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ETHICS CASE
Fostering Student Engagement in Medical Humanities Courses
Commentary by Carolyn Gaebler and Lisa Soleymani Lehmann, MD, PhD, MSc

It's a Tuesday afternoon, and Daniel, a first-year medical student, sits down with his classmates in a sunlit conference room to discuss a documentary they have all just watched about the daily lives of wheelchair-bound patients and the challenges of the complex medical system those patients have to navigate. The course in which the documentary was shown is not graded because of the difficulties in assessing what a student learns from the study of the humanities in the medical context. As Daniel sees his classmates logging onto social networking sites on their laptops and only peripherally participating in the discussion, he wonders if the course should be graded, even though it differs from most medical school courses by trying to foster unquantifiable attitudes such as empathy, patience, and comfort with complexity. What is the best way to demonstrate to medical students that the administration believes that studying the humanities is important to the education of a physician?

Commentary
The situation Daniel describes is all too common. Medical students, basic science faculty, and medical school administrators often have a hard time appreciating the value of the humanities in medical education. Will engagement with the humanities affect students' board scores, their understanding of the mechanisms of disease, or their ability to diagnose a serious illness? The rewards of giving the film sustained attention might include a basic familiarity with the resources available for people in wheelchairs and, perhaps more importantly, the limits of those resources. But the film might also impart a sense of the logistical challenges of living with disability, the structures of marginalization in our society, the hostility or frank indifference of other human beings, the small victories, the idiosyncrasy of experience, the ache of an absent limb, or the tone and texture of other people's lives. What the film and the discussion are designed to elicit is curiosity and empathy.

Daniel's classmates are missing an opportunity to learn from and build upon each other's thinking about the film and to deepen their understanding of patients' experiences with disability that can form a foundation for connecting with those patients in meaningful and effective ways. They forgo absorbing themselves in and opening themselves up to understanding another person's experience.

Like Daniel, we worry about the seriousness with which medical students encounter the social sciences and humanities in our curriculum. To become healers, we must become technically proficient and master a large body of facts, but we also need to learn to interpret those facts within the broader context of social practice—the things

that bring people to medical care and the things that keep them away—and within the narrow but irreducibly complex context of individual lives.

Recognizing this need, an increasing number of medical schools have introduced coursework in the social sciences, ethics, arts, and narrative disciplines. We applaud the efforts of institutions to address this need for humanism in medical education and professional culture more broadly. But, like Daniel, we perceive ambivalence and hesitation around this feature of the curriculum. The hesitation arises not, we think, from a disregard for the goals of the medical humanities—goals like the fostering of empathy, critical thinking, and thoughtfulness, goals of manifest urgency—but from skepticism about the premise that qualities like empathy and thoughtfulness can be taught in the first place. There is little data to prove to medical school administrators or medical students that exposure to the humanities results in more humanistic physicians, greater professionalism, or better patient outcomes.

For students to take their nonscience classes—the format and content of which may seem to some of them foreign and lacking rigor—seriously, their institutions must take them seriously. Building buy-in for the medical humanities calls for both a normative analysis of the intrinsic and instrumental value of the humanities and quantitative and qualitative research to illuminate the role of the humanities in cultivating professionalism and improved patient outcomes. There is a need for more empirical research on the educational outcomes of humanities education in medicine. Does the study of the social sciences and history lead to greater self-awareness and humility? Does the study of ethics promote ethical behavior and comfort with uncertainty? Does a course in bioethics cultivate critical thinking skills and habits that can be transferred to other areas of medicine? Do stories teach empathy [1]? Do patients feel more comfortable with physicians who have wide-ranging intellectual interests and curiosities [2]? Preliminary research suggests that the answer to these questions is yes, but the empirical literature is sparse. There is an urgent need for greater funding to support this research.

There are cognitive as well as affective claims for including material from many disciplines in medical training. In broad strokes, the cognitive arguments use metaphors of stretching and translating: thinking critically in the realm of philosophy helps us think critically in the ICU. The affective arguments privilege wholeness, a profound understanding of the human condition, and professional identity: doctors who are interested in poetry are less likely to burn out and more likely to inspire trust [3]. There are, therefore, at least two different dimensions to the role of the humanities in medical education. Disciplines like ethics and art can develop cognitive capabilities; the social sciences, literature, poetry, film, and history can foster empathy and compassion [4]. The most important link between the cognitive and affective arguments is curiosity. Curiosity is linked intimately on the one hand with wonder, aesthetics, and discovery and, on the other hand, with empathy [5]. The more curious we are about other people's experiences, the better able we are to empathize, and the more we empathize, the more we want to learn how to help our patients achieve better health outcomes.

Once educators are committed to pursuing the humanities in teaching, how might they go about doing that? Making time for the humanities at all stages in medical school curricula is a critical first step. We need to go beyond the required ethics and professionalism courses to a more robust integration of the humanities into medical education. Medical schools could promote ongoing dialogue between students and faculty about the goals of education in the humanities. Faculty role models who are open to and supportive of diverse modes of inquiry can pass that seriousness and curiosity on to students. Similarly, students who are articulate and passionate about history, literature, bioethics, or the creative arts influence their medical school communities.

As Daniel's case illustrates, the culture in which an educational activity is embedded is critically important to that endeavor's success. He wonders if his classmates would be more likely to participate in the discussion if they received grades for this course like they do for their basic science courses. Daniel's conjecture indicts both the students, who have chosen not to give the exercise their full attention, and the institution, which, by intimating that nonscience courses are unimportant or less important than science courses has, in some sense, given them license to disengage.

But grading isn't necessarily the only way priorities are communicated. The preclinical work at many institutions is now pass-fail, yet students take their science classes seriously. Our experience has been that what students respond to, more than simply grades, is being challenged. To engage effectively in science classes, medical school requires a functional proficiency in math, and, in particular, statistics. Writing and reflection are the statistics of qualitative inquiry. We can nurture medical students' intellectual and personal growth by helping them develop their writing. Writing fosters development of the skills needed to deal with uncertainty, encourages us to step back and question our behaviors and attitudes, teaches us to frame problems before we try to solve them, and helps us understand the plurality of patients' experiences. Sharing written responses with other students generates a healthy accountability. Furthermore, reflective writing is an aspect of the humanities that trainees can continue throughout their careers [6]. Reflective writing exercises, rather than grades, are more likely to be an effective strategy to engage students in the humanities.

As physicians, we encounter individuals and communities in some of their most vulnerable moments. Our training for that work must include mastery of knowledge and technical competencies, but if we do not also help future doctors cultivate intellectual and emotional flexibility we do a disservice to the students whom they may someday teach and the patients for whom they will care.

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