Public health humanities

Lise Saffran

Public health humanities promotes sustained engagement with the humanities in order to foster critical thinking about public health issues, framing, interventions, research and the role of public health professionals in community health promotion and policy development. The study of history, philosophy, art, and literature facilitates reflection about how personal history, culture and embodied experiences shape individuals' and communities' interactions with the public health system, and how these differences have the potential to introduce bias or offer opportunities for empathy and connection. Public health's emphasis on populations and community-based prevention programs raises different, though complementary, questions when set alongside medical humanities or even health humanities more broadly defined, including how the juxtapositon of epidemological data and personal narrative can enhance awareness of structural inequalities and the ethical challenges presented by the interventionist nature of public health practice.

Public health differs from medicine and other health professions—nursing, physical therapy etc.—that deliver diagnostic, technical and therapeutic services in that public health focuses on populations rather than individuals. The primary goal of public health is the prevention, rather than the treatment, of disease. Public health theory and practice rely on frameworks, such as the ecological model of health (Hovell et al. 2009), that articulate influences on health located within institutions and resulting from public policy and the social and physical environment. Finally, public health is explicitly interventionist in relation to those environments; the translation of data for the development of evidence-based policy is one of public health's core functions. In their aim to increase awareness of the social determinants of patients' health, medical humanities programs align with public health theory and practice in important ways (Campo 2005; Saffran 2014, Bleakely 2015). Health humanities expands the field to include a broad range of allied health professions in its

framework, as well as non-professional carers. While often going farther than medical humanities in emphasizing non-clinical factors and settings (Jones et al. 2014; Crawford et al. 2015; Jones et al. 2017), health humanities generally remains substantially focused on individual experiences of illness and health, in contrast to public health, which is community-focused.

Writes Rebecca Garden (2014) in *The Health Humanities Reader* »I argue for the health humanities as a critical means of developing a fuller understanding of patients in social context, particularly the power relations and social norms in the clinic that contribute to disparities and discrimination, as well as the social factors that contribute to disease and disability« (Garden 2014:127). Indeed, disability studies is a frequent lens through which the connection between health and the world outside of the clinic or hospital is examined. In describing disability as a product of physical and social environments rather than a condition that is merely influenced by them, Diane Price Herndl (2005) and others shift their focus to community spaces and to the social and political systems that determine their organization and maintenance.

As with health humanities generally, public health humanities promotes the sustained engagement with the humanities as central in encouraging health professionals to view themselves and others as complicated human beings beyond their role as practitioners or patients. The study of history, philosophy, art, and literature facilitates critical thinking about how these roles came to be, how personal history, culture and embodied experiences shape perspective, and how those differences have the potential to introduce bias or offer opportunities for empathy and connection (Charon 2001; Ousager & Johannessen 2010; Crawford et al. 2015). At the same time, public health's emphasis on populations and community-based prevention programs raises different, though complementary, questions when set alongside medical humanities or even health humanities more broadly defined. Acknowledging that providers and patients always meet within systems and structures, implicit bias, for example, manifests differently in relationships between a public health professional or system and a community, rather than between a provider and patient. False assumptions about behavior or motivations applied to a group, for example, can lead to research questions, behavioral interventions or policies that undermine communities' strengths and neglect their cultural and social context (Bailey et al. 2017).

The core science of public health, epidemiology, relies on the aggregation of data in order to illuminate patterns that remain hard to detect when focusing exclusively on individual cases. In much the same way, public health hu-

manities has the potential to connect the creative and critical work of individuals with population data in order to understand community characteristics outside of a clinical or therapeutic context. Charles Winslow's 1920 definition of public health describes the discipline as relying on organized community efforts to improve health (Winslow 1920). The possibilities for connection offered through engagement with the humanities are important within the public health context for their power to mobilize change. Art and literature have the potential to inspire a deep sense of recognition of the human experience, a powerful catalyst for organizing when coupled with epidemiological data. Consider Douglas L. Weed's description of the Names Project, the quilt memorializing individuals who died from AIDS, in the American Journal of Public Health (1995),

> »This Names Project may be the largest »case series« ever produced, and it is a testament to those who have suffered and to their caregivers, a beautifully sobering reminder of the delicate balance humankind keeps with its virulent neighbors.« (Weed 1995: 915)

Similarly, Nehal El-Hadi in *The Production of Presence: The internet and First-Person Illness Narratives* (De Leeuw et al. 2018: 315) notes how governmental public health is increasingly turning to the internet to communicate health messages, as well as how online communities form around experiences of illness. She suggests that first person narratives on the internet be viewed as a resource in understanding the experiences of illness and treatment. Viewed as qualitative data for public health systems, these stories can inform prevention programs, policies, surveillance and monitoring systems and critically shape messages aimed at community members.

The World Health Organization defines the social determinants of health as »the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life« (WHO 2022). Combined with a growing movement within public health to adopt an approach of health in all policies (Leppo et al. 2013) public health, and thus public health humanities, reaches into increasingly varied aspects of the way we live, work, play, and learn. Importantly, this includes systems not traditionally identified as part of the public health system, such as education (Collins & Coplan 2009).

The activities and challenges of global and planetary health research and practice also align with public health humanities in notable ways. Amid mount-

ing evidence that, in the face of planetary challenges such as pandemics and climate change, data alone will ensure neither scientific consensus nor policy change (Kahan 2015), the humanities can and should be central to this project (Saffran 2019). Writing about what a global health humanities approach might bring to the training of global health practitioners, Kearsley Stewart and Kelley Swain (2016) note, »The core skills for global health practitioners do not focus on the doctor–patient dyad, but rather on understanding that the health of a patient is enmeshed in a complex system of individual behaviours, family and community relationships, environmental surroundings, economic limitations, and structural injustices« (Steward & Swain2016: 2586). Acknowledging that the complex systems referenced by Stewart and Swain are also determined by relationships between countries and regions (Benatar 2016), the study of post-colonial literature, history and art offer opportunities for a fuller understanding of global health challenges and actors. Unfortunately, engagement with the humanities is often absent from public health programs in the global North which send students and trainees abroad. Although best practice guidelines often exhort students and trainees from sending countries to »learn appropriate language skills relevant to the host's locale as well as socio-cultural, political, and historical aspects of the host community« (Crump & Sugarman 2010: 1180), engagement with works of art, literature and music are rarely explicitly encouraged, much less required (Asgary et al. 2011; DeCamp 2013).

The urgency of a humanities approach to public health

> »To better understand epidemiology's relationship to public health, indeed to answer questions of who we are, what is right, how to think, and when to act, epidemiologists must go to the core of humanity itself, to history, philosophy of science, ethics, literature, and art.« (Weed 1995: 914)

By using epidemiological data to illuminate patterns of risk, public health is powerful in its ability to expose inequities in health and the social and structural factors that enable them. As a result, public health practitioners, even more than medical and allied health professionals, engage specifically with marginalized communities, very often as representatives of majority communities and from positions of privilege (Mitchell, & Lassiter 2006). In the absence of sufficient reflection and understanding of the context for health behavior, a focus on population data alone can reinforce harmful stereotypes

and fail to cultivate a meaningful understanding of how individual lived experience shapes our health (Kumagai, A. & Lypson; M. 2009; Sharma 2017).

The ethical practice of public health requires practitioners to maintain the awareness that communities are comprised of individuals, with unique histories and perspectives. Consequently, public health humanities is bidirectional; we look to social and structural factors to understand and empathize with individuals and we look to individuals to better understand how our communities are organized and how they relate within existing structures and systems. Engagement with art and literature in public health training can counter reductive tendencies through dialogue and reflection, an approach found to be effective in addressing implicit bias in public health (Sharma 2017). For example, a focus on narrative (detailed more fully in the next section), can be effective in shifting perceptions of attribution – blame – for health outcomes from individual to external factors (Niederdeppe & Shapiro 2011; Shaffer et al. 2019). The study of art and literature reminds trainees that while influences such as culture undoubtedly impact health, individuals cannot be reduced to representatives of any one culture; rather, each individual is multi-faceted, with a rich inner life (Kidd & Castano 2013).

Another ethical hazard that accompanies public health practice involves the move toward health in all policies referenced above. As public health research and practice continue to expand into all aspects of our lives, a public health approach that is ahistorical, or that fails to critically examine the language that we use to frame our activities (such as »target population«) risks reinforcing the very systems that create inequities, The ubiquity of both the policies and the narratives that support them easily render them invisible and »natural« seeming. Writing about public health campaigns aimed at eradicating hookworm in the US South in the early twentieth century, for example, Stephanie Larson examines the way that public health messages influenced and reinforced stereotypes and narratives of »backwardness« and »laziness« among communities at risk in canonical works of American literature (Larson 2020).

Narrative public health

Storytelling has always had a place in public health, from stories told within and among communities about what is dangerous, healthy and wise, to telenovelas, community theater and other storytelling-based health interventions

(Labonte et al 1996; Séguin 1996; Tufte 2005). Whereas clinicians communicate directly with patients, public health employs mass media, including the internet, to communicate with communities (Randolph & Viswanath 2004; Rimal 2009). The digital media environment is particularly story-rich and health advocates and researchers increasingly rely on narratives to illuminate policy issues with vivid, real-world examples (Dorfman & Krasnow 2014; Baumann et al. 2019). Story circles and narrative interventions such as photo voice further contribute to the wealth of stories finding their way into advocacy, educational and fundraising materials (Necheles et al. 2007; Tsui & Starecheski 2018). As an emerging component of public health humanities, narrative public health both overlaps with and differs from narrative medicine – founded by Rita Charon at Columbia, University and widely incorporated into health and medical humanities programs – in important ways.

Narrative medicine programs emphasize the power of both clinician and patient narratives – and the differences between them – to promote self-reflection and enable self-expression (Charon 2001; Silverman 2017). Charon advocates the pursuit of »narrative competence,« as a goal of such programs and defines it as »the set of skills required to recognize, absorb, interpret and be moved by the stories one hears or reads« (Charon 2006: 862). The cultural and ethical awareness cultivated by narrative medicine are qualities no less necessary in public health, which requires professionals who can engage ethically with communities and across disciplines (Association of American Medical Colleges and Association of Schools of Public Health 2012; Committee on Quality Health Care in America 2001). Framing, representation and metaphor have implications for how public health interventions, including policy interventions, are conceived of and communicated (Lawrence 2004; Thibodeau & Boroditsky 2011) and so a close attention to language is an important component of narrative public health. Competence in narrative public health further requires an understanding of how meta narratives, such as white supremacy, define perceptions of illness and risk. It requires, also, an understanding of how historical traumas influence contemporary interactions with the public health system (Mohatt et al. 2014). Recent research, for example, highlights how the reception of Covid19-related messages aimed at African-Americans may be shaped by experiences of current health inequities, as well as historical events such as the Tuskegee Syphillis Experiment (Abassi 2020; Moya et al. 2020).

Public health humanities as a catalyzing force

A final important characteristic of public health humanities springs from the fact that public health is inherently activist. The goal of public health research goes beyond understanding the determinants of health; it includes the application of that knowledge toward creating the conditions in which people can be healthy. The activist and far-reaching aims of public health carry with them an ethical obligation for self-reflection and for the attention to differences in values, embodied experience and perspective that serious engagement with the humanities affords. This includes maintaining a critical perspective toward the history and narratives of public health practice itself. Sayantani DasGupta (2008), writing in The Lancet, describes »narrative humility« as a practice which requires,

> »[…] remaining open to [stories'] ambiguity and contradiction, and engaging in constant self-evaluation and self-critique about issues such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story […].« DasGupta (2008: 981)

A deep engagement with the humanities offers the opportunity to critique the way that stories told within and about public health intersect with societal narratives about individual versus collective action, attribution for human behavior and health and morality. The wisdom of public health, which includes an engagement with questions of representativeness and context, can thus add to our critical understanding of the literature that entertains and informs us, that exists both as a product and a shaper of our imagination. Highlighting the role of imagination in his keynote speech at the Health Humanities Consortium conference at DePaul University in 2019, poet and disability studies scholar Anand Prahlad noted,

> »We are met with the products of imagination at every turn, and by the evidence that as most human societies have existed throughout history, life without active personal and social imagination is practically impossible, unbearable. Before every aspect of culture became materially manifest, people imagined them, for example, food dishes, cloths, architecture, rituals, arts, language, forms of relationships, social identities, etc.« (Prahlad 2019)

The relationship between imagination and public health is exemplified as much by Larson's examination of the symbiotic relationship between public health messages around hookworm and popular literature, described above, as through contemporary depictions of epidemiologists as »heroic warriors« in films about pandemics, outbreaks and contagion (Lynteris 2016).

Shaun A. Stevenson (2016), exploring narrative ethics in connection with community-based research, suggests that narrative can be an effective tool for critiquing bioethics, writing

> »to interpret bioethics through a nuanced and complex understanding of narrative ethics is to better understand the story that bioethics tells, the ideals it holds to be true and just, and the manner in which it may succeed or fail to adequately apprehend pluralistic conceptions of what might be deemed a good life and a livable life.« (Stevenson 2016: 366)

In much the same way, public health humanities offers new perspectives from which to assess the multiple stories of public health—not just the stories we tell others but also those that we tell ourselves about the work that we do and for whom it is done.

References

Abbasi J. (2020). Taking a Closer Look at COVID-19, Health Inequities, and Racism. JAMA, 324(5), 427–429.

Asgary, R. & Junck, E. (2013). New trends of short-term humanitarian medical volunteerism: professional and ethical considerations. Journal of medical ethics, 39(10), 625–631.

Association of American Medical Colleges and Association of Schools of Public Health (2012). Cultural competence education for students in medicine and public health. Report of an expert panel 2012.

Bailey, Z.D., Krieger, N., Agénor, M., Graves, J., Linos, N. & Bassett, M.T. (2017). Structural racism and health inequities in the USA: evidence and interventions. The Lancet, 389(10077), 1453–1463.

Baumann, S.E., Merante, M., Folb, B. L. & Burke, J.G. (2020). Is film as a research tool the future of public health? A review of study designs, opportunities, and challenges. Qualitative Health Research, 30(2), 250–257.

Benatar, S. (2016). Politics, power, poverty and global health: systems and frames. International Journal of Health Policy and Management, 5(10), 599.

Bleakley, A. (2015). Medical humanities and medical education: how the medical humanities can shape better doctors. Routledge: London.

Charon, R. (2001). Narrative medicine: a model for empathy, reflection, profession, and trust. JAMA, 286(15), 1897–1902.

Charon, R. (2005). Narrative medicine: attention, representation, affiliation. Narrative, 13(3), 261–270.

Charon, R. (2006). Narrative medicine. Honoring the Stories of Illness. Oxford University Press: Oxford.

Coleman, R. & Thorson, E. (2002). The effects of news stories that put crime and violence into context: Testing the public health model of reporting. Journal of health communication, 7(5), 401–425.

Collins, J. & Koplan, J.P. (2009). Health impact assessment: a step toward health in all policies. JAMA, 302(3), 315–317.

Committee on Quality Health Care in America (2001). Crossing the quality chasm: a new health system for the twenty-first century (report). Institute of Medicine. Washington DC: National Academies Press.

Crawford, P., Brown, B., Baker, C., Tischler, V. & Abrams, B. (2015). Health humanities. New York, NY: Palgrave Macmillan.

Crump, J.A., Sugarman, J. & Working Group on Ethics Guidelines for Global HealthTraining (WEIGHT) (2010). »Ethics and best practice guidelines for training experiences in global health.« The American Journal of Tropical Medicine and Hygiene, 83(6), 1178–1182

DasGupta, S. (2008). Narrative humility. The Lancet, 371(9617), 980–981.

De Leeuw, S., Donovan, C., Schafenacker, N., Kearns, R., Neuwelt, P., Squier, S.M., McGeachan, C., Parr, H., Frank, A.W., Coyle, L.-A., Atkinson, S., El-Hadi, N., Shklanka, K., Shooner, C., Beljaars, D. & Anderson, J. ((2018). Geographies of medical and health humanities: a Cross-Disciplinary conversation. GeoHumanities, 4(2), 285–334.

DeCamp, M., Rodriguez, J., Hecht, S., Barry, M. & Sugarman, J. (2013). An ethics curriculum for short-term global health trainees. Globalization and health, 9(1), 5.

Dorfman, L. & Krasnow, I.D. (2014). Public health and media advocacy. Annual Review of Public Health, 35, 293–306.

Fraser, D.W. (1987). Epidemiology as a liberal art. N Engl J Med, 316(6), 309–314.

Garden, R. (2014). The Humanities, Narrative, and the Social Context of the Patient-Professional Relationship. In T.E. Jones, D.E. Wear & L.D. Friedman

(Eds). Health humanities reader (pp 127–137). New Brunswick NJ: Rutgers University Press.

Herndl, D.P. (2005). Disease versus disability: the medical humanities and disability studies. PMLA, 120(2), 593–598.

Hovell, M.F., Wahlgren, D.R. & Adams, M.A. (2009). The logical and empirical basis for the behavioral ecological model. Emerging theories in health promotion practice and research, 2, 347–385.

Jones, T.E., Wear, D.E. & Friedman, L.D. (2014). Health humanities reader. New Brunswick NJ: Rutgers University Press.

Jones, T., Blackie, M., Garden, R. & Wear, D. (2017). The almost right word: The move from medical to health humanities. Academic Medicine, 92(7), 932–935.

Kahan, D. (2015). »What is the ›Science of Science Communication?‹« Journal of Science Communication, 14(3), 1–10.

Kidd, D.C. & Castano, E. (2013). Reading literary fiction improves theory of mind. Science, 342(6156), 377–380.

Kowal, E. & Paradies, Y. (2005). Ambivalent helpers and unhealthy choices: public health practitioners' narratives of Indigenous ill-health. Social science & medicine, 60(6), 1347–1357.

Kumagai, A.K., Lypson, M.L. (2009). Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education, Academic Medicine, 84(6), 782–787.

Labonte, R.N., Feather, J. & Hills, M. (1996). Handbook on using stories in health promotion practice. Ottawa, Ontario, Canada: Prairie Region Health Promotion Research Centre.

Larson, S.A. (2020). Hooked: Public Health, Parasites, and Twentieth-Century Literature of the US and Global South. Electronic Thesis and Dissertation (ETD) Repository, Emory University.

Lawrence, R.G. (2004). Framing obesity: The evolution of news discourse on a public health issue. Harvard International Journal of Press/Politics, 9(3), 56–75.

Leppo, K., Ollila, E., Pena, S., Wismar, M. & Cook, S. (2013). Health in all policies-seizing opportunities, implementing policies. Ministry of Social Affairs and Health, Finland.

Lynteris, C. (2016). The epidemiologist as culture hero: Visualizing humanity in the age of »the next pandemic«. Visual Anthropology, 29(1), 36–53.

Mitchell, D.A. & Lassiter, S.L. (2006). Addressing health care disparities and increasing workforce diversity: the next step for the dental, medical,

and public health professions. American Journal of Public Health, 96(12), 2093–2097.

Mohatt, N.V., Thompson, A.B., Thai, N.D. & Tebes, J.K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. Social Science & Medicine, 106, 128–136.

Moya, C., Kline, M. & Smaldino, P. (2020). Dynamics of Behavior Change in the COVID World. Am J Hum Biol, 32(20) e23485

Necheles, J.W., Chung, E.Q., Hawes-Dawson, J., Ryan, G.W., Williams, S.B., Holmes, H.N., Wells, K.B., Vaiana, M.E. & Schuster, M.A. (2007). The Teen Photovoice Project: a pilot study to promote health through advocacy. Progress in community health partnerships: research, education, and action, 1(3), 221–229.

Niederdeppe, J., Shapiro, M.A. & Porticella, N. (2011). Attributions of responsibility for obesity: Narrative communication reduces reactive counterarguing among liberals. Human Communication Research, 37(3), 295–323.

Ousager, J. & Johannessen H. (2010). »Humanities in undergraduate medical education: a literature review.« Academic Medicine, 85(6), 988–998.

Prahlad, A. (2019). Disability, Race, and the City of Imagination: A Plenary Address. Given at the Health and Humanities Conference in Chicago, March 30, 2019.

Randolph, W. & Viswanath, K. (2004). Lessons learned from public health mass media campaigns: marketing health in a crowded media world. Annu. Rev. Public Health, 25, 419–437.

Rimal, R.N. & Lapinski, M.K. (2009). Why health communication is important in public health. Bulletin of the World Health Organization, 87, 247–247a.

Saffran, L. (2014). »›Only connect‹: the case for public health humanities.« Medical humanities, 40(2), 105–110.

Saffran, L. (2020). The world behind the world: art and the climate emergency. Lancet 395(10219), 182.

Séguin, A. & Rancourt, C. (1996). The theatre: an effective tool for health promotion. World Health Forum, 17 (1), 64–69.

Shaffer, V.A., Bohanek, J., Focella, E.S., Horstman, H. & Saffran, L. (2019). Encouraging perspective taking: Using narrative writing to induce empathy for others engaging in negative health behaviors. PloS one, 14(10), e0224046.

Sharma, M. (2017). Applying multi-theory model of health behaviour change to address implicit biases in public health. Int J Community Med Public Health, 4(9), 3048.

Stevenson, S.A. (2016). Toward a narrative ethics: Indigenous community-based research, the ethics of narrative, and the limits of conventional bioethics. Qualitative Inquiry, 22(5), 365–376.

Stewart, K.A. & Swain, K.K. (2016). Global health humanities: defining an emerging field. The Lancet, 388(10060), 2586.

Thibodeau, P.H. & Boroditsky, L. (2011). Metaphors we think with: The role of metaphor in reasoning. PloS one, 6(2), e16782.

Tsui, E.K. & Starecheski, A. (2018). Uses of oral history and digital storytelling in public health research and practice. Public Health, 154, 24–30.

Tufte, T. (2005). Entertainment-education in development communication. In: Hemer, O. & Tufte, T, Media and Global Change, Rethinking Communication for Development (159–174). Buenos Aires: Clasco.

Weed, D.L. (1995). Epidemiology, the humanities, and public health. American Journal of Public Health, 85(7), 914–918.

Winslow, C.E.A. (1920). The untilled fields of public health. Science, 51(1306), 23–33.

World Health Organization (2022). Social Determinants of Health. Available at: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 [05.10.24].