CHAPTER 6

When art and medicine collide: using literature to teach psychiatry

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INTRODUCTION

> When we read alone and for pleasure, our defences are down – and we hide nothing from the great characters of fiction. In our consulting rooms, and on the ward, we so often do our best to hide everything, beneath the white coat, or the avuncular bedside manner. So often, a professional detachment is all that is left after all those years inured to the foibles, fallacies and frictions of our patients' tragic lives. It is at the point where art and medicine collide, that doctors can re-attach themselves to the human race and re-feel those emotions which motivate or terrify our patients . . . Every contact with patients has an ethical and artistic dimension, as well as a technical one.[1]

AIMS OF THE CHAPTER

Duncan Macmillan House is an imposing Victorian building that was formerly an asylum, at the edge of Nottingham city. Nowadays, with the city's enlargement, it occupies a less peripheral position and is the headquarters of an NHS mental health trust. It no longer serves as a hospital. Thoroughly modernised from the inside, it still retains an impressive but somewhat sombre visage. Each time I enter, I wonder what life was like for those who lived or were incarcerated there.

Much of this chapter was written sitting in the library of Duncan Macmillan House, opposite a section devoted to 'fiction and mental illness'. Its shelves hold a wide range of literary styles and works from Bronte's *Jane Eyre*, through F Scott Fitzgerald's narrative of a troubled psychiatrist, *Tender is the Night*, to more recent

books like Mark Haddon's accurate portrayal of the world as experienced by a young man with autism, *The Curious Incident of the Dog in the Night Time*.

Six years ago when I started work as a junior doctor, this section of the library's catalogue didn't exist. Today, judging by the steady stream of visitors, it is one of the most used sections. What this large collection of books illustrates is how pervasive mental illness themes are within our culture and how rich a resource these fictional accounts are in the training and further development of mental health professionals.

Over the last few years, I have had the opportunity to teach psychiatry to both postgraduate and medical undergraduate students. Hesitantly at first, I started to use examples of characters from books and films to illustrate psychopathology, diagnoses and the complex psychosocial problems that often accompany mental illness. I thought that this approach might clarify and reinforce concepts that students often described as abstract. What could be more 'real' than the character suffering from morbid jealousy in *Enduring Love* (1997), who stabs the rival for his love in delusional rage?

Soon after they started, the 'literature' sessions were over-attended. Anyone who has ever tried to maintain the enthusiasm of students on late Friday afternoons will know, this was a considerable achievement.

A couple of years later, the opportunity to teach undergraduate medical students as part of a humanities-based module looking at the links between arts and psychiatry arose. Since then I have led the seminar on 'Literature and Psychiatry' as part of the module.

There is a growing awareness of the usefulness of medical humanities within the medical curriculum. However, the idea that this is an 'add-on' to the mainstream curriculum remains prevalent. Writing in 1999, at the introduction of a new journal on medical humanities, Evans and Greaves noted: 'In many ways, the position of the medical humanities resembles that of medical ethics 20 years ago, when its modern form emerged in Britain as an absorbing academic discourse but not yet the integral part of medical education and practice that it has now become'.[2]

The situation has improved since then, however the use of humanities is still viewed as a peripheral supporting activity rather than a mainstream method of imparting knowledge, skills and attitudes. When I started using these methods a few years ago, other clinicians would comment on how the students would appreciate doing 'something' a bit different and how they might gain 'something' from it. Although I appreciated their acceptance of my teaching style, implicit in their comments was the notion that at best, the humanities would just add 'something' and were not an integral factor in medical education. Richard Smith has observed: 'The additive view is that medicine can be 'softened' by exposing its practitioners to the humanities; the integrated view is more ambitious aiming to shape the nature, goals and knowledge base itself'.[3]

I am aware that some people are sceptical about the approach that this chapter, and indeed this book, takes and they believe that the arts are too 'woolly' to impart meaningful knowledge to the student. There are commentators who suggest that the

arts do not make people more sensitive. Harold Bloom, a literary critic, has observed that reading literature is a selfish activity and does not necessarily make us better, more caring people; it can expand our intellectual horizons but does not engender a sense of altruism.[4] Oscar Wilde famously declared that 'All art is quite useless' and denied any suggestion that it could be educationally or morally uplifting. After considering both the pros and cons of reading literature, Beveridge concludes that it is up to the individual psychiatrist to decide whether literature is worth exploring in his or her professional development.[5]

This chapter is a practical guide to establish a session using literature to teach psychiatry. I will also consider the arguments in favour of using literature to teach psychiatry as this might be discussed at such a session. The chapter also includes a list of resources that could be used, however these are not explored at any great length. Oyebode has provided an excellent account of many of the resources that could be used.[6]

WHY USE LITERATURE?

Theoretically, using literature as a method of teaching psychiatry is aligned to two approaches to learning: experiential[7] and constructivist.[8]

Heron defined experiential learning as 'knowledge by acquaintance' in literal or symbolic form and involving action, reflection, emotion and imagination.[6]

Literature is a form of experiential learning that involves symbolic experience and appeals naturally to the learner's imagination. It elicits an emotional response from the reader as they identify with characters' joys, struggles and aspirations.

Constructivism fosters learning by encouraging the discovery of meanings through the use of personal viewpoints and validation of the learning experiences through intersubjectivity or the convergence of personal meanings.[7] Literature as a teaching tool presents opportunities for both personalised and intersubjective learning. Experiential learning and constructivism share the assumption that true learning is rooted in evocative learning. Unlike with the largely cognitive-oriented traditional didactic teaching, experiential or constructivist based learning methods appeal to emotions and provoke thought, and therefore achieve a higher learner level of retention long after the initial learning episode.[6,9]

Often, health issues are presented to students in a decontextualised manner, which can detract from student interest and learning. Fictional accounts can contextualise the symptoms and articulate the experience of suffering in a memorable manner. Further, literary works engage the reader more fully by engaging their imaginative faculties. In literary accounts, portrayals of suffering can go beyond the terms of nosological classification. This makes the description of the illness more vivid. For example, in *Darkness Visible: a memoir of madness*, William Styron rejects the very term 'depression' as an inadequate word for the suffering he has been through.[10] He describes it as 'a true wimp of a word for such a major illness'.

Understanding the patient and carer experience

Patient narratives are a key source of information about the experience of receiving care. Understanding this experience helps professionals in providing care tailored to patient need and in developing empathy. There is a paucity of information about the patient experience, other than from academic journals or textbooks, although increasingly the Internet is proving to be a source of patient narratives, for example www.healthtalkonline.org. Although surveys presented in research papers are useful sources in conveying the difficulties that patients face, they do not describe the emotions and difficulties that patients and their carers go through. The clinical records can be difficult to access and often contain only the facts and interpretations by professionals. Recently, there has been an effort to encourage patients to add their 'narrative' to the clinical record. However, the uptake has been low. At the time of acute illness, many patients might not be able or wish to contribute a narrative to their record, and on recovery, with the multiple teams involved, there is a lack of clear locus about whom should request such a narrative and where it is best held.

Currently, fiction provides a useful way through which professionals and students can tap into the subjective experience of the patient. As Oyebode has observed:

> What the arts and humanities can do for psychiatry is to reinforce the importance of the subjective. Our current diagnostic approaches emphasise the objectivity of symptoms and understate the importance of how these symptoms are experienced by people; this despite the fact that the roots of clinical psychopathology lie in phenomenology.[11]

Understanding psychopathology

Some texts can provide good examples of psychopathology. The worked example in a later section of this chapter illustrates this. Although there is no substitute for bedside clinical teaching with real patients, literature can provide a method of consolidating knowledge about psychopathology.

Awareness of the self

A work of literature is perceived in different ways according to our differing interests, personalities and varied life experiences. It is inevitable that our past experiences shape the understanding of the text that we are reading. How then, can we use a literary text to aid students' understanding of psychiatry when each student will perceive the piece of work somewhat differently? Rather than limit the use of literature, the varied responses actually illustrate a useful learning point that can be applied to the understanding of psychiatric practice. ICD10 diagnostic classification not withstanding, we each approach patients differently, and more clearly remember or relate to different aspects of their stories. And by discussing these differences in interpretation we can understand more about our roles within the treatment dyad.

Literature can facilitate self-reflection. Works such as Camus' *The Plague* and Chekhov's 'Ward No. 6' delve into the personal, professional and political lives of

a doctor and a psychiatrist. The following excerpt from 'Ward No. 6' illustrates the difficulties faced by a professional:

> Having looked the hospital over, [Dr] Ragin concluded that it was an immoral institution, detrimental to its inmates' health in the ultimate degree. The wisest course would be to discharge the patients and close the place down, he felt, but he decided he lacked the willpower to accomplish this on his own . . . Having taken the job, Ragin adopted an attitude of apparent indifference to the irregularities . . . Ragin much admires intellect and integrity but lacks the character and confidence to create a decent, intelligent environment.[12]

Therapeutic reading and relaxation

Careers within the healthcare profession are rewarding but they are also stressful. Developing the practice of reading for pleasure can be one way to deal with stress. As Sir Aubrey Lewis advocated:

> [The medical doctor] must have not only vocation, but avocation, some-thing which will call him further away into other fresher fields than those of his daily work. Such an avocation is literature . . . It teaches him to see his own work in its right perspective, not divorced from other forms of knowledge to which it is complementary nor sundered from other arts with which it is united.[13]

Reflective practice

Medical students are expected to maintain portfolios with documentary evidence of achievements and competencies. Students often find it difficult to produce reflective pieces. This might be because of the lack of reflection time they have given the intensity of the medical curriculum. In addition, medical students might struggle with the actual process of reflecting on their feelings. After the 'arts in psychiatry' module we conducted interviews with students. They reported 'surprise' when they were asked how they 'felt' about a patient. They suggested that medical school had taught them to value facts far above feelings. Medical humanities might help them develop reflective skills and find a medium through which they might express themselves.

Developing skills in medical ethics

Literature provides an interesting approach to exploring moral dilemmas. William Carlos Williams, a doctor and a writer, presented in a short story 'The Use of Force' (1938) the dilemma of whether force is ever justified in a medical intervention. Although the situation in this story is a young girl's reluctance to allow the doctor to examine her throat, mental health professionals are often confronted with similar dilemmas about whether treatment should be imposed against a patient's will. Short stories have been used as a method of introducing psychiatric ethics to postgraduate residents.[14]

WHAT DO THE STUDENTS THINK ABOUT THIS APPROACH TO LEARNING PSYCHIATRY?

The use of literature to teach psychopathology has been well received by graduate students. Mpofu and Feist-Price reported that in response to open-ended questions about their experience with literature-based learning, the majority of graduate students reported that they remembered a greater number of the diagnostic features for schizophrenia much more readily following this learning than was the case with previous (undergraduate) learning when they deliberately committed these to memory using a variety of mnemonic devices.[15] Many also reported that stories provide contextual understanding and encourage critical thinking. All the students noted that they found the literature-based learning more engaging than the traditional didactic method.

In another study using short stories, Rudin, *et al*. reported that residents rated a literature and ethics seminar highly, as it increased their ethical sensitivity and they found the content of the stories stimulating.[14]

In our own experience we have found that students responded well to the session on literature. All students reported that they enjoyed the session and all felt that it would be useful to their future careers. In the research we conducted (Tischler, *et al.*), some suggested that being a medical student could be limiting in terms of self-development and having time to explore outside interests as the following quote illustrates:

> I certainly stopped reading fiction when I came to medical school and I think it is just 'cause the text books take over (David, male).[16]

HOW TO USE LITERATURE

Setting aims for the session

Sharing clear aims with students provides a framework that guides the session. A discussion of why literature has been used to deliver the specific educational aims of the session should be included. It might be that literature is only one way of many that could have been used; acknowledging this promotes student engagement. Whilst the educational aim ought to be clear at the outset of the session, the reasons for using literature as the means of delivery might be discussed at the end of the session. Having a clear educational aim helps to guide selection of text. For example, I wanted to use a piece of literature to illustrate the psychopathology of schizophrenia and therefore I chose Gogol's *Diary of a Madman* (1834), *see* Box 6.1.

BOX 6.1 *Diary of a Madman*: example of a précis and pre-session questions

I have used Nikolai Gogol's *Diary of a Madman* in several teaching sessions in order to illustrate the psychopathology of mania and teach the diagnostic concepts of schizophrenia, schizo-affective disorder and bipolar disorder.

I have included the précis that is provided to students ahead of the session along with suggested questions.

Diary of a Madman: introductory notes and suggestions for discussion

Gogol's *Diary of a Madman* is the story of the descent into madness of Axenty Ivanov, a low-ranking official in the Russian bureaucracy. It is set in the 1830s and is written in the form of a series of diary entries that demonstrate the increasing disintegration of the protagonist's mind.

Author

Gogol was born in 1809. He started to write plays and short stories whilst at school. He was determined to make his name as a writer and after leaving school he headed for the city of St Petersburg. The *Diary of a Madman* appeared in 1834. His most celebrated book, *The Overcoat*, was published in 1842. He wrote several other books and plays and achieved success as a writer. In his latter years he was afflicted with religious mania and despair. He died in 1852 after subjecting himself to a severe regime of fasting.

Possible areas for discussion

1. What evidence for illness does the diary contain? Can it be described in terms of the 'symptoms' and 'signs' of mental illness that we use today?
2. The protagonist seems to be looking forward to his journey to the hospital because he thinks that he is going to the Spanish Court. The patients we see differ in their levels of insight. Consider a modern-day patient developing a psychotic illness with little insight and sectioned under the Mental Health Act: How might they experience the journey to the hospital? How would they consider the treatment and the ward? How have things improved since Gogol's time?
3. In a *BMJ* paper, Althschuler (2001) argues that the story represents one of the oldest cases of schizophrenia. He suggests that it is a brilliant sketch of the illness. Why do we see so few reports about the illness from that period and before? (The discussion might include notions of illness and labelling, social functioning and schizophrenia, how societies deal with deviant behaviour, what makes a diagnosis and what are the benefits and drawbacks of a diagnosis in modern times).
4. What part of the story captured your attention, if any? Why?

Reference

Altschuler E. One of the oldest cases of schizophrenia. *BMJ*. 2001; **323**: 1475–7. Available at: www.bmj.com/cgi/content/full/323/7327/1475 (accessed 15 May 2010).

Selection of the text

The selection of text depends upon the facilitator's knowledge of literature as well as knowledge of the subject. There are many lists of books that are available from a variety of different resources that illustrate which text could be used for teaching a particular area. In this chapter, we include a suggestive list (*see* Table 6.1). Using

a precompiled list to identify appropriate texts is a relatively easy way of finding suitable material, however, I would recommend discovering in one's own reading texts that might illustrate an aspect of psychiatry that would fulfill a useful learning objective.

It is worthwhile considering the emotional impact a particular text might have. Also, consider the author of the text. Topics such as the author's mental state at the time of writing the book, or the author's own experience of mental illness (if known) often stimulate discussions around the link between mental illness and creativity.

At first I found choosing an appropriate text a rather daunting challenge and I chose from pre-prepared lists. However with time, it became a reflexive skill and I would realise whilst reading a book that it would be a useful work to communicate an aspect of psychiatric practice.

TABLE 6.1 Examples of literary works that can be used in teaching

Title (year of first publication)	Author	Areas illustrated
The Long Way Out (1937)	F Scott Fitzgerald	Schizophrenia, ethics
The Plague (1947)	Albert Camus	Professional ethics
Ward No. 6 and Other Stories (1892)	Anton Chekhov	Psychiatric ethics
Diary of a Madman (1834)	Nikolai Gogol	Psychosis, mania
The Curious Incident of the Dog in the Night Time (2003)	Mark Haddon	Autistic spectrum disorder
The Bell Jar (1963)	Sylvia Plath	Depression, ECT
Enduring Love (1997)	Ian McEwan	Morbid jealousy
One Flew Over the Cuckoo's Nest (1962)	Ken Kesey	Institutional care
'The Use of Force' (1938)	William Carlos Williams	Ethics of care
Tender is the Night (1933)	F Scott Fitzgerald	Professional ethics
Asylum (1996)	Patrick McGrath	Nature and consequences of jealousy
Spider (1990)	Patrick McGrath	Psychosis
Human Traces (2005)	Sebastian Faulks	History of psychiatry
Jane Eyre (1847)	Charlotte Brontë	Stigma
Darkness Visible: a memoir of madness (1990)	William Stryon	Depression
Shame (1983)	Salman Rushdie	Intellectual Disability

It can be better to use less popular books. There is a risk in using the 'obvious' pieces, as time is always a scarce commodity and some students will have read the book and won't bother re-reading it. Others will think that they have a general sense of what

happened in the book. Try to avoid using books that have been made into movies. The movie, which is the producer's vision of the book, soon becomes the 'gold-standard' view and other viewpoints unfortunately get drowned out. As I mentioned before, I once used *Enduring Love* to illustrate morbid jealousy. I asked the class to look through the book and identify evidence for the delusional beliefs of the unwell character, however, astonishingly it soon became clear that the only pieces of evidence that students managed to pick up on were the ones that Rhys Ifans portrayed in the film of the book.

I have tried using both short excerpts from a few books as well as whole books. In my experience, the latter works better. There is a temptation to use a few excerpts from multiple sources (in order to cover more areas), however in practice this is difficult. In order to have an informed discussion having more of the story rather than multiple excerpts is better. The only occasion where I have found multiple excerpts to be useful is where the sole educational aim was to illustrate psychopathology.

The length of the chosen text depends upon the time available before and during the teaching session. If the book is too long, then there is a difficulty in identifying key passages and much time is wasted during teaching with students flipping between the relevant pages and refamiliarising themselves with the issue under consideration. Tightly written shorter books with examples of speech or thought, work well. Short stories, though not as popular as novels in the literary world, work well for this style of learning. Writing about the use of literary classics in teaching medical ethics to physicians, Radwany and Adelson warn that short stories may not develop plot and characters as well as a play or a novel.[17] However, Rudin, *et al.*, who used short stories in teaching psychiatric ethics, found that a highly crafted, condensed short story provided extraordinary impact, emotional resonance, and ethical ambiguity.[14]

Background preparation and the start of a session

A good way to enhance student engagement is to distribute a précis of the piece with a brief summary of the author's biography. An example that we have used in our teaching is provided (*see* Box 6.1).

Questions that follow discussions on works of literature such as 'how did that piece make you feel?' are not commonly encountered in the medical curriculum and students often feel embarrassed to answer such questions. As students have pointed out, they are used to questions of fact and not to questions of feeling. Laying down ground rules to ensure confidentiality and respect for others' views helps to allay anxiety and allows for a more free discussion. Identify a contact person for students if there are problems that arise post-session.

Promoting engagement

As well as clear aims it is important to have clear tasks. The task should enable the student to meet the educational aim. I usually include primary tasks that are based on a reading of the text and secondary tasks that extrapolate from the text in order to facilitate a discussion around application.

Examples of the processes involved in establishing tasks follow:

1. Students often don't consider the experience of patients who are admitted to a mental health ward despite shadowing the junior doctor whilst they interview and examine the new patient. Unfortunately, due to time constraints and the necessity of objectivity, most admission notes report signs and symptoms but contain little of the 'experience' of the patient.

   In order to address this gap in understanding, I set the aim of a session – to consider the experience of becoming a patient. For this task I asked students to read an excerpt from Sylvia Plath's *The Bell Jar* and then: a) consider the emotions that are conveyed; and b) consider what similarities and differences they noted between Sylvia Plath's account of an admission and an admission in a modern day ward.
2. Electro Convulsive Therapy (ECT) is considered a stigmatising treatment and the general public perception of it remains negative, despite the fact that for some patients it can be life-saving. The aim set for the session was to consider the perceptions of ECT against the reality of treatment. I used the portrayal of ECT from the book, *One Flew Over The Cuckoo's Nest*, as the session's text. The tasks set were to: a) identify the similarities and differences between ECT as depicted in the book and the ECT they had observed; and b) consider how they would discuss the treatment with relatives and carers of a patient who was due to have ECT who had seen the film or read the book.

Different students will engage with the materials and tasks in different ways. It is also important to be aware that some students will accept this approach more readily than others. It can be quite a cultural change to be asked questions for which there are no right or wrong answers. For example, all students will answer a question on the first-rank symptoms of schizophrenia in approximately the same way. However, asking about the emotions that students pick up from a work of literature might lead to a variety of different responses and sometimes these will conflict. In my experience, where students have elected to take up a humanities module, they show greater willingness to engage in this approach and accept differences in opinion. However, in non self-selected groups, there can be a section of students who feel that this approach is 'wishy-washy' and 'not scientific enough'. It is that section of students who need to be reminded why this is a reasoned approach to educational aims if humanities-based modules are ever to be mainstreamed in medical education.

Organising responses

The task of the facilitator is to pick up on responses and use them to stimulate further discussion. This can be quite simple, such as thanking a student for volunteering their interpretation and then asking the group for their response. However, it can be difficult to develop any meaning from a number of varied responses to open-ended questions. Without developing some structure for students to place the information, opportunities for learning might be missed.

Using a visual aid to record responses helps to prevent this. After eliciting responses these can be grouped together to aid retention. The visual record also acts

as a prompt to stimulate further reflections. Occasionally, the group will provide responses that could not have been anticipated. It is important to be flexible so that opportunities to develop interesting ideas are available.

Whilst arts-based teaching is less formal than traditional didactic teaching, occasionally it becomes necessary to intervene and remind students of the original aims. In one memorable session we used excerpts from the book *Touched by Fire* by Kay Redfield Jamison to discuss links between mania and creativity. The conversation veered to hearing voices as a sign of manic psychosis. A student made a link between religious prophets and mental illness. The discussion continued for a short while, however as this was leading on to uncomfortable territory for some students, I intervened to bring the group back to the session aims.

Facilitating discussion and popular areas for discussion

Discussion flows from the responses to the tasks that have been set, however certain areas that form recurrent themes are:

- psychopathology: using actual examples of psychopathology and teasing out what this might mean in terms of a diagnosis
- psychosocial issues: the complexities of how and where care is provided and the ways in which families cope with mental illness
- medication: this often receives quite a negative depiction in literature and this is something that facilitators should be aware of. There are many reasons why this might be the case: perhaps those who write of their experiences are those who are not suffering from the more extreme forms of illness for which medication appears most useful, or perhaps medication is not as beneficial as the profession perceives it to be.

Application of the session to the 'real world'

The end of the session relates the discussion and what has been learnt to the real world, guided by the aims of the session. To consider one of the examples described above, at the end of our discussion on admissions to mental health wards, we agreed that patients might feel 'bewildered' on their first admission. However, there was also a realisation that many doctors don't acknowledge this when clerking in new patients. It was agreed that students would discuss with nursing staff how they approached the task of reducing the anxieties of new patients. Students felt that the session had impressed upon them the significance of acknowledging the distress that patients might feel on admission and the importance of multi-disciplinary teams.

Providing the opportunity for feedback

Provide the students with an opportunity to give feedback on the session. We have found it useful to gather both qualitative as well as survey-based quantitative data.

Costs and copyright

The sessions are not materially expensive. Costs to be considered are printing if you are planning to distribute copies of the text and teaching costs for any external speakers.

We used PDFs of the relevant pages that we were able to e-mail to the students taking the module. We also ensured that the books considered were available at the university libraries. Another consideration is copyright rules. Wherever there is any doubt it is useful to speak with the university legal service and/or the publisher.

RECRUITMENT CRISIS IN PSYCHIATRY

I was encouraged that students taking the humanities module I teach have expressed interest in pursuing a career in psychiatry. This is of particular importance currently as psychiatry is suffering from a shortage of trainees.[18]

CONCLUSION

I hope that this chapter has demonstrated the role that literature has to play in psychiatric education and has provided a framework to those keen to make use of it.

REFERENCES

1 Collier JAB, Longmore JM, Hodgetts TJ. Fame, fortune, medicine and art. In: *Oxford Handbook of Clinical Specialties*. 4th ed. Oxford: Oxford University Press; 1995. p. 413.
2 Evans M, Greaves D. Exploring the medical humanities. *BMJ*. 1999; **319**: 1216.
3 Smith R. Editor's choice: struggling towards coherence. *BMJ*. 1999; **319**.
4 Bloom H. *How to Read and Why*. London: Fourth Estate; 2000.
5 Beveridge A. The benefits of reading literature. In: Oyebode F (editor). *Mindreadings, Literature and Psychiatry*. London: RCPSYCH; 2009.
6 Oyebode F. Fictional narrative and psychiatry. *Ad Psychiatr Treat*. 2004; **10**: 140–5.
7 Heron J. *Group Facilitation: theories and models for practice*. London: Kogan Press; 1993.
8 Gadamer HG. *Truth and Method*. New York: Pantheon; 1975.
9 Knowles MS, Holton EF, Swanson RA. *The Adult Learner*. Houston, TX: Gulf Publishing Co; 1998.
10 Styron W. *Darkness Visible: a memoir of madness*. New York: Random House; 1990.
11 Oyebode F. Editorial: literature and psychiatry. *Ad Psychiatr Treat*. 2001; **8**: 397–98.
12 Chekhov AP. *Ward No. 6 and Other Stories, 1892–1895*. London: Penguin; 2002.
13 Lewis A. *Monograph Supplement 10*. Cambridge: Cambridge University Press; 1986.
14 Rudin E, Edelson R, Servis M. Literature as an introduction to psychiatric ethics. *Acad Psychiatry*. 1998; **22**: 41–6.
15 Mpofu E, Feist-Price S. Use of literature in teaching psychopathology: some strategies for health educators. *Academic Exchange Quarterly*. 2002; **6**(3): 49–55.
16 Tischler V, Chopra A, Nixon N, *et al*. Loss and tomorrow's doctors: student perceptions of the value of humanities teaching (under review).
17 Radwany SM, Adelson BH. The use of literary classics in teaching medical ethics to physicians. *JAMA*. 1987; **257**: 1629–31.
18 Channel 4 News. Psychiatry's UK recruitment crisis. 4 June 2009. Available at: www.channel4.com/news/article.jsp?id=3190557 (accessed 16 February 2010).