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Barry Slaven, M.D., Ph.D., F.A.C.S.
Lehigh Valley Hospital, Allentown, PA

This photo was taken because I found the juxtaposition of hands to be
fascinating, epitomizing the theme of “healing hands”...the picture itself has
an ethereal quality that, I believe, adds to its appeal.
With so many journals devoted to some aspect of health care, it seems there is hardly need for our real or virtual mailboxes to be clogged up with more information. It’s my hope that the *International Journal of Healthcare & Humanities* won’t be just another publication to glance at and recycle, but rather a journal that stimulates your creativity, scholarship, and compassion. The notion of combining the rigor of peer review, the constraints of APA formatting, and the beauty of words and art may seem paradoxical, but what better captures the essence of our lives as providers and guardians of health care?

In this era of high tech health care, it’s no secret that the art and science of the caring professions is changed and changing. As we face a more complex practice environment, we need to be ready to flex every bit of our mental muscle in new ways in order to provide the best care possible. That’s where the opportunity for a different perspective, such as this one, comes in. At the place where the humanities interface with health care is a space where we reside, 24 hours a day, 7 days a week, 365 days a year. In that same place is the discovery of innovation, and new energy.

Please visit our website at [www.hmc.psu.edu/humanities](http://www.hmc.psu.edu/humanities) if you’re interested in submitting to future issues, and encourage your colleagues to do the same. As always, your feedback, input, and random musings are welcome. To request a free copy of this inaugural issue, or subscribe, contact The Department of Humanities, H134, Penn State Milton S. Hershey Medical Center, Penn State College of Medicine, 500 University Drive, P.O. Box 850, Hershey, PA 17033-0850.

The International Journal of Healthcare & Humanities  
Editor-in-Chief  
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Each issue of the International Journal of Healthcare and Humanities will contain a few abstracts from recent dissertations on topics relevant to humanities and health care. This column is made possible by the efforts of Dr. Jonathon Erlen, who states:

“The current dissertation gathering project began when the ISIS Cumulative Bibliography created by the History of Science Society moved from the University of Wisconsin to the University of Oklahoma. A new team of bibliographers was created and I took responsibility for selecting recent doctoral dissertations in the history of science, including the history of medicine. It soon became apparent that to accomplish this task would require me to read all three sections of the printed Dissertation Abstracts each month. While doing this project I became aware of the numerous dissertations pertaining to the medical humanities and expanded my search strategy to include art and medicine, literature and medicine, and biomedical ethics besides the history of medicine.”

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If you want to read other abstracts or locate resources on humanistic healthcare, go to:
http://www.hsls.pitt.edu/guides/histmed/researchresources/dissertations/index_html
Prayed Up: A Qualitative Exploration of Disaster Chaplaincy

Abstract (Summary)

The experiences of faith leaders serving as disaster chaplains were explored using a phenomenological tradition of inquiry. Data collection included In-depth interviews and review of documents associated with existing disaster chaplaincy training programs. Four research questions were explored with the goal of discovering how faith leaders could be better prepared to function as disaster chaplains within a secular (non-religious) disaster response workforce: (1) How do disaster chaplains view the similarities or differences of their work when compared to disaster mental health professionals? (2) What professional and/or personal competencies do disaster chaplains need to be effective? (3) How does the experience of working in disaster response impact the disaster chaplain? (4) How can the experiences of disaster chaplains inform development of training for new and experienced people in this role? Results showed that disaster chaplains viewed their role in spiritual care provision as complementary but distinctly different than that of mental health, while planners conceptualized it as a sub-specialty of disaster mental health. The themes that emerged from the experiences of disaster chaplains were used to construct a model of preparedness that can guide selection, recruitment and training of disaster chaplains. Chaplains identified several personal characteristics that could guide faith leaders as they self-select or are recruited for this work. Their experiences also led to identification of knowledge and skills that helped them fulfill their role. The most experienced disaster chaplains placed the greatest value on personal psychological, emotional, and spiritual preparation for the work.

Indexing (document details)

Advisor: DeFrain, John
School: The University of Nebraska - Lincoln
School Location: United States -- Nebraska
Keyword(s): Disaster chaplaincy, Chaplains, Training, Faith leaders
Source: DAI-A 67/09, Mar 2007
Source type: Dissertation
Subjects: Clergy, Adult education, Continuing education
Publication Number: AAT 3233743
ISBN: 9780542864070
‘Wasting Time’: Female Food Refusal in the Fin de Siècle

Abstract (Summary)

The dissertation, “‘Wasting Time’: Female Food Refusal in the Fin de Siècle,” explores the intersection of literary analysis, cultural theory, and gender studies. Specifically, this dissertation engages in close readings of texts by Wilkie Collins, George Gissing, and Sarah Grand to gain insight into late Victorian notions of wasting bodies as ideological formations dependent upon the main of traditional notions of nation, gender and class.

Indexing (document details)
Advisor: Livingston, Ira
School: State University of New York at Stony Brook
School Location: United States -- New York
Keyword(s): Food refusal, Fin de siecle, Wilkie Collins, George Gissing, Sarah Grand, Collins, Wilkie, Gissing, George, Grand, Sarah, Women characters
Source: DAI-A 67/10, Apr 2007
Source type: Dissertation
Subjects: Womens studies, English literature
Publication  AAT 3238963 
ISBN: 9780542930997
Imprisonment or Empowerment? A Study of Contemporary Women’s Films and Their Audiences


Abstract (Summary)

This study consists of an analysis of contemporary American women's films (Chick Flicks) and a primary research study of fans of these films. The purpose of the study is to provide a comprehensive definition of the Chick Flick genre and to gain insight into why this genre continues to be popular with female audiences. The primary research was conducted using a survey as the main communication tool, with follow-up interviews conducted when possible. The survey was administered to 98 women who were taking an online undergraduate Introduction to Humanities course. Participation was voluntary and participants were self-identified fans of contemporary American women's films. The sample was asked a range of questions about Chick Flicks, including asking them to define the characteristics necessary for a film to be considered a part of the genre, as well asking them to provide information about their own viewing habits, film preferences, and reasons for viewing.

Conclusions drawn from the viewers’ responses are discussed and analyzed, and the results of the survey are applied to complex analyses of several women's films created during the timeframe of 1980-2005. The common characteristics of the Chick Flick genre are articulated by analyzing four films: How to Make an American Quilt (Jocelyn Moorhouse 1995), Sleepless in Seattle (Nora Ephron 1993), Where the Heart Is (Matt Williams 2000), and Under the Tuscan Sun (Audrey Wells 2003). Eighteen percent of the viewers surveyed named Pretty Woman (Garry Marshall 1990) as their favorite Chick Flick; therefore, a detailed analysis of that film, the critical responses to it, as well as the audience comments about it, are included. The study concludes with a theoretical discussion of the Chick Flick genre from a feminist perspective.

Indexing (document details)

Advisor: Slater, Thomas
School: Indiana University of Pennsylvania
School Location: United States -- Pennsylvania
Keyword(s): Women's films, Audiences, Popular culture, Chick Flick
Source type: Dissertation
Subjects: Womens studies, Language, Motion pictures
Publication: AAT 3240169
Number: 9780542950179
Allowing Adolescents to Make Life-and-Death Decisions About Themselves: Rights and Responsibilities of Adolescents, Families, and the State

Abstract (Summary)
There is consensus among scholars writing in bioethics, medicine, and the law, that adolescents ought to participate in health care decision making about themselves. There is less agreement on what adolescent ‘participation’ means and about the range of health care decisions that adolescents can and should make, especially whether adolescents should be able to have ultimate authority over life-and-death decision making about themselves. This dissertation argues that adolescents should not be allowed to exercise such authority in the life-and-death decision making setting. A current, misconstrued ‘respect’ for adolescent autonomy is not justified by our inadequate understanding of decision making capacity, especially for adolescents who are in danger of making medical decisions that may greatly impact their future. Deliberation ought to be guided by a triadic approach that incorporates the interests, roles, and responsibilities of parents, health care providers, and the adolescent in a therapeutic alliance focused on beneficence to the adolescent patient.

Indexing (document details)
Advisor: Childress, James
School: University of Virginia
School Location: United States -- Virginia
Keyword(s): Adolescents, Life-and-death decisions, Rights, Responsibilities, Families
Source: DAI-A 67/09, Mar 2007
Source type: Dissertation
Subjects: Philosophy, Developmental psychology
Publication Number: AAT 3235036
ISBN: 9780542888153
Abstract (Summary)
This dissertation proposes that the historical records and stories of enslaved African women have within them creative and life affirming resistance strategies for how women of the past have dealt with violence and oppression. The dissertation draws on mid 17 th to 19 th century slave narratives to describe the depths of multi-dimensional oppression and violence in the lives of enslaved African women. An investigation of pre-colonial West and West Central African women's lives prior to European arrival is examined in order to recover those African-derived aesthetic forms and religious practices that helped enslaved women combat violence and oppression. In the constructive section of this work, nine strategies of resistance are offered as possible modes of resistance for modern-day women. In addition to the nine strategies of resistance, this dissertation offers, in the final chapter, seven ritual practices of freedom and well-being to sustain women beyond violence.
Prescription for a Profession: The Educational Philosophy of Abraham Flexner and Cogency in Medical Education

Abstract (Summary)
In 1908 the Carnegie Foundation for the Advancement of Teaching authorized distinguished educator Abraham Flexner to examine the state of American medical schools and education. The result of the study known as the Flexner Report was an incisive critique that became a most influential document in American medical education. Appearing at the height of scientific and educational movements that strongly favored reform, the Report provided the framework for reconstruction of medical education and was a central catalyst to effect reform and bring American medical education to a position of world leadership. The general purpose of study is defined by elucidation of Flexner's educational thought, investigation of its application and efficacy in the development of medical education, and determination of contemporary relevance. Focus of study concerns the compliance of current medical training with recommendations of the Report, and the adequacy and effectiveness of medical education in context of rapidly emerging results of scientific and technological progress. Methods of investigation were determined by topical aspects of discussion. In addition to historical and biographical approaches, the study used document analysis and survey research methods to generate information. Results of the study determined the conceptual framework for Flexner's recommendations for the reconstruction of medical education based on principles requiring a balance of scientific and humanistic elements whereby the physician is scientifically trained and educated in context of humanism and human valuation. Further results demonstrated the lack of this balance in current medical education. Study of a sample population determined what counts as the educated physician to recipients of the medical practice apart from that which is defined by such institution. That over sixty-three percent discussed predominantly humanistic issues suggests socially constructed components to medical education. Significance or meaning of the study may be central to curriculum and ethical definition in medical education and practice.
Knowing when, how, and why to apologize isn't easy. As with the practice of medicine, proficiency requires not only knowledge, but demonstrating skill in the art of apology. We are all human, and as such, fallible. Whether we can admit it or not, we would love to be infallible. A few folks may believe they are infallible – but we all know that everyone makes mistakes that may result in some emotional or physical injury to others. A sincere apology for those mistakes can go a long way in promoting and maintaining positive relationships with those who have experienced emotional or physical injury because of our errors.

**What is an Apology?**

Some persons and some organizations are better than others at dealing with interpersonal or organizational conflict. Conflict is pervasive in human relationships. Although some persons appear to be predisposed to act as “peacemakers,” this is certainly not the norm. In the face of this fact, some organizations, including a growing number of Academic Health Centers (AHCs) offer conflict management training to their faculty and staff. As a result conflicts are more readily resolved or managed.

Even with conflict management training, sooner or later, we will find ourselves in the uncomfortable position of having been wrong. At this time it is important to remember that even the best of us make mistakes. When we make mistakes, most of us will agree that acknowledging our error(s) and/or wrongdoing and offering a sincere apology are reasonable responses. The psychologist, marriage and family therapist, and pastoral counselor Carl Schneider defines apology as follows: Apology involves the acknowledgement of injury with the acceptance of responsibility, affect (felt regret or shame – the person must mean it), and vulnerability – the risking of an acknowledgement without excuses. (Schneider, 2007)

Knowing the definition of apology doesn't make apologizing any easier. Clearly, it is easier said than done. Acknowledging our human frailty is sobering, to say the least, and most persons are uncomfortable with making sincere apologies. Most of us have not had training in how and when to say “I’m sorry” other than being admonished by adults to “Say you’re sorry!” when we were children. Understanding the “when, why, and how” of apology is a useful skill.

**Types of Apology**

As children, we learned to admit when we were wrong within interpersonal relationships. Different approaches may be necessary depending upon the nature of the situation. In short, there are types of apology. Deborah Levi offers a “typology of apology”:
**Tactical apology** - when a person accused of wrongdoing offers an apology that is rhetorical and strategic – and not necessary heart-felt.

**Explanation apology** - when a person accused of wrongdoing offers an apology that is merely a gesture that is meant to counter an accusation of wrongdoing. In fact, it may be used to defend the actions of the accused.

**Formalistic apology** - when a person accused of wrongdoing offers an apology after being admonished to do so by an authority figure – who may also be the individual who suffered the wrongdoing.

**Happy ending apology** - when a person accused of wrongdoing fully acknowledges responsibility for the wrongdoing and is genuinely remorseful. (Levi, 1997)

One might question if any of the first three types are really apologies at all. In fact, they are, but they don’t measure up qualitatively nor are they as effective as the happy ending apology. Rather than dwelling on the first three types, this article focuses on making ethically sound apologies designed to improve our relationships with others – happy endings.

**When is Apology Warranted?**

Barbara Kellerman makes the point: “When we wrong someone we know, even unintentionally, we are generally expected to apologize.” I think most of us agree and have this expectation of others. But do we really have this expectation of ourselves? Do we really know when an apology is warranted and when it is not? To complicate matters, social roles may require different behaviors. For example, an apology to an individual family member is markedly different than the CEO of an Academic Health Center publicly apologizing for a mistake made in the AHC that resulted in the death of a patient. The complexity of AHCs requires sincere apology that transcends interpersonal relationships, especially in situations where a person or persons experienced “hurt” at the hands of an organization. (British Columbia OO, 2006) Apologizing carries risk in both cases – but the risks are very different as a family member speaks as an individual and the CEO speaks for the collective. Likewise, in both cases, apology has implications – but the implications are typically broad when one is in a leadership role, as in the case of the public apology by the CEO. An apology to an intimate is typically more limited, but no less important. Our lives would be less complicated if we could know precisely when an apology is warranted – and when it is not. In truth, there is no universal answer to the question of when apology is warranted. It may be better to base our decision to apologize on when one is expected. Acknowledging injury and accepting responsibility for causing an injury allows us to meet the expectation of others.

**Why is Apologizing Important?**

You may have heard the euphemism: “good fences make good neighbors.” A corollary might be “mending fences makes for good neighborhoods.” Offering an apology paves the way for reconciliation and, in some cases, forgiveness. Aaron Lazare (2004) argues that effective apologies must, at a minimum, meet one of seven psychological needs:
1. Dignity must be restored to the offended.
2. Both parties agree on a set of values. As such, they agree wrongdoing occurred.
3. It is clear to both parties that the offended person was NOT responsible for the offense.
4. The offended person is assured the offense will not reoccur.
5. The offended person witnesses the offending party experiencing some type of punishment.
6. The offended person is compensated in some manner for experiencing the offense.
7. Offended persons have the opportunity to express their feelings about the offenders, and, in some cases, are able to grieve the loss.

Ideally, when the offended parties have more than one need, all of the needs would be met by the apology. When an apology meets the needs of the offended party, forgiveness – by the offended – is possible. When an apology is effective, the offended party feels lifted of a burden. In turn, forgiveness can help the offender feel lifted of the burden of guilt.

How to Apologize

Learning how to apologize is similar to learning any new behavior. It may feel awkward and may not be polished, but with practice, everyone can learn to do it. There are several tips that will help you as you learn how to apologize.

First of all, wait until the right time and you are in the right place. Although public apology is often appropriate, especially when one is apologizing for the behavior of a group or organization, discretion should be used. Most apologies can and should happen in a private setting. Remember, you will be raising a topic that may recall a bad experience or bad feelings. Be respectful as you approach this task.

Be direct and succinct in your approach. Acknowledge the fact that injury has occurred and then take responsibility for what happened. Be authentic in expressing your remorse and demonstrate your vulnerability. In other words, avoid excuses and offer to repair the damage.

Even if you follow these steps, be prepared for rejection. Sometimes, the person apologizing has an expectation that the apology will lead to immediate forgiveness and acceptance. Forgiveness and acceptance may take time. If you think of the offense as an emotional bruise, think of the healing process as the color changes we see as a bruise heals. It may take a couple of weeks before the “natural” state has returned.

Listening to the response to our apologies is important. In a previous Career Watch article, I offered the advice “Knowing when to keep one’s mouth shut is a virtue.” (Grigsby, 2006) Keeping quiet may be very difficult as post-apology listening is not easy. We may hear unpleasant observations from another about our own shortcomings. We may hear the expression of anger or rage. We may have to endure a tearful episode that, in turn, brings us to tears. One of the ways we let others know we are truly responsible and accountable for our mistakes is
by listening to the other party verbalize the feelings associated with our actions. However, there are two positive aspects that may emerge in this process. First, taking the time to listen creates an opportunity to hear an apology from the offended party in response to our apology. He/she may feel remorse about his/her behavior that preceded the event. He/she may be embarrassed by his/her behavioral response to the offense. Any time strong emotions are involved, the potential for “emotional bruising” increases. Second, we may hear the offended party forgive us for our faulty behavior.

Use Apology to Everyone’s Advantage

Too often, an apology is warranted but never happens. Resulting conflicts fester, at times resulting in an adversarial legal process involving attorneys as the wronged party seeks justice. There is a time and place for using the adversarial process – but there are many times when adversarial processes could be avoided altogether through the proper use of apology. A higher degree of “emotional intelligence” often leads to less conflict in general (Bachrach, 2004). Individuals who are conscientious in understanding organizational culture and developing organizational savvy may be more adept at preventing, reducing, or managing interpersonal conflicts (Bickel, 2005). Knowing “when, why, and how” to apologize within an organizational culture reflects a higher degree of emotional intelligence. Whether we choose to be proactive or reactive, two things are sure: we will make mistakes and conflict will not go away by if we are too proud to say “I’m sorry.”

References


Kellerman B. “When should a leader apologize-and when not?” Harvard Business Review April 2006 Reprint R0604D.


Bioethics and Film: An Innovative Approach for Understanding Obesity
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Introduction

For the past four years our small, mid-Atlantic medical school has been going through a rigorous curriculum transformation. While developing humanities and bioethics curricula for a medical school is no easy task, having the opportunity to develop and implement several innovative programs and courses for our medical students has been truly rewarding. One of these pioneering courses, Understanding Obesity through Bioethics and Film, has been well-received by students and targets a critical healthcare issue – obesity – that receives much media attention, but little critical reflection in clinical and academic settings.

This course has been designed to ignite discussion and foster reflection about the clinical, social, and ethical problems surrounding obesity and body image, while utilizing traditional moral theories, film theory, and students’ clinical experiences and stories. The impetus for creating this course was to confront the mistreatment of obese patients in the clinical setting as witnessed or experienced by medical students and their clinical role models. Our medical students, especially those working in the clinical setting, have reported they are often unable to feel empathy and compassion for their obese patients, even blaming them from their self-destructive behaviors such as over-eating and lack of exercise. Furthermore, early in their medical education, students were taught the science behind obesity and correlated health risks, such as Type 2 Diabetes Mellitus, cardiovascular disease, and polycystic ovary syndrome but were not exposed to some of the social and ethical problems associated with the critical rise in obesity prevalence rates in their own community and across America.

Thus, this course was implemented into the curriculum so that fourth year medical students would recognize the need to: understand obesity from the perspectives of afflicted individuals and their families, to examine why this second leading cause of preventable death (Mokdad, 2004) is not being prevented or adequately treated, and reflect on how they as future physicians can help prevent and treat obesity in their communities.

Method

Discussing and reflecting on obesity and how it is perceived in the clinical setting is an important step in acknowledging personal biases and cultural stigmas. It is also important to model humanistic values, such as compassion, empathy, and respect. Limited to the classroom environment, film is used as a way to model these values, guiding students toward a better, more humanistic, understanding of obesity.

By bringing a variety of films into the classroom, such as documentaries, independent, and Hollywood films, students are privy to the hidden thoughts...
and feelings of real and fictional characters who are either struggling with obesity, or who are trying to understand a loved one who is obese. The films selected for this course provided students with memorable visual images and stories, while challenging them to think about how weight and body image may relate to one's personal identity.

By introducing film theory and re-visiting ethical theory, students begin to see the value and purpose of film beyond a form of entertainment. And, as students pay closer attention to the raw material, methods, techniques, and forms and shapes of each film, the story being told becomes more complex, and each character's lived experience is understood as unique and worthy of acknowledgment.

The Syllabus

Understanding Obesity through Bioethics and Film is taught as a capstone elective for our fourth-year medical students who are weeks away from beginning their residency training. As a fourth year medical school elective, class meets once a week for four hours over the course of three weeks. Students are required to regularly attend class, watch films, participate in classroom discussions, read from a short list of reading assignments, and write three reflection papers (2-3 pages each) based on one film and/or set of readings in each of three categories.

The three, structured categories, based on the primary ethical considerations related to obesity and body image, include: Social Responsibility and Utility, Personal Responsibility and Empathy, and The Slippery Slope of Self Image. The assigned readings for each week reflect ethical situations or dilemmas represented in the selected film (see, for example, Gostin, 2005; Rich & Evans, 2005; Pelican, et al, 2005).

Week One: Social Responsibility and Utility

In the first week, elementary theories about film are introduced. J. Dudley Andrew (1976) provides a rich background in film theory as he introduces major contributing elements, which effectively tell a story through film. Students learn the goal of film theory “is to formulate a schematic notion of the capacity of the film. The generality of film theory gives us a way of understanding an experience in new terms, in terms that let us place it in the universe of our experience as a whole” (Andrew, 1976, p. 7). Every question about film falls under at least one of the following categories: raw material, methods and techniques, forms and shapes, purpose or value. Students use these categories to examine and discuss the elements of each film.

During this week some of the core ethical values of medical practice, such as responsibility, utility, compassion, empathy, and respect, are re-visited. Students use a coherentist framework to examine the moral dilemmas portrayed in the films or as experienced in the clinical setting. This framework, which avoids bottom-up or top-down ethical analysis, utilizes traditional moral theories and background beliefs and theories, including film theory, to guide students toward a more comprehensive understanding of the core values and how they inform formal guidelines and decisions in the clinical setting (see, for example, Daniels, 1979; Nielsen, 1993).
Along with the short didactics on film and ethical theory, the 2004 documentary film, *Super Size Me*, is shown. In this film, author and director Morgan Spurlock looks at the obesity epidemic in the United States as he undergoes an experiment in which he consumes nothing but fast food over the course of one month. As he films his rapidly deteriorating physical and mental health, Spurlock adds additional material about the fast food industry, obesity lawsuit cases, the poor quality of food in our children's school cafeterias, as well as the magnitude of fast food consumption and its effects on global consumerism. Medical students are encouraged to critique the style and methods used in this film to describe obesity, question whether obesity is really an epidemic, and look critically at whether physicians, among others, have a social responsibility to prevent, protect, and care for those who engage in unhealthy eating behaviors. To support their arguments, students refer to their assigned readings and some of the core ethical and moral values of medical practice.

**Week Two: Personal Responsibility and Empathy**

The second week focuses on the individual suffering from obesity and on the family who is struggling to understand and support the afflicted loved one. Students move from looking at obesity as a social problem, possibly even an epidemic, to a personal and familial problem. Discussions focus on whether individuals have a personal responsibility in preventing harmful weight gain through regimented diet and exercise, along with adhering to recommended therapies and treatments when there is an underlying illness or disease responsible for unhealthy weight gain. Personal prejudices and biases are confronted and acknowledged in this week's discussions. As negative attitudes and feelings are addressed and reflected upon, students begin to realize the need for empathy and compassion when communicating to and treating this particular patient population.

The film used for this week, *What's Eating Gilbert Grape*, is written by Peter Hedges and directed by Lasse Holmstrom. This 1993 Oscar Nominated film depicts not only what it is like to live and care for a mentally handicapped younger brother (played by Leonardo DiCaprio), but also what it is like to care for a morbidly obese mother who is house-bound, crippled from the effects of obesity, and who is emotionally suffering from her husband's suicide. Unable to parent her four children, her eldest son, Gilbert Grape (played by Johnny Depp), is burdened with the responsibility of caring for his family. The film looks critically at the changing family dynamics as each new challenge presents itself. Though the focus is not on obesity, the issue is realistically addressed as the family either tries to confront the mother's ill-health or escape from its damaging effects. After viewing this film, students expressed how much the individual characters opened their eyes to the real-life problems of obesity, which isn't always addressed in the clinic.

**Week Three: The Slippery Slope of Self Image**

The final week of the course focuses on self image and how society and those closest to us can negatively and positively impact the way we see and feel about ourselves and our bodies. Students recognize the interactions they have with their own patients can either negatively or positively impact the way their patients see themselves. For example, one student reported that he wrongfully told a patient,
who was experiencing back pain, she ought to lose weight. Without having looked at her medical chart, she tearfully informed him that she had lost over 90 pounds in the past year and was feeling good about herself until now. Openly discussing his experience for the first time, this student did not realize the emotional pain he might have caused his patient; it wasn’t until he reflected on this situation did he feel empathy for her.

Though the selected film for this week, *The Shape of Things*, does not specifically address physician-patient relationships, it does address the manipulative power a person can have over another in shaping who he or she is. *The Shape of Things*, written and directed by Neil LaBute, looks at how a woman physically and psychologically “re-shapes” her soft-spoken, mild-mannered, overweight boyfriend, Adam (played by Paul Rudd), into a more physically fit and confident person. Detecting her manipulative ways, Adam’s two best friends disapprove of his “harmful” relationship. Adam, forced to make a choice between his two best friends and his girlfriend, wrongfully chooses his girlfriend who continues to shape more than his physical appearance and confidence level.

This film elicits some powerful emotions and makes the viewer question, “Do people really have that much power to shape others?” After viewing this film many students cannot believe how they were “sucked into” the film, getting so emotionally charged over a fictional story. At this point, they are reminded of the gripping power of film.

**Evaluation**

The overall assessment of this course was partially based on the medical school’s formal evaluation form using Likert Scale analysis with response choices ranging from “strongly agree” to “strongly disagree”. A total of 19 respondents out of 21 enrolled students fully completed the evaluation form. All students responded positively by either selecting “strongly agree” or “agree” to twelve questions (developed by the health professions administration) focusing on the course content, the quality of teaching by the instructor, and whether such a course is useful for future physicians. For example, 79% of the students “strongly agreed,” and 21% “agreed” the course was appropriately challenging and will be of use to them in understanding issues based on health, illness, and patients and their families.

Approximately 84% of students “strongly agreed” and 10.5% “agreed” that this course is: “something I would recommend to others.” A total of fourteen students (74%) “strongly agreed,” and five students (26%) “agreed” this course “increased my understanding of the subject matter.”

In the written evaluation of the course, some of the student’s written comments include: “[The instructor] taught something unique to medical education”; “Great choice of movies and readings”; “Allowed for open discussions requiring critical thinking”; “Dr. __ made the class an open forum and very non-threatening”; “It was easy to share opinions, and she brought up many provoking points! I enjoyed it.”; “Great course for discussion of obesity. We get so little training concerning this problem; it’s good to discuss it.”
While most of the students had no recommendations for changing the course, some students thought the use of clips from television shows would be useful, as well as bringing even more discussion into the classroom. One student recommended that each student share his or her reflection essay in class so that everyone, including the quiet and shy students, would get a chance to talk. Overall the student evaluations were very positive and insightful.

**Lessons and Limitations**

There are possible limitations in using film in the classroom, such as the length of time required to show an entire film along with a class discussion (i.e., four hours are needed for most films and discussions); the difficulty of selecting films suitable for students with diverse backgrounds, interests, and values; and the difficulties associated with assignment selection (i.e., choosing readings that are not so philosophically dense that medical students cannot relate to the content, but challenging enough so as to not trivialize the issues examined throughout the course).

A more challenging hurdle that may present itself throughout this course involves students’ resistance to the experience of others different from themselves. Because some students were unable to imagine what it would be like to be overweight, obese, or manipulated into changing their body image, they had difficulty feeling empathy for the characters in the films and for their own patients who struggle with these issues. Nevertheless, evidenced by the depth of student reflection and formal assessment of the course, the selected films and assignments, along with in-depth discussions, significantly guided students toward a better understanding of their patients struggling with obesity, thus enabling them to respond to this growing problem in a more empathetic and compassionate way. Furthermore, by providing a safe and confidential classroom environment, students are able to openly discuss their personal biases and prejudices without judgment.

**Conclusion**

Discussions about obesity through film, along with students’ own clinical experiences, reveal a part of medical education that has never been overtly taught before in either a classroom or clinical setting at this school of medicine. In following some of the students’ recommendations for improving the course, more time will be allotted for discussion, including the opportunity for students to read their reflective essays to their peers. This way, every student will have the opportunity to contribute to class discussions, and conversations will less likely be dominated by individuals.

To conclude, it is critical that courses and subject matter such as obesity be overtly taught throughout students’ training as physicians; students would be better prepared in helping this patient population, and perhaps even move beyond their personal biases upon understanding the obese patient as a person with a unique story to tell.
Acknowledgement

This course description and paper was presented at the Association for the Study of Medical Education (ASME), July 11-13, Keele, Staffordshire, UK (July 2007).

References
**Artist's Statement**

In life, the nude model was a dignified and confident woman. Her body flowed like a country landscape, her organic anatomy composed of fleshy rolls and milky skin. In a sense, she was royal.

The purpose of this painting was to capture her secure essence. A purple cloth is draped over her heavy body, not because she is uncomfortable or cold, but because it acts as a lavender cascading waterfall, complementing her honey wheat exterior. She has a certain golden aura around her, inspiring others, especially the artist, to be completely satisfied and proud of the life they live. One arm holds her body in place, conveying that she is able to support herself. Her hand grazes her jaw, peacefully protecting herself. Her eye lids are gently shut, but she can still see.

I communicate with her through brush strokes and she communicates with me through simply being. The cloth, the divan, the wall, and the room all melt into her as she projects herself outward. Her radiance warms the spirit.
Healing the Heart

She, looks lazy and relaxed
rather like an invalid
with a leg wound, the white gauze
covered by a green plaid wool rug,

There she sits on a wooden deck
clings to it as she might hold to a skeleton
Watching for unexpected life from dry wood
Looking for fire from splinters
Trying to heal, exposed to the morning sun,
she chides herself
for not getting up
There are letters to write
calls to make and laundry settled in the wicker basket
She has people and places
and tasks to attend
and another cup of tea, she could have
but there she sits
with a green plaid wool rug
pulled up over her wounded heart

The initiating thought for this poem, was the idea of healing and taking the time to heal. I have been struck with the notion that our health care system rushes a patient through the spectrum of healing. An acute hospital, for instance, is a busy and noisy place. The pace is fast, and rightly so, to arrive at diagnosis and treatment plan. This poem expresses my wish to have the patient just set and REST. And maybe it is about me, just wanting to REST after “looking for fire from splinters.” The poem is certainly showing two sides of the thin line between patient and nurse and their respective needs for true REST.
Post Mortem Review/Journal Club

What will death say of this body
Death with his sharp white beak mouth
and cold misty foul breath
What will that black vulture say?

When there on white porcelain I lie
cool gurgling water beneath rigid toes
I will belong to a pair of medical students
I will become the property of some rude pair
of fornicating wasters of spring
of some rude pair of multiple choice test takers

Flat slack white thighs will deny
the gentle lovers and sandpiper summers
Black dry tangled nest of pubic hair
will deny long nights of sweaty passion
Sunken abdomen, empty open
flown wire cage
will scream in pink throated silence

When the saw removes my skull cap
those gray shiny convoluted ridges
will refuse the red breasted songs of spring
and the yellow feathered dreams
And fledgling schemes that shaped a woman

The forensics of nursing and medicine are mysterious and intriguing. I love the idea of reviews and journal clubs; that is how we learn. And I love the mystery. What does an autopsy NOT tell us? What does a Complete Blood Count (CBC) NOT tell us? What does a chest x-ray (CXR) NOT tell us? When I wrote this, I was thinking that we nurses and doctors, know so little. What we DO KNOW is but a drop in the proverbial knowledge stream. So often we get up on our professional high horses and forget the mystery and the complexities that make up the totality of a human being. How many nurses and doctors, especially in acute hospitals, know the professions of their patients? If the patient is retired, do they know what the patient once did? Each and every day as nurse, I am in awe of what I do NOT know. Mystery.
The Tea-Master 3-11 Shift
I ask you to swallow the tea
remind you that it will make you feel better
I nestle your back to make it easier to swallow
In the long second of your indecision
your eyes migrate and linger on a photo
of your grandson building a birdhouse
with many little round bird doors
His fingers are stubby but he looks confident
He looks straight into the camera
I recall my spry grandmother
sipping iced tea on July days
under an oak tree in Missouri
It perks you up—doesn’t it?
I tell you that it will perk you up
but you are still struggling
wings and feathers thrashing
against pain and sweaty sheets
a drenched old bird in a musty nest
I recall enticing my adolescent daughter
to peace by offering tea in the kitchen
Let’s have a cup of tea and talk
It didn’t always work but it was something
I tell you I know it hurts
try to hold you in the nest of my arms
and remind you again to swallow
We both smile as if we had caught
the same allusive feather at the same time
We recall how the birds return to Capistrano
We know we need to trust something
You swallow and relax into the temporary nest
of my arms and your unmade bed

As a nurse, I really like making other people comfortable. Comfort seems to come about with connection on some level. The nurse and the patient in this poem connect via the metaphor of “swallow.” This is a good poem for teaching the wonderful double meaning of metaphor and demonstrating an example of epiphany. As a nurse, you know you have connected -- you know the moment. I suspect this is healing for nurse and for patient. The nurse and the patient come as strangers to the patient’s bedside with collective experiences. In this poem, those experiences connect and result in comfort. Further, I personally REALLY like this poem because my grandmother, a simple farmer’s wife who understood the healing power of tea and tea ceremony, makes a cameo appearance in what is a collective portrait of numerous patients in my experience. My grandmother would never have described herself as understanding tea and tea ceremony but she did, at the most core level. Ceremony and the routine of ceremony is also part of the subject matter of the poem. The routine of back rubs, milk, and graham crackers for patients on the 3-11 is pretty much gone. The poem is about that “ceremony” and routine. It was healing. Nurses on the 3-11 shift were the “tea-masters” in my mind as I wrote this poem.
The purpose of this project was to help me, as a physician, see my patients broadly as people rather than just as the diseases they suffer. By taking photographs of them in a “non-medical” environment, I sought to appreciate the part of their lives that didn’t focus on taking pills, trying to exercise, and visiting doctors’ offices and emergency rooms.

Over the course of six months, I went to the homes or places of business or recreation of forty-five of my patients. At those locations, I talked with each patient about what he or she was doing at the moment, and made both posed and candid photographs. Each portrait contains a short legend, in dense “medicalese” that tells the patient’s medical diagnoses. It stands in contrast to the portrait itself, which shows a person with little if any evidence of a cardiac problem. These portraits are now on permanent display in a prominent hallway in the medical school/hospital at which I am employed.

By the end, I came to think differently of my patients. In the office or hospital, I was the person in command, and the emphasis was on using my expertise to treat the disease process and little else. Away from the hospital, I saw that my patients had other interests that drove their lives, and that they generally coped well with their cardiac problems. When I went to their “turf,” their interests and what they were doing became the center of conversation.

Although impossible to prove, I believe this interaction with my patients made me a better provider of health care to them. Knowing something about their lives by seeing those lives through the lens of a camera outside the hospital helped me interpret their symptoms when I did see them in the hospital, and aided me in discussing health care options with them. Other physicians have had a similar response after seeing the portraits.

This project affected me in another unexpected way. After creating portraits of selected individuals, I found, if these patients needed to be seen earlier than anticipated, I would bend over backwards to see them out of schedule, even if it was inconvenient for me. I realized these patients had become something more than patients; they had become my friends, and I had to be careful not to show them preferential treatment in the office.

I found that this larger, more complete, view changed me as a person. In her book, Narrative Medicine, (Oxford University Press, 2006), Dr. Rita Charon uses the metaphor of “diastole” to describe the ideal patient–physician interaction. Diastole is the part of the cardiac cycle during which the heart fills with blood in anticipation of systole, the phase where it contracts and pushes out the blood that entered the heart. Charon believes that if we are truly receptive to what we take in about a patient when we interact him or her, and if we allow our minds and senses to go into a diastolic state, our behavior during the systole that follows will be affected for the better. I believe that making patient portraits was an unanticipated diastole for me that has changed not just how I think about my patients but how I act in caring for them.
T. D.: 85 y.o.♀; S/P porcine AVR presentation Class IV
CHF 2° AS dec EF
F.C.: 62 y.o. ♂; PAF/PAF1
F.R.: 62 y.o. ♂; BAV w sev AS w angina; S/P AVR
E.F.: 44 y.o. ♂; S/P primum ASD repair; HTN; hyperlipidemia
The Trial of Edward Jenner:
Performance as Pedagogy in the Medical Humanities
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Abstract

At Widener University, I designed a new Honors course titled “Humanities and Medicine” to broaden students’ understanding of these disciplines’ interrelationships. A major course goal was to have students reflect on the experience of medicine through performance in a public forum, challenging the students to widen their perspectives on medicine, especially dichotomies of life-death, health-illness, and provider-patient. To achieve that goal, the class wrote and performed their own drama—The Trial of Edward Jenner, inventor of the smallpox vaccination. Together, we created a dramatic scenario within a courtroom presided over by Hippocrates. Jenner and actual persons from his life populated the cast, along with witnesses as diverse as Louis Pasteur (for a retrospective perspective), Charles Dickens (for a description of this disease in Bleak House), and Shitala Mala as the Hindu goddess of the smallpox disease. Adding a philosophical viewpoint were two attorneys: Immanuel Kant prosecuting the charges of reckless endangerment of humanity versus John Stuart Mill defending from a utilitarian stance. This paper provides background on this project, evaluations from student participants, and aspects of the original script of The Trial of Edward Jenner.

Background on Medical Theater

The practice of medicine melds both science and art. That is, physicians—along with other healthcare professionals—must strive for the optimal balance of quantitative data and humanistic insight when caring for their patients. The medical humanities, in fact, encapsulate this duality by exploring the humanistic aspects of the medical field in an age of increasing technology and technocracy. Although most medical curricula now include courses that relate to the physicians’ need for sensitivity and empathy through exploration of patient narratives, not as many yet include courses with wider pedagogies drawing on literature, fine arts, and theater.

Over a decade ago, however, Flood and Soricelli (1993) put the issue of medical theater on the very stage through their seminal work, “The Seventh Chair: An Audience Encounter.” Their play drew on characters from literary pieces with medical encounters at their heart; physicians from those plays became characters anew within a therapy session led by a non-eponymous therapist. In the first act, the therapist leads five characters as they strive to resolve personal and professional issues in healthcare. In the second act, the therapist invites the audience as those sitting in the “seventh chair” to interact with the characters, thereby metaphorically putting the audience on the stage.

Since publication of “The Seventh Chair,” a compilation edited by Savitt (2002) was released with its related approach of medical readers’ theater. This compilation
includes 14 scripts adapted from other literary works with medicine or healthcare as central issues; augmenting the scripts are questions to facilitate post-performance discussion with cast and audience members. Savitt also provides directions for minimal staging: characters dress in black, sit on stools, and minimize theatrics for the most part. In this way, cast members (who are expected to be medical students) can enter the world of performance without the trepidations of ‘acting.’

This unthreatening approach of medical readers’ theater to entice students to place themselves into roles of providers and patients has since been adapted for specific uses in medical curricula. Fetters (2006) combines a clip from a well-known movie with a short original script to explore the issue of power in the physician-patient relationship. Along with follow-up discussion, this 2-hour session—albeit short—introduces medical ethics to incoming house officers in family medicine; subsequent sessions in the full curriculum expand on this initial framework.

Additionally, medical readers’ theater serves as one type of pedagogical technique in a half-day workshop targeting third-year medical students as a way to prepare them for the difficult interactions of end-of-life issues that they will inevitably encounter (Torke et al., 2004). This workshop uses a script adapted from an existing short story; role-playing exercises complement the theater technique.

Evaluations by the students of their views of this workshop approach were positive, with about 80% agreeing or strongly agreeing that the theater technique enhanced the course experience (48 of 60 respondents).

As evidenced by this brief review, performance and theater can allow students in medical curricula to envision the provider-patient relationship from different perspectives while maintaining an emotionally safe environment for all participants. Furthermore, the evaluation of non-traditional pedagogies contributes to the evolution of the humanities as a valuable avenue for medical education. In the next section, I discuss the development of a performance project as a major component of an undergraduate honors-level course at Widener University.

Development of Undergraduate Course

Students at the undergraduate level, particularly those studying for careers in any of the healthcare fields, are keenly interested in exploring medicine and healthcare from various vantages. Of course, at this early stage in their higher education, undergraduate students do not yet possess sufficient breadth and depth of background in this discipline to tackle the types of medical-theater projects just discussed in the previous section. At another university, I had worked with honors-level students in an existing course about literature and medicine; a high number of students were typically in that school’s honors program. I thus sought an opportunity to collaborate with our honors program, as these students are by their nature ready and open to educational challenges.

My first venture with medical readers’ theater at Widener University occurred in an experimental course titled “Literature and Medicine.” This earlier course focused on literary expressions of themes related to medicine and healthcare. A major component was staging three student-selected pieces from Medical Readers’ Theater (Savitt, 2002). Aided by an internal grant, I was fortunate enough to secure
the directorial assistance of a theater expert. Students’ responses to performance was so positive that I was determined to use that approach again.

That opportunity arose for the spring semester of 2007. Buoyed by these earlier results, I expanded the experimental course into a permanent one titled “Humanities and Medicine” that examined not only literature but also history, philosophy, and fine arts as vehicles for appreciating the non-scientific aspects of medicine. An underpinning goal of both versions is to challenge students to widen their perspectives on medicine, especially the dichotomies of life-death, health-illness, and provider-patient. A key goal is to reflect on the experience of medicine through their performance. For this course’s wider view across the humanities, the students researched, wrote, and performed their own drama—*The Trial of Edward Jenner*, inventor of the smallpox vaccination.

Together, we created a dramatic scenario within a courtroom presided over by Hippocrates; much of this material originated from Adler’s book, *Medical Firsts: From Hippocrates to the Human Genome* (2004), a required text for the course. In our version of this fairly unknown milestone in medical history, Jenner and actual persons from his life populated the cast. Adding philosophical viewpoints were the attorneys: Immanuel Kant prosecuting the charges of reckless endangerment of humanity vs. John Stuart Mill defending from a utilitarian stance. Witnesses for and against Jenner were as diverse as Louis Pasteur for a retrospective perspective, Charles Dickens for a description of this disease in *Bleak House*, and Shitala Mala as the Hindu goddess of the smallpox disease. At the conclusion of the play, audience members became the jury. Our performance—timed to coincide with our annual student project day—was performed for an audience of approximately 50 students, faculty, and family members. As for the earlier course, our performance was greatly enhanced by the same theater expert.

**Evaluation**

When implementing somewhat atypical pedagogies, instructors are keenly aware that not all will be immediate (or even eventual) successes; hence, evaluation of students’ perceptions of these techniques become paramount to the techniques’ development. For this course’s production of *The Trial of Edward Jenner*, my expectation was that students would more deeply appreciate the complex interplay of medicine and the humanities than through lecture and discussion in a typical course. I collected anonymous—albeit fairly limited—data on students’ perceptions of this technique by asking them to complete two online surveys of five questions each. For the class of 13 students, 12 completed the first survey focused more on their experience with the performance project, and 9 completed the second survey focused on what they learned from that experience.

Regarding their experience with the performance project, students were asked to rate on a five-point scale each of five elements. The percentages of students rating the project as “enjoyable” (4) or “exceptional” (5) follow below:

- Developing overall idea: 75%
- Researching characters: 42%
- Writing script of project: 66%
- Rehearsing & preparing: 84%
- Performing for Widener: 92%
Clearly, these students did appreciate this novel pedagogical technique. Related queries revealed that “researching characters” was scored more lowly because of the tedium of digging up facts on sometimes obscure persons. On a positive note, many students cited the camaraderie that this project engendered.

As for learning from the performance project, the students were evenly divided on whether the project “complemented but did not add to content,” “enhanced understanding of original content,” or “enhanced content while adding new elements” (33% each); none felt that the project “detracted from the course content.” When asked to choose from the following possibilities, students gave this breakdown on how the project enhanced their overall learning experience:

- Taught me to discover information on my own 11%
- Provided me with a fresh perspective on issues 22%
- Allowed me to understand concepts more fully 33%
- Challenged me to go outside my comfort zone 78%

Because this idea of going beyond one’s comfort zone was repeatedly emphasized in the course as a means to encourage exploration, its rating may have been falsely elevated. Still, these selected response excerpts epitomize the very essence of the results that I had hoped to achieve with this performance project:

“We learned about the philosophical, medical, and historical content that was embedded within our play. While researching and watching the performance of our play, I was able to see the learning put into action.”

“It reviewed all the material we covered and brought it to life. The project gave visual representations of the material and allowed us to experience it.”

“It was easier to understand the people and what it was like during that time. If I were to just have read the information, I would have probably forgotten it already.”

Script for the Performance

As might be expected by anyone familiar with theater, the script for our inaugural performance remained in revision up to moments before the play began. And as a course project with about only a month for preparation, the play itself retained some rough spots and minor factual discrepancies. Those issues notwithstanding, this performance project exceeded my expectations as a teacher of the medical humanities. Compliments from my colleagues continued for several weeks after the performance.

I must emphasize, however, that the pedagogical importance of this performance project is less in the product and more in the process. Minor disparities in the script paled in comparison to major enhancements in the students’ learning process, as evidenced by their survey responses. Moreover, our script took deliberate liberties with time and place so as to enhance the leaning milieu. I believe that the cognitive dissonance created within this process enhanced the students’ willingness to step outside their comfort zones, which is essential for understanding any concept from a perspective other than our own.

The key to using performance as pedagogy in the medical humanities is the learning process.

And so … on with the play!
References

Acknowledgments
Special thanks are due to Lisa Eckley-Cocchiarale for her directorial expertise, and to Ilene Lieberman and Mara Parker for their support in developing this honors-level course. This project, including our original script, would not have been possible without the efforts of the students of the 2007 course in “Humanities and Medicine”: Jaime Carr, Christina Dabovich, Jessica Darrah, Lauren Davidson, Stephen Erosa, Andrew Gatti, Denise Georganas, Kathryn Jacobsen, Vanessa Kershaw, Allecia Langston, Meaghan Shinkle, Toni Warner, and Jason Yeager. Aspects of this material were previously presented at the Pennsylvania Medical Humanities Consortium in May, 2007, in Carlisle, PA.
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