

Art Observation as a Vehicle for Clinical Education

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Five medical students stood blindfolded facing a large bronze statue. The others attempted to describe the scene. Some explanations were quite literal: one student told of six men standing in robes, giving the stance and size of each figure. Another student chimed in with details of facial expression. As others interjected with more and more details, each seemingly unrelated to the last, the blind five became increasingly baffled by what the scene that lay before them actually depicted. Blindfolds were removed one at a time. Each student who gained sight had a chance to salvage the description for those who remained blind. Finally, one student started from scratch: these are six men who are down-trodden and defeated. They are the leaders of a city, and while they remain proud, the grave fate awaiting them is clear. They walk to meet certain death, but not in battle – they are a sacrifice. The men understand the gravity of their martyrdom and what it means for the loved ones they leave behind, but this provides little solace as they present themselves to their oppressor.

The scene depicted was Rodin's *Burghers of Calais*.¹ The participants were engaging in a visual arts elective course offered to students at

Weill Cornell Medical College. I was one of the students struggling to describe Rodin's masterpiece. The art elective, entitled Understanding Perceptions, took place in New York City's Metropolitan Museum of Art; it was geared toward showing students the wealth of information that can be gleaned through careful observation. Instruction used artwork as a springboard to make points about skills in clinical observation. I was fortunate to be in the initial pilot group, which afforded me the opportunity to participate in three semesters of the course. Medical pearls aside, who wouldn't want to make a few dozen free trips to the Met and break up the grind of lectures?

We saw a wide range of works from various regions, from the Americas and Europe to the Congo and Southeast Asia, from imprecisely dated relics to the most obscene modern art, and from pieces by acclaimed historic greats to one-off hits by otherwise unknown artists. Each week, we attempted new exercises. The blindfold activity, emphasizing the importance of clear communication, particularly resonated with most students.

There was another well-liked drill where we formed a circle around a statue shaped as an asymmetrical vase. We each spent about 60 seconds sketching our perspective before leaving our notebooks in place and rotating one space clockwise. We started drawing again, but this time from a new perspective and building upon the existing work of our peers. This continued

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Figure 1. Auguste Rodin's *Burghers of Calais*, ca. 1889. Displayed in the Metropolitan Museum of Art, New York.

around the circle until all arrived back at their original notebook to discover what form their sketch had taken. With the vase as a metaphor for the patient and each of us a practitioner, many lessons arise. One clear corollary to medical practice is that each specialty has a different point of view. By seeking to understand those varied perceptions, we gain greater insight into the whole of the patient. Furthermore, we come to grasp the roles of our colleagues more completely. In doing so, we are able to communicate not only with those coming from other viewpoints, but also with those who came before us or those who pick up where we leave off. A broader interpretation extends to include the importance of communication with other health professionals, like nurses and social workers, as well as healthcare entities like insurance companies. Taken together, this insight may enable us to deliver care that is more effective and efficient.

Still other exercises focused on challenging us to explore why we came to certain conclusions about the artwork we observed. We were asked questions that probed our underlying, subconscious reactions to the art. Why did that stout man carved from wood appear so formidable?

What led you to believe the people fleeing the city did so in such a hurry? How does the body language of the depicted chemist make you sense that he is disinterested in his wife? A good portion of our observation was of art portraying humans, but some observation was based on more abstract works. How does the single monochrome canvas you choose from the dozen options reflect your current emotional state? Why do you like this large white canvas with the small yellow splotch of paint more than the canvas across the room with the big red splotch? By confronting our underlying attitudes that led us to make certain judgments and decisions about the art, we gradually came to experience an increased awareness of the process of our own observation. In doing so, we could much more easily acknowledge uncertainty and recognize potential misperceptions.

Art-centric observational courses like this one have sprung up in one form or another at medical colleges across the United States. The impetus seems to stem in part from the fact that, although we learn how to take a history and perform a physical exam, little, if any, time is dedicated to teaching medical students how to observe – arguably a distinct skill unto itself. While observation could be categorized as a physical exam component, didactics tend to focus on a checklist of physical maneuvers. A recent commentary on new strategies to teach the physical exam in *Academic Medicine* notes that the traditional head-to-toe physical exam – as performed by both students and clinicians – may be done “by rote, without thinking critically or attempting to interpret their findings.”² The article discusses a national survey of medical education directors

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that seeks to find consensus on “core” physical exam maneuvers. Survey results show that “General Appearance” is the most agreed-upon tenet of the core physical exam,³ a “maneuver” almost strictly comprised of observation. However, such acknowledgement and inclusion in a list of maneuvers undermines the philosophy of observation: that one does not finish observing just because the mental box is checked at the onset of a patient encounter. Observation is perhaps more correctly thought of as a process that occurs over the course of the entire patient interaction.

Observational skill is hardly trivial. Of course, as humans, students already possess some baseline ability to see and understand, and those basic human skills will develop through the fire of clinical years. However the same could be said of the ability to take a history, which is more or less a methodical way of talking to others to find out what happened to them – something most of us do every day. And yet, setting students loose on patients without any history-taking skills – that is, with no understanding of what specific questions are important or how sensitive subjects may be broached – is not commonly practiced. Implicit in the act of observation is a mandate to interpret what has been observed and integrate that into the context of the situation – much like what must be done with the history

The motivation behind a medical curriculum is in many ways a reflection of the values held by the medical community and is driven more by philosophy than evidence. When the *New England Journal of Medicine* launched a new series on medical education in 2006, the debut article looked at changes in the landscape of medical education in the century following Abraham Flexner’s 1910 report to the Carnegie Foundation.⁵ The article held that, “The purpose of medical education is to transmit the knowledge, impart the skills, and inculcate the values of the profession in an appropriately balanced and integrated manner.”⁵ Such a mission statement is necessary to ensure that curricular elements serve the overarching goals of education.

If we expect current students to be optimally successful in all levels of training and ultimately as clinicians, dedicated observational training should be a part of the medical curriculum. Observation takes place during the history and physical exam but is a distinct skill unto itself. As Osler points out, observational proficiency is hard-won. But it is a skill worth honing as careful observation allows us to more fully understand the nature of patient complaints. In order to hone observational skill, there must be some basic foundation that can be shaped and molded. Such a foundation is created through dedicated training.

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and physical exam. Few are inherently capable of picking up on fine details and making deductions, like Abraham Verghese’s now-so-often-cited example of the physician who inspired Sir Arthur Conan Doyle to create Sherlock Holmes. Indeed, William Osler said, “There is no more difficult art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language.”⁴

Art observation is one logical vehicle for such broad instruction. Artwork displays a wide range of human emotion and allows for a great deal of reflection and interpretation. Courses in art observation can easily be tailored to emphasize the specific insights any particular school wishes to impart to students. Art encompasses many mediums and styles, helping to give it widespread appeal and the capacity to inspire understanding across cultures.

A lack of evidence to support the efficacy of art observation in improving student skills should not stop incorporation of this didactic technique into medical curricula. It should be noted that “lack of evidence” is, in and of itself, a dangerous turn of phrase,⁶ which in this case simply means that there is not yet enough data on the matter to say one way or another (though initial studies have shown promising results in small samples).⁷ My own experience in an art observation course has convinced me of the great potential that such an educational vehicle has to effectively instruct students. I hope that others can agree on the importance of observation in medicine and the promising prospects of art observation.

Months after the final Understanding Perceptions session, I was in the thick of a medicine rotation. I performed a thorough history and physical on a terminally ill man in the emergency department. As I presented the new admission on morning rounds, I decided to take a slightly different approach to the “General Appearance”: this is a man who shows patience and warmth in the face of pending death. He is the head of his household, and while he shows no fear, there can be no question that his ailment is incurable. He understands the gravity of his condition and what it means for the loved ones he

leaves behind, but his posture is spirited, and there is hope in his eyes, as he strives to live another day.

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