011), necessary innovation is frustratingly slow. We believe that medicine's historical legacies must be challenged, transforming hierarchy into democracy (to include patient participation), with male domination and "heroic" medicine morphing into a more feminine, collaborative care.

As we look forward to such radical change, we argue in this book that transformation in medical education can be informed by looking back, a long way back – to ancient Greece. In Homer's *Iliad* and *Odyssey* we find a wealth of learning and inspiration to inform and shape current medical education. This connection, perhaps surprising at first sight, has shaped this book.

The Homeric imagination

Surprised at how difficult it still is to introduce the arts and humanities into the medicine curriculum (even to explore the intrinsic beauty of science), we have worked hard over the years to show how the medical

humanities can benefit medical education. An important part of that process for us has been a return to Homer to illuminate and "think otherwise" about communication and professionalism in 21st century medical practice. If "Homer" (recognising the issue of authorship) were here today, he would perhaps say "only over my dead body should people ignore the legacy of my texts" - the epics of the *Iliad* and the *Odyssey.* Helene Foley (2001) describes "the Homeric imagination" as "an evolving historical reality". In other words, Homer never dates, but is a constant source of inspiration.

At the beginning of Homer's *Odyssey*, we are introduced to the "song" of Odysseus who "wandered off far and wide … he saw the cities of many peoples and knew their mind". What a liberal idea from a book written down in the eighth century BCE from a much older oral tradition – that a person should experience "otherness" so that he or she can think differently, or in our term, "think otherwise". Odysseus may already have been open-minded, but exposure to otherness through travel confirms his identity, or complex multiple identities, as "versatile": "the man of many twists and turns", and "the one who could change in many different ways who he was".

Odysseus' epithets include *polymetis* (of many counsels), *polymechanos* (resourceful, inventive), and *polytropos* (turned every way). Nicolson (2015) refers to him as the "poly" man. Where Odysseus gets to know different ways of thinking through exposure to otherness, so he gets to know how to think differently in himself, or acquire what we now call "critical reflexivity" (Bleakley 1999). In short, he is ultimately adaptive, sensitive to what he can learn from new, often challenging, encounters and new frameworks for thinking and responding. Such education into cultural relativism and psychological reflexivity seems a modern notion, but Homer prefigures this outlook. We suggest that education into tolerance of ambiguity, grounded in learning from the "other", is central to a successful medical education that properly addresses communication, professionalism, ethics, and the expression of considerate, humane values.

Carol Dougherty (2001) suggests that travel educated Odysseus into "mind leaps": "As when the mind leaps, the mind of a man who has travelled across/ much territory and thinks with shrewd intelligence, 'If only I were/ there or there' and wishes many things …" (*Iliad* Book 15). The earliest use of the term *theoria*, says Dougherty (2001, p.4), "designates the process of traveling". Theory is then a direct result of seeking active exposure to the "other" or "travelling" to seek encounters with the other. We can read "travel" both literally and as a metaphor for scanning possibilities rather than dogmatically jumping to conclusions.

For medical students and doctors, travel is common: between ideas and competing theories; in traversing differential diagnoses; between clinical sites and hospital-based placements as an apprentice, and finally across specialties to arrive at a career focus. The object of such "travel" is to encounter the widest variety of views, patients and clinical contexts early in a career to build a flexible yet subtle medical imagination. This project deserves the best and most refined support from medical educators.

In a key talk from 2005, Professor Lee Shulman, then President of the Carnegie Foundation for the Advancement of Teaching, describes the orthodoxy of the "signature pedagogy" for medical education (Shulman 2005). Strip away the pre-clinical years of classroom-based anatomy and science learning, and the main focus for a medical education is hospital-based bedside teaching, as a traditional apprenticeship. Despite, as noted above, the fact that many more patient presentations (largely chronic care) occur in General Practice than in hospitals, and that patients now spend far fewer days in hospital than they used to - making continuity of study difficult for medical students and junior doctors - nevertheless, the rituals concerned with acute care bedside teaching remain high profile, and not much has changed in this respect since Shulman's account a decade ago.

Shulman describes the signature pedagogy of medical education as a "formation of character". He goes on to say that when, in 2005, he attended a team at a major medical school hospital to observe clinical rounds, this was something he had not done since "about 1972" when he was intimately involved in medical education. In the intervening 33 years, he noted that not much had changed about the signature pedagogy except that patients - the curriculum content - did not stay in hospital as long and so continuity was disrupted. Shulman notes an extraordinary continuity elsewhere: "what was fascinating is the routinisation, almost to the point of ritual, of clinical rounds". What he did not say was that routinisation might be a symptom of stale practice, or lack of innovation in response to the rapidly changing context of healthcare.

"Ritual", from the Latin *ritualis*, means not only "custom", but also "correct performance". This is a scripted performance, an habitual and strongly socialised way of behaving, that is the primary focus of Homer's epics, based around two main principles: the glorification/ honouring of heroes, and the primacy of hospitality. The latter is, in turn, based upon two sub-principles – the solidarity of family and the conditional welcoming of strangers into a household. We say 'conditional' because ancient Greek hospitality is a formalised "gift exchange" process. While I am taken into your home as a stranger, bathed, fed and entertained, the expectation is that I will do the same for you.

These two principles – the honouring of heroes and hospitality - their sub-principles, and the rituals associated with them, have also historically defined modern medicine. Doctors are potentially heroes and the hospital is the site of hospitality. Until recently, junior doctors were called "house officers" or "housemen" and slept on site at the hospital. Doctors are the head of the family of healthcare teams and patients are offered conditional welcome and respite under care. The "condition" contemporary societies place on the availability of healthcare is that it can be resourced, somehow, either through taxes (such as a national health system "free" at point of service), or through health insurance.

In Homeric epic, ritual is tied with reciprocity (to which hospitality is central (Reece 1993)), where, as long as the rules of hospitality are followed, tragedy is avoided. In the tragic genre, however, the order of reciprocity is disrupted as family members feud and outsiders are treated with suspicion and judged (Seaford 1995). Where the curve of the epic narrative includes the hero's homecoming or a celebration of the death of the hero doomed by fate (Allums 1992), the tragic narrative concludes in a painful mess, leaving scars and stains (Hall 2010).

These archetypal frameworks are important for understanding medicine because it is the only profession in which tragedy (illness, suffering and death) provides its *raison d'être,* but the profession itself must not be engulfed by that tragedy. Rather, it must maintain its epic structure of ritual and reciprocity/ hospitality to not allow itself, as a social institution, to be engulfed by the very tragedy that it treats. As doctors and medical managers alike will tell you, medicine cannot afford to suffer. Yet it does, and it is this suffering of medicine that is the subject of this book and upon which a return to Homer can offer some illumination. We need to stress that we celebrate the achievements of medicine and the daily hard work of doctors and healthcare staff, but it is medical culture's symptoms that intrigue us and that we address in this book from an unusual angle.

Again, medicine is, historically, grounded in the epic genre with the making and honouring of heroes at its core (see chapters one and two), in order to "fight" (medicine is replete with martial metaphors) disease, where disease and suffering advertise the genre of tragedy. The paradox of this position is that the harder medicine fights off the tragic, the more this genre comes to inhabit medical culture and the lives of doctors as a return of the repressed. The tragic returns in distorted or unexpected forms, the most obvious being iatrogenesis – where medicine itself unintentionally harms patients, for example through hospital-based infections, or medical error such as misdiagnosis, dysfunctional teamwork or prescribing error

(see chapter nine). As medicine treats symptoms, so it displays its own symptoms. And these must be treated.

This historically formed state of medicine is changing rapidly and this book responds directly to such flux. We are now recognising the limits of epic medicine and learning how to accept elements of tragedy within medical practice that might be suitably addressed, such as compassion fatigue (see chapter six), anger and abuse (see chapters eight and eleven), and burnout (see chapters twelve and thirteen). Homer, again, provides a suitable guide to "thinking otherwise" about these encompassing issues in medicine and how we might address them through reformulating medical education.

Medicine too is formed by comic and lyrical genres (see chapter seven), although we recognise that humour in medical circles is often "black" and at patients' expense (Piemonte 2015), and a lyrical medicine has found it difficult to gain a foothold in the last five hundred years of martial, heroic medicine in the Metropolitan West.

It is in ritual as routinisation that medical students learn how to position themselves within the medical hierarchy, to make diagnoses and check these with superiors, to arrange treatments, and to record information. This all seems very mechanical. Indeed, the habitual or routinisation part is mechanical and previously scripted (as historical legacy, made so clear by Shulman's remarks above). We find its parallel in the structure of Homer's poems as sets of songs originally learned by heart and performed for an audience (see chapter 5). The performance of medicine in part mirrors this routinisation. However, within this inflexible structure - a means of memorising facts - is a field full of opportunity for interpretation. Medical work is never as routine as Shulman's signature pedagogy suggests. It is full of surprise, ambiguity and the unexpected. Learners must be able to think on their feet, adapt and be creative according to new context – in particular communicating with such a wide variety of patients, whose symptom presentations and narratives are necessarily unique.

While the structure of Homer's poems as we read them from the page in modern translations is largely formalised, what the characters and stories do to us as audience is open-ended and an invitation to invention. Reception of Homer invites thinking imaginatively, and Homer's tales, while again patterned or formulaic, invite open and inventive reception. As Carol Dougherty (2001) argues, we must read Homer ethnographically, as travellers meeting "otherness" that serves to re-formulate our values and practices. In this ethnographic work, we merely repeat what Homer has taught us through the figure of Odysseus – that we learn by comparing and contrasting our values and actions with those of others.

Why Homer?

This book is then an invitation to think otherwise about medicine, medical education and the identities of doctors using Homer's *Iliad* and *Odyssey* as the media. While doctors undertake a well-documented socialisation into a uniform character, the reality of their work is that they are constantly adapting to a liquid clinical context through meeting a variety of patients. Hence, we ask the reader to think otherwise particularly about the identities of doctors exposed simultaneously to a conformist medical culture and a range of otherness in the procession of patients throughout their careers.

In spite of its grounding in Bronze Age events, filtered through an Iron Age song and oral poetry tradition, Homer's work offers a foundational text for understanding and re-imagining such multiplicity in the human condition. Homer's work is not just a convenient medium. Rather, it is an Ur-text about community, the human spirit, manners, character, ethical conduct and learning. From reading Homer, we have learned that medical culture and medical education can be re-visioned thoroughly, providing radical insights. Of course this might be achieved drawing on the Bible, the Vedas, Virgil, Dante, Chaucer, Milton, Shakespeare, Cervantes, Chekhov, Tolstoy, or Proust for example, but Homer resonates with medicine for two particular reasons.

First, from the doctor's point of view, for at least 500 years, the central metaphor for medical intervention has been "medicine as war". However much this continues to stigmatise patients, doctors continue to "wage war" on cancers and "mobilise forces" against invading armies of bugs. The *Iliad* is the West's primary war text, focused on forty or so days in a decade long conflict between the Greeks and Trojans, grounded in an illicit love affair between the Trojan Paris and the Greek Helen, and crystallised in deeply personal and brutal warring encounters of body and feelings between Achilles and his king Agamemnon, and then Achilles and his foe Hector.

Second, from the patient's point of view, illness has been framed as a "journey" and errancy. Through the figure of Odysseus, the *Odyssey* describes human wandering, the wandering mind, and the mindset and values needed to deal with the unexpected. Whatever the current standing of these two metaphors - and their usefulness for contemporary medicine has been deeply questioned - we are bound to understand them if we are to stand under medical culture and practice to gaze at its normally hidden belly. We must gain new perspectives on how medical students are educated and socialised, or acquire identity as a doctor. Our current

understanding is limited, divisive, and even hampers medical education where it reproduces unproductive hierarchy and fails to deal with young doctors' emotional needs.

It was once assumed that students entering medicine would have received an education in Classics, beginning in Homer. This could be seen as preparation for what we now call "professionalism" - the ability to carry out one's job ethically and humanely. Where communication with patients, healthcare colleagues and junior doctors was once framed as benevolent paternalism, doctors were male and viewed as heroes, reproducing the Homeric themes of "honour and glory" (*kleos*) in "war" (clinical practice), and strong leadership in captaining the ship in "homecoming" (*nostos*) (successful outcomes to clinical interventions).

But we see potential in reading Homer with a sideways glance to think otherwise with the texts of the *Iliad* and *Odyssey* for better understanding of contemporary themes in medicine: in particular the roles of women and the feminising of the culture, and the rise of patient-centredness and inter-professional teamwork – all aspects of a democratised medicine concerned with social justice that may be summarised as the democratic dispersal of the medical gaze. This is a medicine in which medical students are politicised and actively challenge social injustices. Allied with this is the steep rise in interest in narratives in medicine and the importance of metaphor within medical discourse (Bleakley 2017). Our project then, in mobilising Homer, is more radical than "thinking medicine with Homer" – it is, again, "thinking medicine *otherwise* with Homer". Thinking otherwise is to think imaginatively, radically, aesthetically, ethically and with humanity.

"Communication" and "professionalism" in medicine for us go beyond face-to-face consultations with patients and teamwork with colleagues. The historical, cultural and social contexts for medical practice demand investigation to ask "why do we do things this way, now?", "are our practices appropriate?" and "if not, then how can we change them?" As noted above, we must understand, for example, why junior doctors are suddenly, and radically, politicised (at the time of writing, we have just seen the first wave of doctors' strikes as a protest against work conditions in the NHS in England); how medical institutions such as hospitals can be understood as complex, adaptive systems; and why many medical students see their future as a job rather than a vocation. To address issues such as these, we need to mobilise background contexts, the first of which is history. Western literary history begins with Homer.

Again, why return to Homer rather than, say, Shakespeare or Milton? And why, for example, does Ulysses keep getting re-invented? - the latter

question answered by W.B. Stanford's *The Ulysses Theme* (1968) invoking an archetypal perspective. These books - first written down in the 8th century BCE from oral storytelling set in the Late Bronze Age Aegean - have provided a primary inspiration not only for the Western literary imagination but also for practical and ethical co-existence in society.

The *Iliad* is a book of war and the *Odyssey* a book of adventure and homecoming; both have themes of forgiveness and hospitality (see the appendix for summaries of both books). While the kind of heroism portrayed by Achilles and Odysseus, the main protagonists of the *Iliad* and *Odyssey* respectively, may seem brutal to us – their brand of heroism depends upon creating victims who suffer a loss of esteem in their presence – they are complex and paradoxical, rather than flawed, heroes. It is by entering these worlds of complexity and paradox that we can shed new light on social issues in medicine such as the emotional lives of doctors.

G.K. Chesterton (1999/1908, p.63) remarked that: "Tradition means giving votes to the most obscure of all classes, our ancestors. It is the democracy of the dead. Tradition refuses to submit to the small and arrogant oligarchy of those who merely happen to be walking about". Invoking Chesterton's "democracy of the dead", we might treat any contemporary issue through calling on the voices of tradition; and for medicine, why not call on Homer? We follow Hernandez's (2007) "Reading Homer in the 21st Century" in allowing the voices of the oral poets who sang Homer to resonate in our own times, as a "reproduction of knowledge kept by the Muses". We have merely joined the legion of singers or *rhapsodes*, as part of a procession or parade.

Just as we stick strictly to Homer (for example, "thinking medicine otherwise" with Hesiod's pastoralism and lyricism would be a separate book), so we stick to medicine and do not stray into wider healthcare, although there is no reason why that should not happen. Our agreed agenda is medical culture. Within medicine, we have strenuously avoided repeating the outcomes of work already done on Homer, the body and medicine. For example, Homer's graphic depictions in the *Iliad* of bodies rent in war offers a mini anatomy lesson - a distinction is made between wounds that are fatal and those that are not; and bandaging and herbal treatments for various battlefield wounds are also described (Friedrich 2003). Further, there are idiosyncratic observations, such as Hector's breathlessness on the battlefield suggesting asthma (Jackson 2010). These anatomical and physiological concerns are not something we pursue. Our focus is elsewhere and we have nothing to add to what has already been

thoroughly researched concerning Homer and war wounds or medical conditions on the battlefield.

Using Homer in new ways to refresh medical education

What then, is different about our approach in contrast to this body of literature? Our focus is, again, illustrating how we can use Homer to think differently and creatively about issues associated with the human side of medicine, in particular the construction and management of identity through styles and modes of communication (for example, the "hero" identity discussed in chapters 1 and 2). This includes ethics and professionalism, within which are nestled the thorny issues of communication lapses, collapses, inability to jump synapses, and other mis-takes. Doctors and patients might speak differing languages that call for cross-translations, where much may still be lost in translation (chapter 3), where frustrations can readily spill over into anger and abuse (chapter 11), and errors accumulate (chapter 8); there is a range of styles of communication with both patients and colleagues, some wholly inappropriate, unreflective, and unskilled (chapter 5); and there are pitfalls of contemporary medical education in reducing communication to blunt-edged "skills" and "competences", where refinement, aesthetics and creative communication are abandoned for common "core" practices (chapter 5).

Just as we might be straining out the art of communication as an unintended consequence of simulation-based clinical skills training, so we miss, through the blunting or an-aesthetising processes of socialisation and identity construction of a doctor - overworked, over-tired, and over in another ward when needed urgently - the opportunity to appreciate the rituals and habits of clinical work as "song" (chapter 4), and as lyrical (chapter 7), where medicine again deals with the tragic (suffering, facing death), and works according to the epic (heroism and homecoming).

Some doctors and surgeons are "unteachable", habitually abusive, difficult, or "serial errorists" disguised as charming villains (chapter 8). Colleagues and students alike are encouraged to whistleblow where they see clear ethical transgression, but how do you manage this in an ingrained culture of opacity and protective inward focus, even as a culture of public transparency and reparation for mistakes is emerging (chapter 9)? Can doctors, already "bone tired" through work exhaustion and expectations of perfect performance (chapter 12), show weakness and fragility, even shame (chapter 8) in the face of error?

These, amongst others, are our key questions. In some cases, we suggest provisional answers – tactics, strategies and scaffolding of learning. But in

other cases, the best we can do is to raise issues of consequence that are historically determined, and second-guess the future from current trends. In these areas, we ask readers to join us in tolerating the ambiguity of knowing that we don't know. But, as we hope you will agree, we are not short of ideas. Our hope is that we stir up a passion to revisit Homer and re-discover the riches of the *Iliad* and the *Odyssey*. We are sure that you will agree with us that the connections between Homer's work and medicine's work are far from tentative. Our wider project is to advertise the value of application of classical literature and philosophy to contemporary medical practice and education. Classical literature, in particular, except that about ancient medicine, has been very little examined for its potential to affect the care of patients and shape the practices of medical education.

Notes

1. Probably "his" rather than "hers", although Andrew Dalby (2006) would disagree.
2. We agree with Furbank (1992, pp.33-46) that enthusiasts can go too far and irritate the non-classicist: Chapman's "Of all books extant in all kinds, Homer is the first and best", for example. We hope to make our case and ask our readers to bear with us.