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BOOK REVIEW: "Health Humanities and Applied Literature"

Paul Crawford, et al., *Health Humanities*. Palgrave Macmillan, UK, 2015. Pp. 208. ISBN 978–1–137–28260–6 paperback (Retrieved from http://booksc.org/book/36004561/5e41f0)

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Health Humanities written by Paul Crawford, Brian Brown, Charley Baker, Victoria Tischler, and Brian Adams was first published in 2015 by Palgrave Macmillan, UK. The book is a result of many years of experience of work in the field and comes at a right time after the successful organisation of some international conferences on health humanities by Professor Paul Crawford, et al. in the preceding years. Structurally, it includes the following chapters: 1) "Health Humanities", 2) "Anthropology and the Study of Culture", 3) "Applied Literature", 4) "Narrative and Applied Linguistics", 5) "Performing Arts and the Aesthetics of Health", 6) "Visual Art and Transformation", 7) "Practice Based Evidence: Delivering Humanities into Healthcare", 8) "Creative Practice as Mutual Recovery", and finally "Concluding Remarks". The book also contains, amongst other things, three important entries: "List of Figures and Tables", "References", and an "Index", which add to the attraction of the book and make it an authentic read. In the "Acknowledgements" section of the book, the authors thank many health-related organisations in the UK, specially the Creative Practice as Mutual Recovery consortium for practically helping them with their "Mutual Recovery", a subject that has duly and frequently been dealt with in chapter eight.

In the first chapter, the authors make a distinction between two key terms: "medical humanities" and "health humanities". The former focuses on the traditional marriage between Medicine and Humanities. The latter touches upon the "appliedness" (1) of arts and humanities in health, healthcare, and well-being, when the works and mutual services of doctors, nurses, hospital staff, informal carers, caretakers, care workers, caregivers, and patients and care receivers are taken into consideration. In comparison with medical humanities, health humanities is a "superordinate term" (19). Apart from hospitals and clinics, other places such as "schools", "prisons", private homes, and "community settings" are thought of as locations in which arts and humanities can be applied to healthcare (19). It is the ability of "humane ways" (18) of arts and humanities together with the literary

experiences they convey which contribute to the enhancement of the experiences of the doctors, nurses, and carers. They get "transported" as a result of listening to the expressive therapy of the patients. The professional staff in hospitals may resort to a variety of literary tools and terms as are fashionable in the 21st century to tell sympathetic stories to their patients/sufferers, and listen to the stories told by them. The subjective experience of the patients, service users, and self-caring individuals help the doctors to understand the source of their illnesses better. The chapter concludes with the phenomenal remark that health humanities "promotes co-design, co-creativity and co-learning rather than an expert to lay approach. . . . It extensively calls for a more extensive, mutual and applied field of work for delivering better social and cultural futures" (19).

In the second chapter, the application of anthropology to medicine is emphasised. Anthropological views can contribute to a large extent to the development of health humanities. It is said that if healthcare practitioners know about anthropology, they can better serve patients and clients with "lay beliefs and practices" (36), because the knowledge of anthropology helps the practitioners to avoid "misunderstanding their audience" (36). In this chapter, emphasis is put on "the importance of examining people's own explanatory models about their health" (36). What then really matters is the mutual understanding between the doctor and the patient. The differences between the doctor and the patient's accounts of the latter's illness are not just because of their amount of knowledge but "different values and interests" (37).

The third chapter touches upon Applied Literature, a subject of huge interest to modern literary researchers. The names of three erudite journals with subject matters on medicine and literature are put forward here: *Literature and Medicine*, *Journal of Medical Humanities*, and *Medical Humanities*. In the chapter, it is mentioned that clinicians, doctors, medical students, and interested researchers may wish to know about the contribution of literature to medicine. First of all, stories about "illness, health, death, disability and survival" (58) interest the healthcare staff humanely and empathically. It helps them to view the patient not just as a "body, a constellation of symptoms, a syndrome or a diagnosis" but as an "autonomous and active partner in their care . . . [with] the lived experience of . . . [the patient] *outside* and *beyond* the biomedical gaze" (59). As far as man lives on earth, there are always stories to be told which will act as a "salve for the most wounded of souls, the wounded healer, the wounded carer, the observer interested in wounds" (59). Telling stories, help the sufferers lessen their traumas in an age of trauma.

Chapter four includes arguments on the importance of narrative criticism in health humanities. Crawford et al. (2015) argue that it is easy to detect if a narrative has a beginning, a middle, and an end in its plot structure and what regular patterns, motifs, and moral lessons it intends to convey to the practitioners and patients. A

story may resonate intertextually with the previous ones. In this way, a text is a "co-construction" and "co-production" (73) influenced by what the clinician and the client have for each other. Linguistics helps us "elicit the patternings in larger data sets", i.e. it gives the "under-served . . . [in] face to face healthcare" opportunities and situations to express themselves (81). The "narrative medicine" in health humanities gives the doctors something beyond what traditional "symptom checklists" or "vital signs" can give (81); such stories consolidate the bonds of friendship between the caregiver and care receiver. In fact, they contain "true medicine" because are "patient oriented medicine" (81).

In chapter five, the prevailing healthcare culture is contrasted with health humanities. Here are a couple of differences sketched out in the chapter: the former is "monological" (102), the latter "dialogical" (102); the former is positivistic, the latter based on "situated realities" and "negotiated meanings" (103); the former defines health as a "physiological or behavioural fact" (103), the latter maintains that human health is associated with "*being-in-relationship"* (103); for the former, the context is "typically regarded as a set of variables, and still part of the same, technical chain of causality" (103), for the latter, emphasises is put on the "multidimensionality and relativity of social context" (103); for the former, the performing arts act "as technical procedures, demonstrate a measurable, statistically predictable impact upon health" (103), for the latter, on the other hand, arts "contribute ways of knowing as contexts, dialogue, and negotiated meanings" (103); and, consequently, for the latter, health and humanities are in a mutual relationship in which "*health is performed"* (103-04). Both "performing arts and health . . . [are] *ways of being*" mutually serving one another "in the interest of improving the human condition, in large part via addressing matters of equality and social justice surrounding health practices" (104). The practice of allowing arts to work for health and health for arts facilitates the aestheticization of hospitals and health clinics and the time spent amongst the patients ("relational, human, *kairos*") (104). The conclusion to "working in synergy, [is that the two] can enrich one another for the benefit of individuals, communities and society" (104). To avoid "re-traumatisation or re-symptomisation", the performers must observe "ethical considerations" in their performance for "health promotion, health communication, and health enquiry" (105). This strategy will work fully only if ethics which is part and parcel of humanity comes "naturally, with relative ease" (105).

In chapter six, Crawford et al. intend to open up new lines of thought concerning the interrelationship between the applicability of health studies and arts and humanities. The authors maintain,

> Art represents a cultural, aesthetic and historical mode of representation, one which is immediately potent due to the dominance of our visual sense

> and the visual culture in which we exist, and as such can be a catalyst to enhance health and well-being. (119)

To remind us of what has gone before, the basic uses of art are brought to our attention: art represents work on "neuroaesthetics" ("brain's response to art") (106-07), it is "therapy" (106), it is "an educational tool" (106), it is used "to enhance clinical and public environments" (106), it is used to "facilitate communication . . . and 'spiritual regeneration'" (106), it has been used for centuries in the production of "figurines" (106), it served as "foundational to culture" (106), it has "utility in a variety of formats" (107), and it has been used as "an elitist pastime" (107): in the 18th century Britain, for instance, the well-to-do travelled throughout Europe familiarising themselves with art forms; upon return, they filled up their homes with artefacts and used them for pedagogical purposes. Arts serve as a "means to connect individuals and alleviate social exclusion" (107). Arts evoke certain feelings in the viewer and help them achieve "self-actualisation" (108) and "self-realisation" (112), because they are "therapeutic as it [they] provides stimulation and pleasure at the point of creation, in its completion, and in the pleasure artistic outputs can bring to viewers" (108). In severe cases of trauma, dementia, schizophrenia, and alzheimer, art has the "ability to heal" because it can express the inexpressible (110). In this chapter, the relation of the art form to health humanities has been bookmarked as a successful example of interdisciplinary studies in which the patient experience is foregrounded and empathy encouraged. In this "patient-centred way . . . patients [are encouraged] to be active and equal decision-makers in their care" (113). The term "sciart" is used to denote the relationship between art and science (117). If hospitals are decorated with artefacts to help the patients forget about their pains by watching these artefacts, then hospitals can act as "cultural resources" (114). The ultimate aim is to transport (to borrow Longinus's remarkable term) the patient to enable him/her talk about his illness freely. The unique mission of art is therefore to "enhancing human health individually and collectively, through therapy, education and exhibition" (118). Examples of artwork imparting huge therapeutic meanings are paintings and statues made based on John Keats's "On Seeing the Elgin Marbles", "Ode on a Grecian Urn", "To Autumn", and P. B. Shelley's "Ozymandias".

In chapter seven, distinctions are made between two key terms: "evidence based practice" and "practice based evidence". The former is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients, based on the skills which allow the doctor (sic) to evaluate both personal experience and external evidence in a systematic and objective manner. (121)

Different evidences carry different values and merits. And, a small scale research, in the opinion of Crawford et al. (2015), better suits the purposes of the practitioners

and sufferers than "large scale randomised controlled clinical trials" ("experiments") (121-22). The "best scientific evidence should inform practice" as it includes "technological paradigm" (122). Even the best evidences may not be so efficient when it comes to practicing them, as "people often have complex multiple health problems and needs" and, therefore, "in practice it is often difficult to be precise about what is wrong with people and what exactly it is that the intervention is addressing" (123). On the other hand, practice based evidence is "a bottom-up means of gathering evidence from the experience of everyday practice, drawing on the expertise of practitioners and service users to inform recommendations for future practice and, ultimately, policy" (124). But then it is "not an easy task" to clearly show "what is happening within arts and humanities" to draw the relevant evidences for later theorising (124). To just finish when evidences are found is an incomplete endeavour as this reminds us of times when "as if research has ended as soon as the report is written to the funders, the paper has been accepted for publication, seminars have been given and participants and stakeholders have all gone home" (125). The best research findings were those which were "contextualised in terms of . . . [the practitioners'] own professional experience" (125). The practitioners could then mix and mingle "locally-situated practices" with their own research. Crawford et al. (2015) remark that mere "research findings do not necessarily represent truth about reality" (125).

In another development, the authors have highlighted the high importance attached to narrating fairy tales and folktales for healing the mental wounds of the patients. They contend that "fairy tales are a 'metaphorical mode of communication' which people use to understand both themselves and the social world around them" (125). Examples of great fairy tales include, among other great works, Shakespeare's *The Tempest* and *Midsummer Night's Dream*. These ". . . stories soothe people with the analogies that they provide, normalising, through metaphor, the vicissitudes of life's travails. . . . [they] serve an epistemological function – that is, they are concerned with the nature of knowledge" (126). This "allow(s) clients (and maybe practitioners too) to examine their own difficulties through this process of mutually negotiated meaning" (126). In the latter part of the 20th century, a variety of postmodern literary theories emerged which allowed "peoples, groups and kinds of experience that have hitherto been marginalised . . . [to] be heard" (127). The chapter concludes with an explanation of many useful literary terms and devices such as "transgressive validity", "emancipatory action research", "simulacra/ironic validity", "paralogical form of validity", "rhizomatic validity", "voluptuous validity", and "hermeneutics". Each of these deserves to be properly studies and applied in separate studies. However, in order to get a "more complete picture of what may be going on when the humanities are applied in healthcare," it is better to

"integrating (Sic) a variety of suitable methods" that would benefit "service users, investigators, practitioners or commissioners" (136).

In chapter eight, the final chapter of the book, the authors state that given the fact that the book was meant to be a "slim manifesto volume" (137) much useful "arts and humanities-based knowledges and practices" have been omitted. We are once again referred to the important discussion of the reciprocal and mutual value of arts and humanities and health humanities. The democratic nature of services in healthcare has once more been emphasised. Creativity and creative practice have been emphasised upon as these are the tools which interest both the informal carer and the sufferer alike and cause faster mutual recovery in a traumatic world. We may conclude this review by mentioning the following points:

- Hospitals must be refurbished with beautiful decorations.
- Soft, soothing music must be played inside the hospital as this leaves a more positive impact on patients and evokes kind, gentle, and hopeful thoughts in them.
- Patients must be allowed to bring along their own embroideries, artefacts, and spiritually uplifting objects to the hospital as these help speed up their full recovery.
- Local interconnectedness and reciprocal community of informal carers are a must to take care of some healthcare financial burdens. People (informal carers) are "greatest healthcare asset worldwide" and they must be helped to help themselves as hospitals begin to hedge financial responsibilities towards patients. In a cash-strapped society, informal carers must help themselves to provide respite and moral health and physical well-being for themselves.
- "Health and well-being benefits" (141) must be provided to all. Grounds must be prepared for "egalitarian, appreciative and substantively connected communities – resilient communities of mutual hope, compassion and solidarity" (142), because the solutions to health problems must be "community-based solutions" (142).
- Finally, "Compassionate design" must be privileged and spread amongst all to have active participation in the enhancement of healthcare (143). "Compassion depletion" (148) must be avoided and gradually uprooted.

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