Medical Humanities: *Histories of the Normal and the Pathological in Body and Mind*
Code: HUM 3051

Course Coordinator : dr Rob Houtepen (FHML, Health Ethics and Society)
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Contents

General Information

Overview

Medical humanities acknowledge that instead of being fixed entities, health and illness are constantly changing, ambiguous phenomena. What is called healthy (sane) or ill (insane) depends indeed on a large variety of issues and dynamics: cultural, socio-economical, and religious aspects; moral system; legal system; science; technology; art and media etc. This course approaches the question of health and illness through a philosophical, anthropological and sociological exploration of "bodies" and "minds". Through a historical and cross-cultural perspective it will discuss various concepts of body and mind. We will discuss how and why some bodies and minds are considered as normal and others as abnormal or pathological. For this we will draw on scientific, social, cultural and economic contexts, but also on how bodies and minds are represented in art and (popular) culture.

Objectives

The course has the following objectives:

- To provide students with a grasp of different conceptions of 'body', 'mind', and different understandings of the relation between body and mind related to healthcare and psychology.
- To provide students with a grasp of how cultural, social, economic, legal, scientific and religious contexts play a role in the regulation of what can be seen as healthy and normal, and what as pathological or deviant
- To teach students how to critically analyze philosophical, anthropological, and sociological texts.
- To enable students to contribute to contemporary debates pertaining to health, illness and medicalization.
- To allow students to develop their own understanding of classifications of health and illness.

Prerequisites

COR1002 philosophy of science

Structure of the Course

The assignments will revolve around the following 4 topics:

- Making visible of and picturing bodies and minds (Assignments 1 & 2 + field visit)
- Metaphors and literary language (Assignment 3 + book review)
- Normality and deviance (Assignment 4-7)
- Capital in the body (Assignment 8-10)

Literature

There is no course book. Students will study a variety of classic and cutting-edge articles and book chapters. Students will get access to these at the course opening. For earlier access, contact the course coordinator.

Assessment

Students will be expected to write and present (a) a book review and (b) a final paper:
A. At the beginning of the course students select a title from a list of 'experiential' books on health and illness, body and mind. These may either be autobiographical writings or literary texts such as novels (this list will be provided through Eleum). Students read the selected book independently, subsequently write a review of it and present that review to the group (1500-2000 words and 10 minutes). The review and the presentation need to contain the following aspects: an outline of the books content / storyline, analysis of how the phenomena of health and illness / 'madness' are represented in the book, and – if applicable – an analysis of how the author thematizes the relation between body and mind. The book review, together with the presentation, will count for 40% of the final grade, and has to be handed in not later than the end of week 3.
B. Final papers, of approximately 2000 words, will give students the opportunity to make an argument of their own. Students will be asked to define and defend their preferred views on health, illness, normality and abnormality, drawing on the material offered during the course, and further research into these matters. They will present these views to the group in the last meeting of the course. This paper, together with the presentation, will count for 60% of the final grade, and is due on the last case discussion in week 8. Students can have individual meetings with the course coordinator to discuss their papers during the period.

Papers will be graded according to the following criteria:

- Does the paper display a clear understanding of the material under consideration?
- Does the paper have a clear thesis?
- Is the thesis supported by cogent arguments which are properly grounded in the texts?
- Is the paper original?

For a grade of 6, a paper must display basic comprehension of the material discussed and an indication of a thesis. For a 7, a paper must show detailed understanding of the material under consideration and the arguments used in that material, as well a clear thesis statement that is argued for. For an 8, the paper must use the material and arguments discussed to support the thesis in question. 9's demonstrate their particularly ambitious theses with particular ingenuity and resourcefulness, transcending the material under consideration. 10's advance the state of that of medical humanities. During the course we will discuss how to write a good paper. The grading is primarily based on the papers, but the presentation will count. Where the final grade is influenced by the presentation to the degree that it deviates from the grading of the papers, this will be explicitly explained and substantiated. The relevant criteria for a presentation and its grading are in the appendix.

Attendance, Extra Assignments and Resit Policy

Students must attend a minimum of 12 of the 14 meetings. Students who have attended 11 meetings may apply for an extra assignment according to UCM procedure. Students who attend 10 meetings or less will fail the course. If a student misses one of the two presentation meetings, their presentation should be given in another group meeting.

Since the lectures form an integral part of this course, students are also supposed to sign attendance for lectures. Students are supposed to attend at least 6 of the 8 lectures. Students who fail this attendance norm may apply for an extra assignment according to UCM procedure.

Students whose final grade is below 5.5 may resubmit one of their two papers, the grade for which will replace the original for that paper.

Course Provider

The course coordinator, who may be contacted for any reason and at any time, is:

Dr. Rob Houtepen
Department Health, Ethics and Society (HES)
Room DEB 1. B2 096
Debeyeplein 1 (Randwijck, in front of hospital)
T: +31 (0)43 3881134 Administrative office HES: 3881144/3882145
E: r.houtepen@maastrichtuniversity.nl

According to email etiquette you can expect a response to your email within 2-3 working days. To prevent redundant emailing, please check first for a possible answer to your query on EleUM.

Schedule meetings, assignments and lectures

Introductory assignment: Brainstorming bodies and minds
Ass. 1: The clinical gaze – a modern phenomenon
Ass. 2: Transparent bodies and minds
Ass. 3: Metaphors: the war on cancer
Ass. 4: The coming into being of (ab)normality: menopause and local biology
Ass. 5: Normality and disability
Ass. 6: Making up people
Ass.7: The loss of sadness: depression
Ass. 8: Commodification of the body
Ass. 9: The body's capital – Boxing in the ghetto
Ass. 10: Cosmetic and reconstructive surgery

week	*Monday afternoon*	*Thursday Afternoon*
1 Reading chosen book	**9-4:** 13.30-15.30 Plenary Course Introduction 16.00 Lecture Prof. dr. Eddy Houwaart. *Coming into being of the clinical gaze*	**12-4**: 11.00-13.00 and 13.30-15.30 Introductory assignment + Case 1
2 Reading chosen book	**16-4:** 11.00-13.00 and 13.30-15.30 Case 1 + 2	**19-4:** 11.00-13.00 and 13.30-15.30 Case 2 + 3 16.00: Lecture Dr Rob Houtepen *How metaphors structure perception*
3 Reading chosen book	**23-4:** 11.00-13.00 and 13.30-15.30 Case 3 + 4 16.00 Lecture Prof. dr. Jenny Slatman *Coming into being of the normal body*	**26-4:** 11.00-13.00 and 13.30-15.30 Case 4 + 5
4	**30-4:** 13.30-18.00 *Presentations book reviews* *Two groups parallel*	**3-5:** 11.00-13.00 and 13.30-15.30 Case 5 + 6 16.00 dr Arno Lataster *Lecture Images of Anatomy* (Study room Anatomy)
5 Start thinking about paper	**7-5** Rob 11.00-13.00 and 13.30-15.30 Case 6 + 7 16.00 dr. Maria-Teresa Brancacchio *History of causal models in epidemiology*	
6 Start outline / notes paper	14-5 11.00-13.00 and 13.30-15.30 Case 7 + 8	17-5 11.00-13.00 and 13.30-15.30 Case 8 + 9 16.00 Lecture: dr Carijn Beumer *Cultural perspectives on health and illness*

7 Write paper		24-5 11.00-13.00 and 13.30-15.30 Case 9 + 10 16.00 Lecture Gili Yaron *Facing One's Loss of Face*
8	28-5 11.00-13.00 and 13.30- 15.30 Case 10 16.00 Lecture Prof Dr. Rene van der Hulst *History of plastic surgery*	31-5 11.00-13.00 and 13.30- 15.30 *Presentations final paper* *Two groups parallel*

Medical history book tips

In the previous run of the course, students asked for extra reading (indeed). The advice is to read a general history of medicine as a background book. You will find you'll also be able to make use of it for your final paper. The course coordinators favorites are:

- R. Porter. *The Greatest Benefit to Mankind. A Medical History of Humanity*. New York-London: W.W. Norton & Company HarperCollins, 1998. Or if you prefer a short version:
- R. Porter. *Blood and Guts. A short history of Medicine*. New York-London: W.W. Norton and comp., 2003.

The leading academic work is:

- R. Porter (Ed.). *The Cambridge illustrated history of Medicine*. Cambridge: Cambridge University Press, 1996.

Alternatives:

- J.C. Burnham. *What is medical History?* Cambridge: Polity Press, 2005.
- W. Bynum. *The History of Medicine. A very short introduction*. Oxford: OUP, 2008.
- R. Cooter, and J. Pickstone (Eds.). *Medicine in the 20th century*. Australia etc: Harwood Academic Publishers, 2000.
- J. Duffin. *History of Medicine: A scandalously Short Introduction*. Toronto: University of Toronto Press, 2010.
- F. Huisman, and J.H. Warner (Eds.). *Locating Medical History. The Stories and their Meanings*. Baltimore-London: Johns Hopkins University Press, 2004.
- I.C. Lawrence, M. Nive, V. Nutton, R. Porter, and A. Wear. *The Western Medical Tradition, 800 BC to AD 1800*. Cambridge: Cambridge University Press, 1995.
- Loudon. *Western Medicine: An Illustrated History*. Oxford-New York: Oxford University Press, 1997.

(*) Timeline of medical science:

https://www.youtube.com/watch?v=uEtqxMVIHyc

(*) Medical milestones according to the readers of the *British Medical Journal*:

http://www.bmj.com/content/medical-milestones

Introductory Assignment – Brainstorming bodies and minds

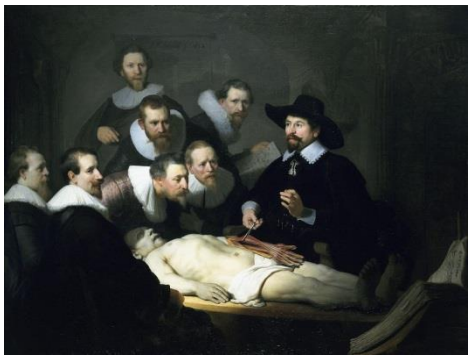
This course focuses on the meaning of health and illness in our times. Since illnesses express themselves through our body it might seem pretty straight forward to define the boundary between health and illness. This, however, is not the case. How health and illness are defined and are understood is constantly changing. A reason for this constant change is that concepts of body, mind, health and ill are constantly changing. This course aims at making explicit what kinds of concepts are at play in various contexts and practices and, conversely, what the use of these concepts bring about in various contexts and practices.

Concepts are historical.
Concepts are metaphorical.
Concepts are performative.

- Reflect on and describe various meanings of the concepts "body" and "mind" (historical, cultural differences)
- Provide metaphors pertaining to body and mind
- Provide metaphors pertaining to health and illness
- Could you provide an example of how the use of a certain (medical) label impacts on the way a certain condition is experienced and approached?

Assignment 1 – The clinical gaze – a modern phenomenon

The Roman physician Galen (129-216 AD) claimed, among other things, that the human womb consists of 7 chambers. Claims like these were based on mere speculation, and on dissections on animal cadavers. Dissections on human cadavers were rarely performed in Antiquity and in the Middle Ages. It is only after the 13th century that dissection of humans became a more common practice. While dissecting and meticulously scrutinizing human bodies the Flemish anatomist Andreas Vesalius (1514-1564) unmasked a host of errors in Galen's medicine, and heralded the Age of modern anatomy, modern medicine.



"*What is observation worth, if we are ignorant of the seat of the disease? You may take notes, for twenty years, from morning to night at the bedside of the sick, upon the diseases of the heart, the lungs, the gastric viscera, etc. and all will be to you only a confusion of symptoms, which, not being united in one point, will necessarily present only a train of incoherent phenomena. Open up a few corpses, this obscurity will soon disappear, which observation alone would never have been able to have dissipated*"
~Bichat (French pathologist, 1771-1802)

"*The gaze implies an open field, and its essential activity is of the successive order of reading: it records and totalizes; it gradually reconstitutes immanent organizations; it spreads out over a world that is already the world of language, and that is why it is spontaneously related to hearing and speech, it forms, as it were, the privileged articulation of two fundamental aspects of saying (what is said and what one says)*".
~Foucault *The Birth of the Clinic*, p. 121

Readings:

- Foucault *The Birth of the Clinic*, chapter 8, 124-148
- John Long (1992). Foucault's Clinic. The Journal of Medical Humanities. Vol 13(3). 119-138 http://link.springer.com/article/10.1007/BF01127371
- Jonathan Sawday (1995). The Body Emblazoned, Chapter 2, 16-38

Assignment 2 – Transparent bodies and minds

Through anatomical dissection bodies were opened up and their invisible interior became visible and tangible. Since the invention of x-rays in 1895 by Wilhelm Roentgen, the interior body has become accessible and visible without dissection. At the turn of the previous century, Roentgen's invention marks a new area. The body can be entirely screened and elucidated by shining light through it. Especially since the 1960s, the development of all kinds of imaging technologies, such as endoscopy, ultrasound, MRI, PET and CT scans, has expanded enormously. The body, so it seems, has become entirely transparent.

The Visible Human Project is a fine example of how the 16th century public anatomical theatre's educational purposes are reiterated in contemporary imaging technologies.

Imaging technologies are also increasingly used to scrutinize and map our brains. Colorful brain scans increasingly replace brain maps drawn by hand. Scans seem to penetrate deeper and deeper in our mental life. But is it really possible to make the mind, our mental live, visible?

Readings:

- José van Dijck (2005). *The transparent body. A cultural analysis of medical imaging*, chapter 7. 118-137
- Michael Hagner (2009). The mind at work. The visual representation of cerebral processes. in the *Body within: Art, Medicine and Visualisation*, 67-90

Assignment 3 – The *war* on Cancer

The National Cancer act, signed into law by president Nixon, 23 November 1971.

In 1971 the American president Richard Nixon signed the national cancer act. Thanks to this new law the National Cancer Institute got more power and resources to tackle cancer, to find a cure for this lethal disease. Nixon called it the beginning of the "war" on cancer. The metaphor of war suggests that cancer is an enemy – an enemy of state even – which can and should be conquered. As we all know now, the use of this military metaphor has been enormously successful for raising funds for cancer research and treatment.

However, for cancer patients and their relatives, the use of the warrior metaphor may go together with highly undesired moralism: when cancer beats you – which is still very often the case – you lost the war, you are a loser.

Susan Sontag claims that in our times we use a large host of metaphors for cancer because the etiology of this disease (like tuberculosis in the 19th century) is still largely unknown. According to her, cancer is surrounded by a lot of fantasies, comparable to fantasies inspired by tuberculosis in the 19th century. Various literary texts play around these fantasies and metaphors.

Especially since various metaphors involve impermissible moralism, Sontag hopes that cancer metaphors will become obsolete one day. Is it possible to communicate about cancer without metaphors? Are some metaphors (morally) better than others?

Readings:

- Susan Sontag (1977). Illness as Metaphor, 3-87
- Julia Williams Camus (2009). Metaphors of cancer in scientific popularization articles in British press. Discourse Studies, Vol 11(4). 465-495 http://dis.sagepub.com/content/11/4/465.short

Assignment 4 – The coming into being of (ab)normality: menopause and local biology

What is normal and what is abnormal?

Since the 19th century diseases and health issues, both mental and physical, are often considered as a *deviance* of what is normal. This way of reasoning is based upon (1) the widespread idea of the father of modern physiology – Claude Bernard – that pathological processes only differ in a quantitative way from normal physiological processes, and not in a qualitative way; (2) the increasing application of statistical measures in medicine. Hence the birth of the "normal", "standard" body (and mind).

If the standard for normal female embodiment is restricted to reproductive possibilities, including monthly menstruation, the end of menstruation can be considered as an abnormal, pathological condition, which subsequently calls for medical treatment.

"Menopause" is a term which has been introduced in the 1880s and which replaced the term "climacteric" which referred to symptoms of the aging body both in women and men. Japanese women report very few issues while experiencing their end of menstruation. There is no Japanese word for "hot flashes".

Is menopause a Western "invention"?

Readings:

- Lock, M. and V.-K. Nguyen. (2010). *An anthropology of biomedicine*. Malden, MA & London: John Wiley & Sons. p. 32-56, p. 83-94

Assignment 5 – Normality and disability

Diseases come and go. Homosexuality stopped being a disease in 1974 after it was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Osteoporosis (decalcification of bones in elderly people) became a disease in 1994 when it was recognized as such by the World Health Organization. The difference between healthy and pathological, between normal and abnormal, between sane and insane relies for an essential part on man-made classifications.

Is disability the result of physical or mental impairments in an individual, or is it society that creates disability? Is deafness a disability? Or is deafness a form of normal human phenotypical variation?
It is well-known that deaf parents often prefer to have deaf children. Embryo selection could guarantee these parents to have a deaf child.

Readings:

- Jackie Scully (2004). What is a disease? Disease, disability and their definitions. *EMBO reports* Vol 5 (7), p. 650-653 http://embor.embopress.org/content/5/7/650
- Tom Shakespeare (2013) The social model of disability. In The Disability Studies Reader (4th edition). London, Routledge, p. 214-221
- Rosemarie Garland-Thompson (2012). The case for conserving disability. *Bioethical Inquiry*. Vol 9. 339-355 http://link.springer.com/article/10.1007/s11673-012-9380-0
- http://beyondinclusionfilm.com/

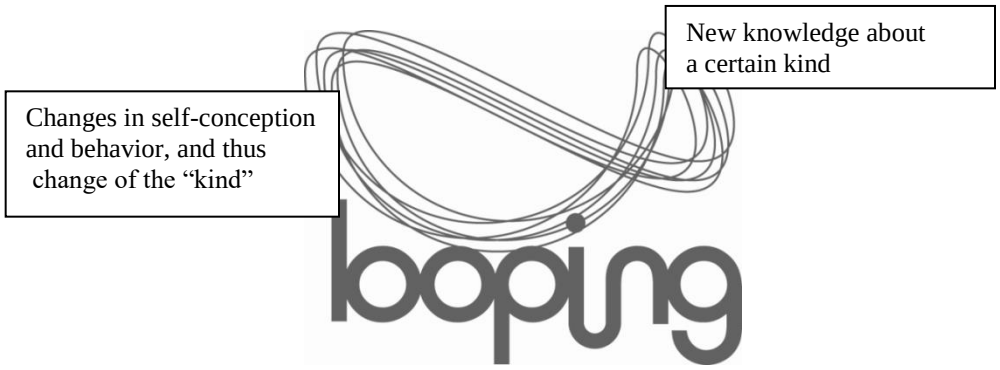
Assignment 6 – Making up people

Did the menopause already exist before 1880? Did Multiple personality disorder already exist before 1875? Did ADHD already exist before DSM-III (1980)? How "real" are health problems?

According to the Canadian philosopher of science Ian Hacking (born 1938) the reality of health problems becomes clear if we consider them as a manifestation of a "human kind" which needs to be distinguished from "natural kinds". Examples of human kinds include "menopausal woman", "split personality", "ADHD personality", "autist", "alcoholic", "bulimic" etc. Calling mud "mud" makes no difference to the mud (natural kind) but calling a person, for instance, "autist" (human kind) makes a difference to that very person

"A kind of person came into being at the same time as the kind itself was being invented" (Ian Hacking, Making up people, p. 165)

"To use a name for any kind is to be willing to make generalizations and form expectations about things of that kind" (Ian Hacking, The looping effect of human kinds, p. 361)



Readings:

- Ian Hacking (1986), Making up people, in *Reconstructing individualism*. T. Heller, M. Sosna, and D.E. Wellbery, Stanford University Press: Stanford, CA. p. 222-236. http://www.icesi.edu.co/blogs/antro_conocimiento/files/2012/02/Hacking_making-up-people.pdf
- Ian Hacking (1995). The Looping Effects of Human Kinds. in *Causal Cognition. An Interdisciplinary Approach*. D. Sperber, D. Premack, and A. Premack, Oxford University Press: Oxford. p. 351-383 http://isites.harvard.edu/fs/docs/icb.topic606668.files/Course%20Readings/1%20Introduction%20Reflective%20Self/Hacking.Looping.Effects.1995.pdf

Assignment 7 – The loss of sadness: depression

The Dutch central institute for statistics (CBS) reported in 2013 that approximately 10% of the Dutch population suffers from mild to severe depressive symptoms. Furthermore it is estimated that about 1 million Dutch people use antidepressant. Since the last decades the prevalence of depression and of antidepressant use has increased enormously, not only in the Netherlands but in the entire Western world. How is this possible? Is mankind progressively getting sadder and sadder? Is life getting more difficult? Has antidepressant use increased so much because the new antidepressants that were introduced in the 1990s (such as Prozac) have far less side-effects than previously prescribed medication?

Before 2000, the medical term "depression" was not really known in Japan. Feelings of sadness were not considered as something pathological, but rather as something normal, which every individual at some point in her or his life has to deal with. This, of course, was bad news for pharmaceutical companies that want to expand their market. They therefore started public campaigns to educate the people about depression.

Trailer:
https://www.youtube.com/watch?v=JXupw_pBcsg

Psychiatry draws heavily on progressively extending descriptions and definitions of mental disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Which role plays this much used classification system in the contemporary approach and treatment of depressive symptoms?

Readings:

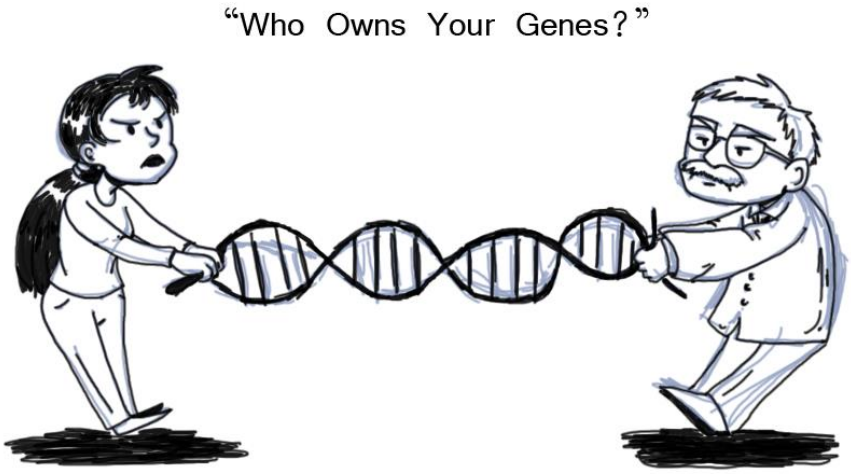
- Ethan Waters (2011). The mega-marketing of depression in Japan. In *Crazy Like Us: The Globalization of the American Psyche*. Free Press. pp. 187-255
- A.V. Horwitz & J.C. Wakefield (2007). *The loss of sadness. How Psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press, Chapter 9, p. 179-193

Assignment 8 – Commodification of the body

My body is mine and not yours. It is stated in the Dutch constitution that every person's bodily integrity needs to be protected. This implies, among other things, that, in principle, no one is allowed to intrude upon my body without my consent.

My body is mine, but is it really my property? I am allowed to donate my blood. Men can donate their sperm. I may want to donate one of my kidneys to a relative. However, I am not allowed to sell one of my kidneys.

The fact that there are laws that prohibit organ trading does not prevent that bodies and body parts are more and more commodified in our time: e.g. female donors offering their eggs for large sums of money, companies involved in genetic research make profit while using body tissues (harvesting DNA and patenting gene sequences). According to Donna Dickenson this contemporary "body-shopping" is based upon the ongoing objectification of bodies.



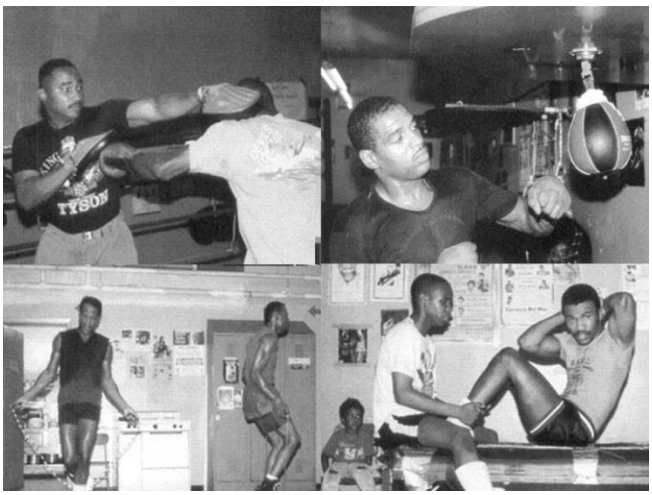
Readings:

- Donna Dickenson (2007). *Property in the body: Feminist Perspectives*. Cambridge University Press, Chapter 2, Property, Objectification and Commodification. 26-57
- Donna Dickenson (2008), *Body-shopping: Converting body parts to profit*. Oxford: One world, Chapter 2, What makes you think you own your body, p. 22-42

Assignment 9 – The body's capital – Boxing in the ghetto

The degree to which individuals within a certain social group are successful and prosperous does not only depend on the amount of money they possess. The French sociologist Pierre Bourdieu (1930-2002) distinguishes between various forms of capital: economical (income, savings); symbolic (amount of recognition); social (connections and networks); and cultural (education, etiquette, inherited cultural dispositions, skills acquisition). The amount of the various forms of capital that an individual possesses determines to which social class this individual belongs. It is not obvious to free one-self from one's own social class, because class is defined by habitus: a set of dispositions to perceive and act in specific ways. Social classes, so Bourdieu argues, reproduce themselves.

When you are born in the black ghetto of Chicago you probably won't possess much of the various forms of capital such as mentioned above. Loic Wacquant (born 1960), a pupil of Bourdieu, describes how (professional) boxing can increase bodily capital, which is a form of cultural capital, in black men. They are prepared to endure though work-outs and to even sacrifice themselves.



Certain bodily features have great value within certain social contexts. The contemporary wish to modify one's body – to embellish it, to make it stronger – can be explained as the desire to increase one's bodily capital.

Readings:

- Loic Wacquant (1995). Pugs at work: Bodily capital and bodily labour among professional boxers. *Body & Society*, Vol 1, 65-93 http://loicwacquant.net/assets/Papers/PUGSATWORK.pdf

Further reading:

- Nick Crossley (2001). *The social body: Habit, Idenity and Desire*, London: Sage, chapter 6, Habitus, capital and field. Embodiment in Bourdieu's theory of practice. p. 91-118

Assignment 10 – Cosmetic and reconstructive surgery

Plastic surgery is not only used to heal wounds and restore physical damage. Next to hand surgery, burn treatment, micro surgery, and reconstructive surgery this surgical sub-discipline also includes cosmetic surgery. Plastic surgery thus entails both *therapy* and *enhancement*. Plastic surgery, both reconstructive and cosmetic or aesthetic surgery, has a long and rich history. In the 20th and 21st century cosmetic surgery has expanded enormously.

If it is true that the way we appear to others and ourselves becomes increasingly more important for our identity, and for being included in a social group, cosmetic surgery plays an ever crucial role in our society. It can help us to "pass", and it can help to even remake our selves.

Thanks to the development of immunosuppressant medication and the ongoing advancements in reconstructive surgery, it has become possible to transplant *visible* body parts, such as hands and faces since the 1990s. This kind of reconstructive surgery enables the construction of a new bodily self, a new bodily identity, on the basis of body parts from *different* bodies.

The French Denis Chatelier received two donor hands in 2000 after he lost his own hands due to an accident with firework. Until now his new hands function well, and he is satisfied with them. It is as if he has incorporated a strange body (*Fremdkörper*) into his own body. The *strange* hands have become his *own* hands.

Are there any limits to the amount of strangeness that can be incorporated in one's own body?

Readings:

- Sander Gilman (1999). *Making the body beautiful. A Cultural history of aesthetic surgery. Princeton University Press.* Chapter 1, Judging by appearance, 5-42
- Jenny Slatman and Guy Widdershoven (2010). Hand Transplants and Bodily Integrity. *Body & Society*, 16 (3), 69-92 http://bod.sagepub.com/content/16/3/69.short

Appendix: Grading criteria for presentations HUM3051

Grade	Content criteria	Presentation criteria
6	Clear statement, basic argumentation, discussion	Basically organized and delivered (at least 3x "+" for presentation criteria), see below*
7	Clear statement, basic argumentation, discussion	Well-organized and delivered (at least 5x "+" for presentation criteria), see below*
8	Clear statement, in depth argumentation, discussion	Well-organized and delivered (at least 5x "+" for presentation criteria), see below*
9	Clear statement, in depth argumentation, discussion	Well-organized and very convincing presentation (8x "+"for presentation criteria), see below*
10	Original, state of the art statement, argumentation and discussion	Well-organized and very convincing presentation (8x "+"for presentation criteria), see below*

***Presentation Evaluation Criteria**		
Criteria and prompts	**(+,+/-,-)**	**Comments:**
Organization: - Presentation clearly structured and academic in nature - Points are clear and supported by explanations, statistics, examples - Ideas link together coherently - Points are balanced - Timing is accurate - Time management		
Delivery: - Voice: pace not too fast or too		

slow, clearly audible due to volume and enunciation - Body-language supports and does not distract from presentation - Structure and content delivered fluently; doesn't read from notes - Energy: varies tone, shows enthusiasm or interest in subject		
Visual Aids: - Supports and do not distract from the oral delivery - Easy to read/ understand - Effectively integrated into the presentation		
Audience: - Content is relevant and made interesting for audience - Engages audience: e.g., attention grabber, personal story, humor - Makes eye-contact - Raises thought provoking questions - Responds well to questions		