

Conceptualizing Medical Humanities Programs in Low-Resource Settings in Africa

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Abstract

The role of the humanities in medical education remains a topic of dynamic debate in medical schools of high-income countries. However, in most low- and middle-income countries, the medical humanities are less topical and rarely even have a place in the curriculum. Reasons for this dearth include inadequate resources to support such programs coupled with misapprehension of the role and significance of the humanities in medical education.

In this article, the authors argue that the humanities have a vital role to play in the low-resource settings of African medical education. They discuss the complexities of the continent's sociohistorical legacies, in particular the impact of colonization, to provide contexts for conceptualizing humanities programs in African schools. They outline the challenges to developing and implementing such programs in the continent's underresourced medical schools and present these as four specific conundrums to be addressed. As a general

guide, the authors then suggest four nonprescriptive content domains that African medical schools might consider in establishing medical humanities programs.

The goal is to jump-start a crucial and timely discussion that will open the way for the feasible implementation of contextually congruent humanities programs in the continent's medical schools, leading to the enhanced education, training, and professional development of its graduating physicians.

The humanities ... are the crucible within which our evolving notions of what it means to be fully human are put to the test.... They are thus, inescapably, political ... [b]ecause they complicate our vision, pull out our most cherished notions ... grow uncertainty ... expand the reach of our understanding ... force us to draw and redraw the borders of tolerance.... The humanities, in short, are a superb delivery mechanism for ... democratic values.

—Mark Slouka, “Dehumanized”¹

The role of the humanities in medical education continues to be a topic of intense debate in high-income countries (HICs), especially in Europe and the United States. However, in medical schools of low- and middle-income countries (LMICs), particularly in Africa, the topic is currently a less contentious issue, mostly because of the scarcity of humanities programs.² The reasons for this dearth are likely related to resource constraints³ as well as to the continent's

immense cultural and ethnic diversity and its complex historical legacies.

In this article, we argue that the medical humanities could play an invaluable role in African medical education. We believe the time is opportune for developing such programs following the considerable gains achieved in general medical education in Africa over the past decade through initiatives such as the Medical Education Partnership Initiative.⁴ Given that more than a hundred new medical schools are projected to open over the next decade in Africa,^{5–7} devising a timely conceptual map for medical humanities programs presents a unique opportunity as well as several distinct challenges.

Below, we discuss complexities of Africa's sociohistorical legacies, to provide contexts for conceptualizing the development of medical humanities programs. We present four conundrums in conceptualizing and implementing such programs. Finally, we suggest four possible curricular domains as a guide for African medical schools wishing to implement or redesign a humanities program. Our goal is to jump-start a timely and crucial debate on devising contextually appropriate and feasibly implementable humanities programs within the curricula of the continent's established and emerging new medical schools.

Complexities of African Contexts

Africa is composed of 54 countries and myriad ethnic groups, languages, and cultures.⁸ Discussing the continent as an entity glosses over and essentializes its many ethnicities and contexts. We, the authors of this article, were all born and raised in Africa and are thus attuned to a range of the continent's contextual complexities. We start by discussing the contexts most relevant to the development of medical humanities programs in Africa.

A decade ago, Bleakley et al⁹ insisted that the relationship between “postcolonial theory and medical education” deserved closer attention. They warned against “the dangers of pushing through international initiatives without careful consideration of local perspectives” and cautioned that education strategies and curricula should not be “cooked up” in Western universities and exported to LMICs without taking account of local contexts. Instead, approaches to education should be context-specific and formulated “in the heat of practice.”¹⁰ (We use the term *Western* throughout this article to mean broadly *European* and *Anglo-American*.) These admonitions apply with equal force to the development of medical humanities programs in Africa.¹¹

The historical exploitation of the African continent from slavery through colonialism (and neocolonialism) has

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profoundly impacted African cultural and personal identities. Identity issues also affect professional identity development of African physicians and other health workers, a topic that might be addressed by the medical humanities.

A common misconception in Western education is that African nations had little experience in formal education (let alone the humanities) before European colonization and that African education systems are thus rooted in the Western canon of learning. This view is evident in some of the racially tinged writings of European intellectuals like Kant, Hegel, and Hume and in the novels of colonial-era authors like Conrad, Haggard, and Kipling, who implied that rigorous thinking and the humanities were virtually nonexistent in Africa before European colonization. To this end, peoples of non-European descent, such as Africans under colonialism, were designated and subordinated as “the Other”¹² to imply cultural inferiority. Edward Said¹³ (author and postcolonial theorist) coined the term “Othering” to connote such colonialist exclusion, subordination, and marginalization of indigenous peoples.

Written evidence of precolonial African humanities is admittedly sparse. African intellectuals like Gyekye,¹⁴ Wiredu,¹⁵ Houtondji,¹⁶ Mudimbe,¹⁷ and wa Thiong’o¹⁸ in his landmark work *Decolonising the Mind* have argued that the painful depersonalization that generations of Western-schooled Africans endured, and the brutal imposition of European languages over African languages, seriously debased and stunted the natural growth of African cultures. This systematic debasement undoubtedly impeded development of the humanities across the colonized continent. Even today, Africans’ personal and cultural identities remain fractured, and Africans are preoccupied with “decolonizing the African mind.”¹⁹

Given these historical exigencies, an uncritical reliance on Western humanities frameworks that fails to take account of the continent’s painful historical legacies would be unacceptable to many Africans and would likely yield adverse outcomes. These exigencies, and the fact that many of the education settings of the continent are underresourced, present

specific challenges in conceptualizing and developing medical humanities. We present some of these challenges in the form of the following four conundrums.

Challenges in Conceptualizing and Developing Medical Humanities in Africa: Four Conundrums

Conundrum 1: How can program developers balance the universals of human experience with the particularity of contexts?

[M]edical humanities as a field has often been strongly, although not wholly, reflective of the traditions of Western (Anglo-American and European) culture, particularly what used to be referred to as “high” culture.... What constitutes the “medical humanities” could differ profoundly from place to place, particularly in the developing world.

—Claire Hooker and Estelle Noonan, “Medical Humanities as Expressive of Western Culture”²⁰

The development of African medical humanities programs presents a challenge of balancing what humans share universally against recognition and respect for the continent’s local cultures and contexts. Nussbaum²¹ argues that the humanities should foster “the ability to transcend local loyalties and to approach world problems as a ‘citizen of the world.’” But Wiredu²² questions “how far issues and concepts of universal relevance can be disentangled from the contingencies of culture.” In the postcolonialist contexts of Africa, such “universals” of humanism tend to be negatively identified with Western culture and colonialism. Likewise, the medical humanities are still widely viewed as Western and exclusive of other approaches to medicine, as Hooker and Noonan²⁰ and others²³ have pointed out:

[S]ince Western cultural traditions embody certain ideas about selfhood, patienthood, illness and medical care, the dominance of these traditions may exclude important ways of knowing and being for both Western and non-Western patients and doctors.²⁰

Medicine’s complex relationship with colonialism further exacerbated Africans’ early distrust of Western culture. For example, Lyautey, the French colonial administrator, viewed medicine’s

lifesaving qualities as justification for colonialism’s brutality:

The only excuse for colonialism is medicine.... [What] ennobles ... and justifies [the brutality of colonization] ... is the action of the doctor.... The physician, if he understands his role, is the most effective of our agents of penetration and pacification.²⁴

Behind the façade of benevolent European rule that Western medicine helped construct lay a more sinister reality that shaped the ongoing mistrust of medicine in many African communities. Tropical medicine, as it was called in colonial times, was insidiously implemented in specific contexts to control and restrict the movement of indigenous peoples (e.g., by implementing overly restrictive and even fake quarantine measures).²⁴ During this period, medicine attempted to sustain the health of the virtually enslaved workforce to keep it effective and viable, and also to keep the colonial troops and administrators healthy. Colonial powers wished to understand diseases as manifested in indigenous populations versus expatriates because these diseases ravaged colonial troops and other expatriates at higher mortality rates than those for the indigenous peoples.²⁴ At the same time, colonial rule dismissed African medical knowledge as witchcraft and forced indigenous African health care practitioners underground.

This simultaneous malpractice of Western medicine and devaluation of African medical knowledge created an ongoing suspicion of Western culture and medicine that is manifested still today in the resistance of many African communities to Western medical treatments and preventive practices such as immunization and treatment of epidemics like Ebola, cholera, and HIV/AIDS. Navigating these painful historical and sociopolitical legacies of the African continent and balancing them against universals of human experience and the ethical application of modern medicine and science presents a challenging conundrum for medical education and humanities in Africa.

Conundrum 2: How can program developers justify the relevance of the humanities in low-resource settings?

Justifying the relevance of the humanities and expending precious resources on them in the medical curriculum, in the

face of competing demands from the basic and clinical sciences, presents a conundrum for underresourced medical schools in Africa.

Macneill and others^{25–28} present numerous compelling arguments to demonstrate the value of humanities in Western medical schools. In her seminal book, *Not for Profit: Why Democracy Needs the Humanities*, Nussbaum²¹ argues that the humanities have a vital role to play in sustaining democracy. Suppressing the arts and humanities can jeopardize a democracy by stifling the vital voices of critically conscious citizens. Arguably, as a consequence of colonial rule and as an unintended consequence of ravaging wars for independence, several African countries were left with fragile democracies ruled as one-party states by authoritarian leaders. The humanities could serve a democratizing function in these settings

Nussbaum, Bleakley, and others^{21,25,29} suggest that the arts and humanities provide the imaginative conditions for engendering democratic values that are antithetical to autocracies:

The humanities diagnose social ills, such as unproductive authoritarian behavior grounded in intolerance and ambiguity; and suggest cures, such as tolerance of difference through open debate and collaborative activities.²⁵

Bleakley²⁵ insists that the humanities “educate for tolerance of ambiguity as a basis to learning democratic habits.” Whereas medicine as a discipline strives to *resolve* the uncertainties of diagnosis and illness, the humanities *thrive on* (and even *create*) uncertainty and persistent questioning. Such ambiguity and uncertainty coupled with the critical questioning that characterizes the humanities are anathema to authoritarian regimes:

Art is the great enemy of ... obtuseness, and artists (unless thoroughly browbeaten and corrupted) are not the reliable servants of any ideology, even a basically good one—they always ask the imagination to move beyond its usual confines, to see the world in new ways.²¹

Kenyan author Ngũgĩ wa Thiong’o³⁰ argues in an essay entitled “Art War With the State: Writers and Guardians of a Postcolonial Society” that artists pose a threat to authoritarian regimes because they question

societal assumptions and demonstrate to the public alternative aspirational worldviews. Contemporary U.S. author Mary Karr³¹ puts it more graphically:

If you ever doubted the power of poetry, ask yourself why, in any revolution, poets are often the first to be hauled out and shot—whether it’s Spanish Fascists murdering García Lorca or Stalin killing Mandelstam. We poets may be crybabies and sissies, but our pens can become nuclear weapons.

The humanities also have a vital role in developing in students “critical consciousness”—a term coined by Freire²⁶—which Bleakley³² defines as “a ‘reading of the world’” that allows students

to sensitively gauge the positions of others and to engage in dialogue to address issues such as inequality and inequity so that previously silent and silenced voices can be heard.

Physicians as privileged and respected members of society also have a vital, but often underrecognized, role to play as advocates of the poor and in speaking out against inequality and injustice. But the intangible attributes instilled through the humanities, important as they could be in such advocacy, remain hard to justify—especially in underresourced settings—when juxtaposed against the certainties of medical science that can readily demonstrate effective outcomes in treating patients.

Conundrum 3: How can program developers measure impact and demonstrate outcomes for the humanities?

Developers of medical humanities programs in Africa will be hard-pressed to justify the place of humanities in a crowded science-based curriculum by demonstrating tangible outcomes. In recent decades, Western medical education has embraced *competencies* and competency-based medical education (CBME) as a framework for demonstrating outcomes of medical education. Whether CBME is the most effective way of assessing outcomes remains contentious even in HICs.^{33–36} Some educators insist that competencies should be directly observable.³⁷ Others argue that not all educational attributes can be framed as competencies, and not all competencies can be assessed by direct observation—for instance, reflection, curiosity, reflexivity, and imagination—

and should therefore be “off limits to the competency gaze.”³⁸

Dissimilarities in cultures and “ways of knowing” further complicate the attempt to measure educational outcomes through the Western construct of competency assessment.^{23,39} The competency model, with its emphasis on observable outcomes, standardization, and externally imposed criteria, may be misplaced and ineffective in humanistic fields of knowing. Charon⁴⁰ captures this distrust of outcomes measurement:

One can and ought to wonder whether it is beside the point to try to measure, through reductive processes of evaluation, that aspect of learning which is meant as an antidote to the reductiveness of the curriculum itself.

Whereas McManus⁴¹ insists that the humanities “must bite the bullet of definition and measurement even if it seems to be ‘defining the indefinable,’” Bleakley⁴² argues that trying to measure outcomes in the medical humanities is pretending to “measure the immeasurable.” He insists that the drive for outcomes measurements is a

symptom of the inability to tolerate ambiguity ... [that] has been generated by skeptics [of the humanities] and not advocates ... the former placing the burden of proof of effectiveness on the shoulders of the latter.²⁵

We maintain that even though not readily measurable, the humanities can add value by enhancing students’ conceptual thinking capabilities (and “critical consciousness”³⁴) as well as their tolerance of ambiguity, resilience, and capacity for empathy.^{44,45} In low-resource settings in Africa, skeptics are likely to be emboldened in their opposition to the humanities under the pretext of guarding valuable and limited resources against a “luxury” the efficacy of which cannot be measured. Such skeptics will need to be convinced of the value of the humanities. As Greene and Jones⁴⁶ rightly point out, the basic sciences are not held to the same standard:

Proponents of the evidence-based curriculum design demand proof that the medical humanities produce better doctors. But such proof is seldom demanded from the basic sciences. When schools reduced anatomy instruction, no one conducted follow-up studies to see if schools still graduated competent surgeons.

In underresourced African medical schools, justification for the medical humanities is likely to be challenged by deans and administrators with a demand to demonstrate impact and outcomes. Humanities programs need to be prepared to counter this freighted challenge.

Conundrum 4: How should program developers conceptualize appropriate curriculum content?

The immense diversity of Africa's contexts and its complex legacies presents a fourth conundrum for the medical humanities in developing programs with appropriate curricular content. Selecting what content is most congruent and fitting for specific contexts, and that also best fits the educational mission of different countries and their medical schools, will present specific challenges for educators. Belling⁴⁷ and Bleakley²⁵ implore the medical humanities not to fall into a *content trap*—in which educators become preoccupied with the question of which specific subjects, topics, and even facts to teach—rather than engaging the humanities toward cultivating qualities such as creative imagination, reflection, curiosity, and empathy. The biomedical model that still dominates much of Western medical education continues to value factual evidence and logic over intuition, imagination, and creativity and prefers defined content rather than conditions that create ambiguity, uncertainty, and speculative discussion.

To avoid a counterproductive content split in the curriculum—at least between sciences and humanities—perspectives and approaches from the humanities and social sciences might, for instance, be integrated into medical case studies to stimulate students to think about their responses to societal and historic forces causing illness. Africa's collectivist cultures and participatory approaches to learning and general acceptance of alternate “ways of knowing” may quite readily accept this integration of knowledge.

Whitehead et al⁴⁸ also caution that educators temper their expectations of the curriculum's capacity to cure “the ill of society” or fix social problems (even if “democracy needs the humanities,” as Nussbaum²¹ insists). Furthering this

argument, Bleakley⁴⁹ proposes that “[t]he medical humanities may be reformulated as process and perspective rather than content” and that medical educators shift their emphasis towards “support of learning rather than transmission of teaching.”

If a purpose of the humanities is to create and deal with uncertainty and ambiguity,⁵⁰ one might ask, Why teach medical humanities in low-resource settings, which are already fraught with such uncertainties and ambiguities? The humanities, however, nurture and develop learners' capacity to tolerate such ambiguity and uncertainty and to deal with these unsettling situations with resourcefulness and resilience.³⁹

Thus, rather than focusing on content as in Western individualist education systems, African medical educators might instead also consider qualities of process in humanities curricula, as this may align better with collectivist cultures and participatory approaches to learning.^{34,36,51}

Four Proposed Domains to Consider in Developing African Humanities Programs

What might the structure and content of African medical humanities programs look like? Our intention here is not to be prescriptive but, rather, to present some features as guidance in developing homegrown African humanities programs. We propose four domains for African schools to consider in developing such programs. Programs could be constructed to include all four domains, or components thereof, or to have a primary focus on just one or two domains. Another option might be to incorporate these domains as “threads” through an alternate program structure.

Identity—individual versus collective

[I]ndividualism (“the heroic doctor”) must be replaced by the collectivism of patient-centered, interprofessional teamwork to create the environment within which political transformation to authentic democratic practices can occur.
—Alan Bleakley, “The Perils and Rewards of Critical Consciousness Raising in Medical Education”³²

A critical domain for teaching medical humanities in Africa would focus on issues of personal and collective identity. Such a domain would encompass

not only the impact of slavery and colonialism on African identities but also the ontologic spectrum of human experiences from the individual to the collective. Most indigenous cultures (especially in Africa and the global south and particularly in low-resource rural areas) hold a relatively collectivist view of identity compared with the individualism of the global north. African philosopher Kwame Gyekye⁵² asserts that there are

sufficient commonalities in many areas of the cultures of the African people to make interminable disputes over the use of the term “African” unnecessary and unrewarding.

While such generalities are anathema to many social scientists because they risk the essentialization of indigenous peoples, collectivist “relational” approaches to identity continue to predominate many aspects of life in Africa.

In indigenous knowledge systems, health is experienced not only as an individual state but also as a sense of collective well-being. Healing is achieved through human interaction and inclusion in communities. This has also been articulated in the fields of psychology⁵³ and occupational therapy⁵⁴ and explored in health professions education.^{55,56} Psychologists make the distinction between the private self, the public self, and the collective self, and people in different cultures exhibit these three kinds of selves in different proportions.

One expression of a way of being from the global south that is critical for appreciating a collectivist dimension to human occupation is the African ethic of *Ubuntu*. This concept, which has correlates in other contexts and cultures,^{57–60} describes how “individuals become individuated through their engagement with others, and their ability to live in line with their capability is at the heart of how ethical interactions are judged.”⁶¹

The collectivist worldview has implications for health care and health professions education. For instance, it demands that greater attention be paid to the immediate and extended family of a patient. African cultures are especially respectful of ancestral heritage, and people often consult indigenous healers to discern the reason for an illness or

misfortune rather than just treating symptoms or finding a cure.

Health science students are also diverse in their origins and lineage and have become increasingly aware of their own identities as well as their political alignments. Any teaching and learning in the medical humanities needs to account for such diversity and could be applied toward self-reflection and deep learning through facilitated interactions in the classroom as well as in the community to enhance patient care and affirm individual and collective identities.

The arts, language, literature

Medical schools with limited resources in Africa may too readily consider the arts a questionable luxury. Bleakley²⁵ insists, however, that “we must unhook ourselves from the legacy of aesthetics as ‘high art’ and that aesthetics is confined to ‘pleasure.’” The arts in Africa go beyond aesthetics of pleasure to affirm community, as well as personal and collective identity, all of which contribute to physicians’ professional development and identity formation.

Bleakley²⁵ argues that the uncoupling of the arts from the purely aesthetic opens up alternate perspectives of the arts as fostering “sensibility” (the potential of the senses for “close noticing”) and “sensitivity” (consideration for the feelings of others). “Close noticing” enhances clinical perception, which has diagnostic utility; consideration of others’ feelings is associated with empathy and being a caring physician. Beyond the purely aesthetic, the arts thus have a distinctive role in medical education in development of physician empathy and clinical astuteness.

The colonial desecration of African cultures, including literatures, music, and arts, had a negative impact on African identities, as wa Thiong’o¹⁸ argues:

The real aim of colonialism was to control peoples’ wealth.... [T]his involved two aspects of the same process: the destruction or the deliberate undervaluing of a people’s culture, their art, dances, religions, history, geography, education, orature, literature, and the conscious elevation of the language of the colonizer.

The arts could reaffirm fractured African identities if they are presented

and incorporated authentically, and their inclusion in a medical humanities program could likewise be reaffirming and positively impact physicians’ professional identity formation.

In medical humanities courses in HICs, literature is often included through “narrative medicine” to simulate empathy⁶³ and to teach students to better understand and analyze the vital components of patients’ stories of illness.^{40,64} The latter capability has been defined as “narrative competence”—“the ability to acknowledge, absorb, interpret, and act on the stories and plights of others.”⁶⁵ In addition to drawing on the publications of African writers (and other global writers of relevance), medical humanities programs in Africa should also draw on oral African literatures. While often drowned out by Western narratives and African literatures written in European languages, the lingering oral tradition of storytelling would help medical humanities programs develop narrative competence in trainees. How do patients in different African cultures experience illness and tell their illness stories? What are the structural components of stories and storytelling in African contexts? How should doctors learn to listen to patients’ stories and communicate through stories in the interests of healing?^{66,67} What should the role be of reflective practice and reflective writing in humanities curricula in Africa (where drama and storytelling may come more naturally than writing)?³⁹

Critical thinking, metacognition, theory of mind

An important function of the humanities in medical education is to engage the trainee’s mind cognitively and emotionally to enhance both conceptual thinking skills and the capacity for empathy, self-awareness, and understanding of others. A proposed content domain might include the categories of critical and conceptual thinking, metacognition, and theory of mind. Whereas the relevance of critical thinking for clinical reasoning in medical education is self-evident, educationists have only more recently promoted the value of other *metacognitive* attributes such as cognitive flexibility, emotional agility, self-monitoring and regulation, as well as attributes encompassed by *theory of mind*,⁶⁸ which entails the capacity to

understand and predict the mental states (e.g., thoughts, beliefs, desires, intentions) of patients, colleagues, and others both with respect to one’s own and others’ cultures.^{69–74}

These attributes help physicians navigate the uncertainties and complexities of medicine and better understand the minds/emotions of others toward building empathy and resilience.^{71,72} Low-resource settings are fraught with uncertainties, and working in such settings calls for resilience, empathy, and the capacity to tolerate uncertainty. Making students aware of their own and others’ thinking processes would help them in dealing with uncertainty and developing such empathy and resilience. Baruch⁷⁵ points out,

The opportunity to come into close proximity with our thinking process and to train our minds to work more openly is a powerful function of the arts and creativity in medical education.

Whereas metacognitive attributes (thinking about thinking and emotion) focus on *one’s own* mental states and appear aligned with Western individualism,^{36,51} theory of mind attributes⁷⁴ align with the collectivist contexts that would find a natural place in African humanities programs.^{34,36,51,76}

Ethics, human rights, social justice

Given the continent’s multifarious sociocultural, ethics, and human rights issues coupled with its history of colonial injustices, another medical humanities domain might include discussions of ethics, human rights, and social justice that would also make explicit the links of these disciplines to social determinants of health and to indigenous traditions and forms of knowledge. This domain may face a challenge in navigating between a collectivist tendency toward tolerance and conformity versus collective action for social justice, which requires speaking out and challenging abuses of power and authority.⁷⁷

Also relevant are ethical issues pertaining to the privileged position of physicians often working in settings of poverty, who may be guilty of what sociologist Pierre Bourdieu terms “symbolic violence”⁷⁸ to connote a “blindness of privilege . . . that instills in those who have great advantages a blindness to the needs of those who do not.”⁷⁹ This social gap presents an

ethical and social justice challenge for physicians that should be addressed in a medical humanities program. Finally, ethics, human rights, and social justice are critical components of the democratic ideal, which, as we have argued throughout this article, the humanities strive to sustain.

These four proposed content domains (or components thereof) may be adapted to the contexts and goals of specific schools, and in ways that align with how each school chooses to resolve the conundrums we present (and other challenges the school may face) in developing and implementing its medical humanities program.

Hard Challenges and the Urgent Need to Address Them

Conceptualizing the medical humanities in Africa's low-resource settings presents a constellation of hard-to-resolve challenges and conundrums associated with the continent's immense diversity and its painful colonial (and other) legacies that have instilled distrust of the Western canon of the humanities. Exacerbating the problem are nettlesome decisions about program content, the general dearth of human and material resources, and the ongoing challenge of having to justify the humanities' relevance in a science-heavy medical curriculum. With more than a hundred new medical schools projected to be established on the continent over the next decade, there is an urgency to address these challenges so that the humanities may find their opportune place in the curriculum of Africa's medical schools. The continent needs health professionals who are holistically versed in both the sciences and the healing arts of medicine.

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