Health humanities: the future of medical humanities?

Paul Crawford
Professor of Health Humanities, Faculty of Medicine and Health Sciences, The University of Nottingham, UK

Brian Brown
Reader in Health Communication, Faculty of Health and Life Sciences, De Montfort University, UK

Victoria Tischler
Lecturer in Behavioural Studies, Faculty of Health and Life Sciences, The University of Nottingham, UK

Charley Baker
University Teacher in Mental Health, Faculty of Medicine and Health Sciences, The University of Nottingham, UK

Abstract
This discussion paper reviews and critiques literature related to the evolution of the medical humanities as an academic discipline and its contribution to healthcare provision. We argue that despite considerable advances in the field of medical humanities, needs have been identified for a more inclusive, outward-facing and applied discipline. These needs can be met in the form of what we have called the health humanities, which both embrace interdisciplinarity and engage with the contributions of those marginalised from the medical humanities – for example, allied health professionals, nurses, patients and carers. It is argued that there is a need for new thinking to develop the discipline of health humanities, to develop, provide and share research, expertise, training and education.

Introduction
The impact of the humanities is being felt across a whole range of healthcare disciplines. The growth of this movement has been spearheaded by the so-called medical humanities, which have now achieved the status of a 'mature discipline' (Ahlzen, 2007). This is underscored by the recent award of two substantial grants by the Wellcome Trust to Durham University and Kings College London to establish research centres: the Centre for Medical Humanities and the Centre for the Humanities and Health, respectively. In education for the health professions, alternatives to traditional, exclusively science-based curricula for medical education have been prompted by a number of considerations on the part of educators and professional bodies on both sides of the Atlantic through the 1990s (Christakis, 1995; General Medical Council, 1993; Enarson & Burg, 1992; Schwarz & Wojtczak, 2002). This has led to opportunities for the development of curricula for healthcare professions to include the humanities, with literature, history and philosophy often leading the way.

Classically, the utilisation of the humanities has involved ethics or 'moral attitude' (Olthuis & Dekkers, 2003) or making students aware of philosophical issues (Brawer, 2006). More recently this has broadened to include literature (Dysart-Gale, 2008), expanding clinical empathy (Garden, 2008), dealing with the more exasperating experiences of clinical life (Gordon, 2008) and developing community education with a commitment to interdisciplinarity (Donohoe & Danielson, 2004).

In addition, we have seen a focus on both medicine and the humanities as interpretive enterprises (Gillis, 2008), and recognition of healthcare practice as a kind of performance, analogous to being a musician (Wooliscroft & Phillips, 2003), where the importance of improvisation is noted (Haidet, 2007). The growth of the philosophy of medicine as a discipline has also been substantial (Dekkers & Gordijn, 2007; Stempsey, 2007). The intention behind much of this work is that medicine should reconfigure its boundaries to become interdisciplinary while simultaneously becoming disciplined through the humanities (Bolton, 2008: 131) on the premise that '*arts and humanities approaches can foster significant interpretive enquiry into illness, disability, suffering, and care*'.

The humanities and arts are also of value in enabling practitioners and students to appreciate the context of their craft. For example, Wallace (2008) describes how an appreciation of Henrik Ibsen's 1882 An *Enemy of the People* (2009) helps us gain a critical purchase on the processes of governance in healthcare. Wallace here demonstrates how the arts – in this case, literature – can assist critical reflection on what is happening to us as human beings in relation to the policies and institutions in which we are embedded.

Therefore, looking towards a more systematic inclusion of the arts and humanities in clinical education is both forward thinking and represents desire for progress. It is important, therefore, for mental health practitioners and service managers to reflect upon the diverse contributions of the humanities to healthcare and upon the role that creative disciplines and humanities can have in ameliorating the situation of patients and beleaguered professionals themselves.

The humanities in healthcare

The very term 'medical humanities' encapsulates the dominant force in the discipline. Historically, medicine has captured the intellectual and clinical high ground. But this is not the whole story. It is not only education for doctors that has developed the medical humanities. The humanities have long held a place in nurse education (Dellasega *et al*, 2007), where their inclusion was deemed appropriate to inculcate an appreciation of the fullness and complexity of human experience. The 21st century has seen a growing commitment to a nursing curriculum that involves a full appreciation of this complexity (Davis, 2003). The use of the arts in learning for nurses has also been encouraged by the use of problem-based learning (McKie *et al*, 2008) and the desire to encourage them to engage in reflection about their practice. Poetry and novels can aid this task, particularly those focused on the experience of certain illnesses, conditions and treatments, as can reflection about the teaching process itself (McKie *et al*, 2008: 163). Hence there are many further pleas for the rubric of nursing to extend beyond evidence-based practice to include information literacy, the humanities, ethics and the social sciences (Jutel, 2008).

There are several ways in which we could conceptualise the relationship between the humanities and mental health care. One way of thinking about their relationship is to draw a distinction between 'additive' and 'integrative' approaches (Evans & Greaves, 1999). The additive model tries to humanise an existing biomedical knowledge base, whereas the integrative approach attempts a more thoroughgoing process of refocusing medicine to address what makes us fully human. As Evans and Greaves (1999: 1216) put it, this latter approach is one '*whereby the nature, goals, and knowledge base of clinical medicine itself are seen as shaped by the understanding and relief of human bodily suffering. This more ambitious view entails that the experiential nature of suffering be brought within the scope of medicine's explanatory models, if necessary by reappraising those models.*' This potential to develop a philosophically attuned awareness of the interpersonal processes involved in the provision of healthcare offers the opportunity to mount informed critiques and stage novel debates about the meaning of both health and healthcare, which go beyond the customary question of 'what works'.

In medicine, the value of narratives is increasingly appreciated (Greenhalgh & Hurwitz, 1998) and the techniques of interpreting narratives, especially in mental health, may be analogous to making sense of a patient's case history (Beveridge, 2003) and appreciating the nuances and subtexts of a patient's thinking. Especially in mental health nursing, the arts have been employed as diversional and therapeutic interventions, and, for both therapy and education, '*art offers a showing of human experience in unique ways*' (Biley & Galvin,

2007: 806) to facilitate shared understanding of people's unique experiences. There have been attempts to use literature in mental health nursing training, to facilitate students' understanding of different kinds of distress and mental disorder (McKie & Gass, 2001).

Given the disciplinary diversity, and the range of therapeutic crafts that have made use of the arts and humanities, we favour the term *health humanities* rather than medical humanities. This choice of terminology recognises the fact that, in a whole range of healthcare disciplines, there are signals that the humanities are being called upon to play a role in education and practice. In occupational therapy, for example, literary works have been drawn upon to create reflective discussion for some years (Murray *et al*, 2000). Occupational therapy has a long history of engagement with the creative arts (Thompson, 1998), with evidence that this practice is appreciated by patients, particularly if they are able to set their own goals and terms of engagement (Lim *et al*, 2007). In mental health care, there is a continued emphasis on the role of the arts and creativity in occupational therapy (Schmid, 2004). There is growing interest in creative disciplines such as dance and drama in physiotherapy (Christie *et al*, 2006). The arts and creative therapies as disciplines in their own right have made inroads into fields as diverse as cancer care (Carlson & Bultz, 2008; Puig *et al*, 2006), mental health care (Beveridge, 2003; Biley & Galvin, 2007) including forensic contexts (Smeijsters & Gorry, 2006) and psychotherapy (Crawford *et al*, 2004), dementia care (Innes & Hatfield, 2001; Mitchell *et al*, 2006) and social care work with children (Landreth, 2002; Lefevre, 2004). Therefore, to embrace this transdisciplinary engagement with the arts and humanities, we have coined the term *health humanities* rather than medical humanities.

The relationship between the medical humanities and service user concerns is underdeveloped, yet if we cast the net more widely so as to include the full range of healthcare disciplines, it becomes possible to appreciate the potential more fully. The question of finding a voice and a position from which to speak is fundamental to making oneself heard as a service user and this is addressed in Gillie Bolton's work (Bolton, 1999a; 1999b). The inclusion of service users as co-researchers in healthcare inquiry may be accomplished in and through their interest in, for example, poetry, rediscovering creativity

or becoming part of a 'living library' (Wilson *et al*, 2010), which facilitates the opportunities for service user led research.

Moreover, in our opinion it indicates that the hitherto more narrowly defined *medical* humanities do not necessarily have a monopoly over this work. The vast body of practical work undertaken globally in the expressive therapies demands and deserves admission into the broader, more inclusive health humanities. Expanding the field of medical humanities to include allied health professionals, and empowering individuals to use these complementary alternatives to unidisciplinary medicine, can enable practitioners and researchers to be equally empowered.

The humanities in mental health care

For a specialism where communication is so central, it is perhaps surprising that the medical humanities are not further advanced in mental health care. Naturally, there are some important exceptions. For example, Clarke (2009) argues persuasively for the use of literature to enable us to humanise psychiatry. In this view, a familiarity with the humanities is vital to clinical practice and the interpretative and critical domains of intellectual life. Reading and interpretation foster skills that enable us to listen carefully in the clinical setting, to think and reflect, as well as to consider and engage empathically. Oyebode (2009) and his co-authors consider the role of poetry, autobiography, letters and fiction in the quest for deepening clinical observation and empathy, clarifying descriptions of phenomena, especially emotions and experiences that are outside the supposedly normal range. Baker *et al* (2010) explore accounts of madness in novels from 1945 to the present. As well as providing insights for practitioners, literature that focuses on madness – sometimes transformed into film or theatre, or serialised for television – provides a key element in shaping public perceptions of madness itself, of institutions and personnel that contain madness and, crucially, of individuals deemed mad themselves. Even psychiatry textbooks have literary advisors (eg. Stringer *et al*, 2009).

One Flew Over the Cuckoo's Nest (Kesey, 1962) has proved a compelling text for scholars of literature and mental health (Stripling, 1995; Baker *et al*, 2010), especially those seeking to indicate how hospital regimes may be inhumane

and how patients' struggles against them are interpreted as further signs of their illness, meriting more invasive treatments. In the case of controversial treatments such as electroconvulsive therapy (ECT), Hilton (2007) describes how novels such as Sylvia Plath's *The Bell Jar* (1963), Janet Frame's *Faces in the Water* (1961) and Ken Kesey's *One Flew Over the Cuckoo's Nest* (1962) can illuminate what such procedures might feel like from the patient's point of view. As Hilton (2007: 11) says: '*fictional accounts drawing on autobiographical experience can give us valuable insights into the practice of psychiatry, the doctor–patient relationship, and patients' concerns which may be less obvious to practitioners*'.

Whilst there is a relative quietism in the medical humanities concerning mental health, the most striking source of transdisciplinary innovation in mental health care comes from the creative and expressive therapies. It is this sheer variety of such approaches that makes our call for a broadly based and inclusive health humanities all the more urgent. There are lively programmes of innovative practice ongoing in the so-called 'expressive therapies' (Malchiodi & McNiff, 2006), such as dance therapy (Goodill, 2005; Payne, 2004), poetry therapy (Kempler, 2003; Mazza, 2003), art therapy (Edwards, 2004), art in groupwork settings (Argyle & Bolton, 2004; Liebmann, 2004), psychodrama (Fonseca, 2004) and dramatherapy (Weber & Haen, 2005). Dance therapy has been explored as a way of enhancing empathy (Press, 2009). The use of theatre has been advocated as a means of interpreting and disseminating research findings (Rossiter *et al*, 2008). The creative therapies have offerings to make to mental health and well-being across the life cycle. Malchiodi (2008) advocates creative therapies using play and imagination with traumatised children, as these have a unique ability to enable youngsters to express distress that may not be accessible via talk therapy. Creative activities have been advocated as a way of enhancing the mental health of older adults (Flood & Phillips, 2007). In the case of mothers with postnatal depression, Perry *et al* (2008) show how the arts can have positive effects, for example, by helping clients' relationships, providing new ways of expression and bringing about behavioural changes.

In describing an art-based initiative for mental health service users in Scotland, Parr (2006) presents some revealing comments from participants:

'*I think art was . . . it* **contains** *. . . so if you are feeling really really bad and anxious, then, yes, you are making a bad anxious, messy picture, but you are somehow or other, it's like a bit of shit you get out.*' (Parr, 2006: 156)

'*It* [art] *was another form of communication, because I couldn't talk very well. Actually I* [just] *couldn't talk sometimes and I wasn't being understood, so I used painting and writing as other forms of trying to communicate with people . . .* [and so] *for me it was vital.*' (Parr, 2006: 156)

Frequently, these initiatives are appreciated by clients and described as being crucial to their recovery. Whilst precise causal relationships between expressive therapies and clinical improvement are sometimes elusive, the subjective value ascribed to these initiatives by users is considerable.

The account we have presented above is not exhaustive, but it should suffice to indicate the breadth and nature of work undertaken across a range of disciplines to introduce the arts and humanities into therapies.

Health humanities – a new approach

Arguing for a broader and deeper approach than is presently found in the medical humanities in order to create an inclusive health humanities is particularly apposite in mental health, where many of the key sites for the generation of new ideas are outside medicine, lying instead in the creative arts, expressive therapies and service user movements.

The medical humanities are already well established disciplines, as evidenced by journals such as *Medical Humanities* (UK) and *Journal of Medical Humanities* (USA), as well as the UK-based research centres that are attracting prominent funding. Furthermore, in many US medical schools, the medical humanities inform curricula. In most European countries it is expected that students of medicine will know some philosophy. Rather than being ghettoised into a particular module or specialism, the humanities are more embedded in the educational culture (Marshall, 2005).

We can see there is much work afoot in the medical humanities, but the extension to create an overarching health humanities is necessary so as to include the variety of healthcare disciplines

that are developing related approaches. There is still much work to do in cross-fertilising these activities so as to maximise the benefit to practitioners, patients and carers. Despite thriving medical humanities in Europe and the US, there is a growing need for new forums in which to debate and develop the role of the humanities in health as a whole rather than solely in medicine. It is therefore timely and appropriate to address the broadening demand from other professions to become involved – this is critical, as the majority of healthcare as it is practised is non-medical and may indeed be voluntary in the form of charitable or informal care. In hospitals and residential settings, clients spend more time with care assistants, catering and cleaning staff, as well as informal and family carers, than they do with doctors. Complementary and alternative healthcare is growing in popularity and there may be hitherto unexplored ways in which the humanities can help place these traditionally poor relations of medicine into a theoretical context and inform practice.

The health humanities can also address the nature, experience and purpose of the healthcare disciplines themselves. For example, it becomes possible to consider what it means to care in the context of professions increasingly preoccupied with technological and risk management approaches and a populace preoccupied with celebrity (Barker & Buchannan-Barker, 2008). Moreover, the suffering and unhappiness of healthcare practitioners themselves can be ameliorated through technical descriptions of constructs such as occupational stress or burnout. As Cole and Carlin (2009) document, there is a whole variety of ways in which physicians suffer, from feelings of despair and dehumanisation to elevated risk of alcohol or drug problems, depression and suicide. It is to the sharing of stories and the humanising of the practice of medicine that Cole and Carlin look to improve the situation of physicians.

Moreover, as different disciplines come to value the contribution made by the humanities, and opportunities emerge in health for the development of new approaches in the humanities, it is important to develop this wider inclusive arena for such movements, research and opinions to be both situated and nurtured. Crucially, the role of patients or service users themselves as agents of change,

or as key contributors to their own recovery as self-helpers, has as yet attracted little sustained critical attention.

Naturally, there are issues that excite debate and critique in the newly emerging health humanities, and it is our intention to facilitate the exploration of limitations and weaknesses of this approach too. For example, criticisms have been levelled at the apparent lack of consensus as to what exactly constitutes medical humanities and what the discipline is for (Petersen *et al*, 2008). The relationship of the humanities to medicine itself is also likely to prove contentious. Bishop (2008) challenges the assumption that the humanities should merely exist to make medicine perform 'better' in a narrow technical sense. Instead, the humanities can enable us to challenge this narrow instrumental view of human activity at its very roots. Medical humanism in its present guise might promise intimacy and care but is it, asks Bishop (2008: 21), also about control? This point is underscored when we consider the relative lack of a user presence in the medical humanities, whereas, as we have suggested, humanities could be at the centre of attempts to give voice to service users and enable an empowered service user presence in healthcare research.

Conclusion

This paper has argued that despite considerable achievements in the medical humanities, a more inclusive and applied approach to humanities in healthcare is vital. We aim to move this agenda forward by building on the work outlined in this paper and engaging internationally with scholars, practitioners, healthcare providers, patients and their carers to develop and promote the emerging discipline of health humanities and to harness the full measure of potential benefits of the arts and humanities in the provision of healthcare.

Address for correspondence

Professor Paul Crawford
School of Nursing, Midwifery & Physiotherapy
Division of Nursing (Derby Centre)
The University of Nottingham
London Road Community Hospital
London Road
Derby DE1 2QY
UK
Email: Paul.Crawford@nottingham.ac.uk

References

Ahlzen R (2007) Scientific contribution: medical humanities – arts and humanistic science. *Medicine, Health Care and Philosophy* **10** 385–393.

Argyle E & Bolton G (2004) The use of art within a groupwork setting. *Groupwork* **14** (1) 46–62.

Baker C, Crawford P, Brown B, Lipsedge M & Carter R (2010) *Madness in Post-1945 British and American Fiction*. London: Palgrave.

Barker P & Buchannan-Barker P (2008) Mental health in an age of celebrity: the courage to care. *Medical Humanities* **34** 110–114.

Beveridge A (2003) Should psychiatrists read fiction? *British Journal of Psychiatry* **182** 385–387.

Biley FC & Galvin KT (2007) Lifeworld, the arts and mental health nursing. *Journal of Psychiatric and Mental Health Nursing* **14** 800–807.

Bishop JP (2008) Rejecting medical humanism: medical humanities and the metaphysics of medicine. *Journal of Medical Humanities* **29** 15–25.

Bolton G (1999a) *The Therapeutic Potential of Creative Writing: Writing myself*. London: Jessica Kingsley.

Bolton G (1999b) Every poem breaks a silence that had to be overcome: the therapeutic power of poetry writing. *Feminist Review* **62** 118–133.

Bolton G (2008) Boundaries of humanities: writing medical humanities. *Arts and Humanities in Higher Education* **7** (2) 131–114.

Brawer JR (2006) The value of a philosophical perspective in teaching the basic medical sciences. *Medical Teacher* **28** (5) 472–474.

Carlson LE & Bultz B (2008) Mind-body interventions in oncology. *Current Treatment Options in Oncology* **9** 127–134.

Christakis NA (1995) The similarity and frequency of proposals to reform US medical education. Constant concerns. *Journal of the American Medical Association* **274** (9) 706–711.

Christie D, Hood D & Griffin A (2006) Thinking, feeling and moving: drama and movement therapy as an adjunct to a multidisciplinary rehabilitation approach for chronic pain in two adolescent girls. *Clinical Child Psychology and Psychiatry* **11** (4) 569–577.

Clarke L (2009) *Fiction's Madness*. Ross on Wye: PCCS Books.

Cole TR & Carlin N (2009) The suffering of physicians. *Lancet* **374** 1414–1415.

Crawford R, Brown B & Crawford P (2004) *Storytelling in Therapy*. Cheltenham: Nelson Thornes.

Davis C (2003) Nursing humanities: the time has come. *American Journal of Nursing* **103** 13.

Dekkers W & Gordijn B (2007) Medical humanities and philosophy of medicine. *Medicine, Health Care and Philosophy* **10** 357–358.

Dellasega C, Milone-Nuzzo P, Curci K, Ballard JO & Kirch DG (2007) The humanities interface of nursing and medicine. *Journal of Professional Nursing* **23** (3) 174–179.

Donohoe M & Danielson S (2004) A community-based approach to the medical humanities. *Medical Education* **38** 204–217.

Dysart-Gale D (2008) Lost in translation: bibliotherapy and evidence-based medicine. *Journal of Medical Humanities* **29** 33–43.

Edwards D (2004) *Art Therapy*. Thousand Oaks, CA: Sage Publications Inc.

Enarson C & Burg FD (1992) An overview of reform initiatives in medical education 1906 through 1992. *Journal of the American Medical Association* **268** 1141–1143.

Evans M & Greaves D (1999) Exploring the medical humanities: a new journal will explore a new conception of medicine. *British Medical Journal* **319** 1216.

Flood M & Phillips KD (2007) Creativity in older adults: a plethora of possibilities. *Issues in Mental Health Nursing* **28** (4) 389–412.

Fonseca J (2004) *Contemporary Psychodrama: New approaches to theory and technique*. New York: Psychology Press.

Frame J (1961) *Faces in the Water*. London: WH Allen Ltd.

Garden R (2008) Expanding clinical empathy: an activist perspective. *Journal of General Internal Medicine* **24** (1) 122–125.

General Medical Council (1993) *Tomorrow's Doctors: Recommendations on undergraduate medical education*. London: General Medical Council.

Gillis CM (2008) Medicine and humanities: voicing connections. *Journal of Medical Humanities* **29** 5–14.

Goodill S (2005) *An Introduction to Medical Dance/Movement Therapy: Health care in motion*. London: Jessica Kingsley.

Gordon JJ (2008) Medical humanities: state of the heart. *Medical Education* **42** 333–337.

Greenhalgh T & Hurwitz B (1998) *Narrative Based Medicine*. London: British Medical Journal Books.

Haidet P (2007) Jazz and the 'art' of medicine: improvisation in the medical encounter. *Annals of Family Medicine* **5** (2) 164–169.

Hilton C (2007) An exploration of the patient's experience of electro-convulsive therapy in mid-twentieth century creative literature: a historical study with implications for practice today. *Journal of Affective Disorders* **97** 5–12.

Ibsen H (1882; 2009) *An Enemy of the People, The Wild Duck, Rosmersholm*. Oxford World's Classics. Oxford: Oxford Paperbacks.

Innes A & Hatfield K (2001) *Healing Arts Therapies and Person-Centred Dementia Care*. London: Jessica Kingsley.

Jutel A (2008) Beyond evidence-based nursing: tools for practice. *Journal of Nursing Management* **16** 417–421.

Kempler N (2003) Finding our voice through poetry and psychotherapy. *Journal of Poetry Therapy* **16** (4) 217–220.

Kesey K (1962) *One Flew over the Cuckoo's Nest*. New York: Signet Books Inc.

Landreth GL (2002) *Play Therapy: The art of the relationship*. New York: Psychology Press.

Lefevre M (2004) Playing with sound: the therapeutic use of music in direct work with children. *Child and Family Social Work* **9** 333–345.

Liebmann M (2004) *Art Therapy for Groups: A handbook of themes and exercises*. London: Psychology Press.

Lim KH, Morris J & Craik C (2007) Inpatients' perspectives of occupational therapy in acute mental health. *Australian Occupational Therapy Journal* **54** 22–32.

Malchiodi CA (2008) *Creative Interventions with Traumatised Children*. New York: Guilford Press.

Malchiodi CA & McNiff S (2006) *Expressive Therapies*. New York: Guilford Press.

Marshall RJ (2005) Knowledge is a call to action. *Medical Education* **39** 978–979.

Mazza N (2003) *Poetry Therapy: Theory and practice*. London: Routledge.

McKie A, Adams V, Gass JP & Macduff C (2008) Windows and mirrors: reflections of a module team teaching the arts in nurse education. *Nurse Education in Practice* **8** 156–164.

McKie A & Gass JP (2001) Understanding mental health through reading selected literature sources: an evaluation. *Nurse Education Today* **21** 201–208.

Mitchell G, Jonas-Simpson C & Ivonoffski V (2006) Research-based theatre: the making of 'I'm Still Here'. *Nursing Science Quarterly* **19** 198–206.

Murray R, McKay E, Thompson S & Donald M (2000) Practising reflection: a medical humanities approach to occupational therapist education. *Medical Teacher* **22** (3) 276–281.

Olthuis G & Dekkers W (2003) Medical education, palliative care and moral attitude: some objectives and future perspectives. *Medical Education* **37** 928–933.

Oyebode F (2009) *Mindreadings: Literature and psychiatry*. London: Royal College of Psychiatrists Publications.

Parr H (2006) Mental health, the arts and belongings. *Transactions of the Institute of British Geographers* **31** 150–166.

Payne H (2004) Becoming a client, becoming a practitioner: student narratives of a dance movement therapy group. *British Journal of Guidance & Counselling* **32** (4) 511–532.

Perry C, Thurston M & Osborn T (2008) Time for me: the arts as therapy in postnatal depression. *Complementary Therapies in Clinical Practice* **14** 38–45.

Petersen A, Bleakley A, Brömer R & Marshall R (2008) The medical humanities today: humane health care or tool of governance? *Journal of Medical Humanities* **29** 1–4.

Plath S (1963) *The Bell Jar*. London: William Heinemann Ltd.

Press CM (2009) Self-psychology and the modern dance choreographer. *Annals of the New York Academy of Sciences* **1159** 218–228.

Puig A, Lee S M, Goodwin L & Sherrard PAD (2006) The efficacy of creative arts therapies to enhance emotional expression, spirituality, and psychological well-being of newly diagnosed Stage I and Stage II breast cancer patients: a preliminary study. *The Arts in Psychotherapy* **33** 218–228.

Rossiter K, Kontos P, Colantonio A, Gilbert J, Gray J & Keightley M (2008) Staging data: theatre as a tool for analysis and knowledge transfer in health research. *Social Science & Medicine* **66** 130–146.

Schmid T (2004) Meanings of creativity within occupational therapy practice. *Australian Occupational Therapy Journal* **51** 80–88.

Schwarz MR & Wojtczak A (2002) Global minimum essential requirements: a road towards competence-oriented medical education. *Medical Teacher* **24** 125–129.

Smeijsters H & Gorry C (2006) The treatment of aggression using arts therapies in forensic psychiatry: results of a qualitative inquiry. *The Arts in Psychotherapy* **33** 37–58.

Stempsey W (2007) Medical humanities and philosophy: is the universe expanding or contracting? *Medicine, Health Care and Philosophy* **10** 373–383.

Stringer S, Church L, Davison S & Lipsedge M (2009) *Psychiatry: Principles, reality, next steps*. Oxford: Oxford University Press.

Stripling MY (1995) *Bioethics and Medical Issues in Literature*. Westport, CN: Greenwood Press.

Thompson M (1998) Creative arts in occupational therapy: ancient history or contemporary practise? *Occupational Therapy International* **5** (1) 48–64.

Wallace S (2008) Governing humanity. *Journal of Medical Humanities* **29** 27–32.

Weber AM & Haen C (2005) *Clinical Applications of Drama Therapy in Child and Adolescent Treatment*. London: Routledge.

Wilson C, Fothergill A & Rees H (2010) A potential model for the first all Wales mental health service user and carer-led research group. *Journal of Psychiatric and Mental Health Nursing* **17** 31–38.

Woolliscroft JO & Phillips R (2003) Medicine as a performing art: a worthy metaphor. *Medical Education* **37** 934–939.