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SHORT TAKES: INNOVATIONS IN HEALTH HUMANITIES

A New Construct in Undergraduate Medical Education Health Humanities Outcomes: Humanistic Practice

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Abstract

Proposed educational outcomes for the health humanities in medical education range from empathy to visual thinking skills to social accountability. This lack of widely agreed-upon high-level curricular goals limits humanities educators' ability to design purposeful curricula toward clear, common ends and threatens justifications for scarce curricular time. We propose a novel approach to the hoped-for outcomes of health humanities training in medical schools, which has the potential to encompass traditional health humanities knowledge, skills, and behaviors while also being concrete and measurable: humanistic practice. Humanistic practice, adapted from the concept of ethical sensitivity, is an intentional process of applying humanities knowledge and skills to a clinical scenario by 1) noticing that the scenario requires humanities knowledge or skills, 2) informing one's clinical and interpersonal strategy and behavior with humanities knowledge or skills, 3) reflecting on the effectiveness of the strategy and behavior, and 4) reorienting to develop new approaches for future practice. The construct of humanistic practice may help address some of the foundational problems in health humanities outcomes research since it transcends the traditional diverse content domains in the health humanities, can link patient and provider experiences, and may bridge the divide among the additive, curative, and intrinsic epistemic positions of humanities to medical education.

Keywords Undergraduate medical education · Health humanities · Programmatic outcomes · Assessment

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Disagreement About Hoped-For Outcomes of Health Humanities in Medical Education

Despite the inclusion of arts and humanities curricula in many schools of medicine, there is no clear consensus about the nature or purpose of health humanities teaching in those contexts. Indeed, a 2016 literature review identified three ways in which the humanities might relate to the goals of medical education: intrinsic (i.e., a natural, essential part of medicine), additive (i.e., a complement to medicine), or curative (i.e., a remedy that can address shortcomings of medicine and medical education) (Dennhardt et al. 2016). These three epistemic positions are wholly distinct ways of understanding the nature, purpose, and outcomes of arts and humanities curricula for medical students. A recent scoping review of arts and humanities literature found heterogeneity in the application of these approaches: nearly two-thirds of studies positioned the arts and humanities as "additive" to medicine, with the use of a curative (17%) or intrinsic (5%) positionality less common (Moniz et al. 2021).

The lack of agreement in the purpose, nature, scope, and epistemic function of the humanities in undergraduate medical education (UME) offers one explanation for the inconsistencies in the empirical study of humanities outcomes. A methodological review of the assessment of humanism in medical students found nine different outcomes in quantitative studies: empathy, respect, compassion, humanism, altruism, identity, excellence, integrity, and service (Buck, Holden, and Szauter 2015). A subsequent scoping review of qualitative and mixed-methods studies about health humanities curriculum and evaluation found six focus areas for humanities teaching and learning: knowledge acquisition; mastering skills (e.g., observation, reflection); relational aims including perspective taking; personal growth and activism; wellness and self-care; and critical evaluation (Carr et al. 2021). Educational scholars have further explored other relevant outcomes, including visual-thinking skills (Agarwal et al. 2020; Keogh, Lee, and Gibbon 2020; Klugman, Peel, and Beckmann-Mendez 2011), professional identity formation (Green 2015; Joseph et al. 2017; Kenny, Finneran, and Mitchell 2015; Shapiro et al. 2021; Volpe et al. 2019), and more recently, social accountability (Balhara, Ehmann, and Irvin 2022). These numerous and varied outcomes, which span the epistemic domains above and include both behavioral and intellectual goals, are unique and valuable contributions to the training of physicians. However, the state of the literature makes it difficult to infer how each outcome might relate, if at all, to the others or which should be the focus. Indeed, Carr and colleagues' scoping review concluded that there is an absence of a "consistent framework for health humanities learning, teaching and assessment, and hence, little capacity for systematic evaluation within or across curricula" (Carr et al. 2021, 574). In concert with the practical time and space limitations of any given curriculum, educators and programs have tended to prioritize a few idiosyncratically chosen outcomes for emphasis, such as empathy or visual thinking skills.

The lack of widely agreed-upon high-level curricular goals limits humanities educators' ability to design purposeful curricula toward clear, common ends. In our experience, ambiguity about intended outcomes also limits the ability to measure curricular success within UME programs, which is necessary for several reasons: to justify curricular inclusion, to validate curricular resources, and to demonstrate student learning in relation to national standards or expectations. In the absence of standardized goals and measures, educators and program administrators are left only with local and often individualistic perceptions to calibrate curriculum development. Broad agreement and standardization about UME goals

could provide more holistic and specific guidance for curricular development and assessment of learning outcomes.

There are numerous ways in which other elements of medical education in the United States and Canada are measured—the LCME graduation questionnaire and student scores on USMLE Step 1, for example—which provide a mechanism to measure student learning in basic biomedical, public health, and health systems sciences. The *Diversity, Equity, and Inclusion Competencies Across the Learning Curriculum* (AAMC 2022) is a case in point. These new competencies set a welcome standard for all medical schools and residency training programs in this domain, helping individual schools target areas for improvement and identify elements that are already part of the curriculum. There are no such standards for UME health humanities. The AAMC's *Foundational Role of Arts and Humanities in Medical Education* (FRAHME) report (Howley, Gaufberg, and King 2020), which is intended to provide medical educators with resources to develop and/or improve the use of arts and humanities in their teaching, does not provide competencies. Instead, the report offers guidance on strategies for integrating the arts and humanities in medical education and identifies areas of needed research. While the FRAHME report reinforces the importance of UME health humanities and illustrates a range of curricular interventions, it does not recommend (or even suggest) health humanities goals or assessment strategies. The health humanities, thus, fall short when compared to other domains in medical education in terms of shared and assessed outcomes. Our current best practice framework in the field (FRAHME) replicates the existing problem by offering a smorgasbord of options to deliver arts and humanities content.

The need for and stakes of effective, outcomes-oriented humanities education have never been higher. Medicine is confronting humanistic crises—from the epidemic of provider burnout to the impacts of systemic racism in healthcare—that the humanities are uniquely well-situated to address (Kumagai and Naidu 2019; Magaña, Lux, and López-Calvo 2023). Additionally, as medical education has shifted to competency-based assessments, humanities' continuing focus on assessing knowledge attainment is increasingly out of step with medical educators' emphasis on observable and measurable skills. Our own anecdotal experience teaching UME health humanities supports the urgent need for a consistent framework that can be shared, measured, and elaborated as standard learning goals across curricula.

Proposed New Construct: Humanistic Practice

To meet this need, we have created a construct that defines and strengthens the relationship between education in the humanities and future medical practice: humanistic practice (HP). This novel approach has the potential to encompass the myriad health humanities learning goals while also being concrete and measurable. HP is an intentional process of applying humanities knowledge and skills to a clinical scenario by 1) noticing that the scenario requires humanities knowledge or skills, 2) informing one's clinical and interpersonal strategy and behavior with humanities knowledge and skills, 3) reflecting on the effectiveness of the strategy and behavior, and 4) reorienting and reflecting to develop new approaches for future practice. We have piloted this concept in a semester-long course for first-year medical students.

We adapted the concept of humanistic practice from the established concept of ethical sensitivity (Muramatsu et al. 2019; Rest 1979; Weaver and Morse 2006). Ethical

sensitivity is a person's ability to notice ethical dilemmas when encountered. The probability of an ethically appropriate reaction to an ethical dilemma increases dramatically when the actor is aware that they are enmeshed within an ethical dilemma. For example, a student who has learned about the purpose and elements of informed consent may be more able to recognize when a particular patient is not giving complete and authentic informed consent. A student who has not learned about informed consent, on the other hand, may be less likely to notice that anything unusual or sub-optimal has occurred.

Ethical sensitivity thus offers a model for considering how health humanities education changes medical students' approaches to common clinical challenges. Consider the following scenario, which describes ineffective and inappropriate clinical behavior:

> Dr. S is treating Ms. Q for chronic knee pain. While describing the pain, Dr. S interrupts and suggests that Ms. Q's weight and physical inactivity are making the pain worse. Ms. Q, who hasn't gotten to tell Dr. S that this is a longstanding injury from her Division I basketball career, feels dismissed and frustrated, and quips that she would exercise more if she didn't have so much pain.

The HP model suggests that students working with this vignette could be prompted to use humanities concepts or frameworks to identify multiple problems in the encounter. One synthesis might be that Dr. S failed to get a whole story, perhaps because of implicit weight or substance abuse bias. Learners are then asked to marshal what they know about implicit bias and/or narrative medicine to formulate a targeted plan—here, for example, to take Ms. Q's frustration as an opportunity to elicit her story of pain. Through case discussion, simulation, or clinical practice, students can then test and evaluate that intervention. Finally, students take a "step back" to determine not just how their plan worked in that context but also how they might want to adjust their future practice based on the present experience.

HP is intentionally designed to be both outward- and inward-facing. The process of HP prompts students to synthesize the multi-level and dynamic relationships between themselves, their patients, and the social context of medicine. For example, in the case above, HP helps students to identify Dr. S's individual implicit biases about weight and substance abuse. It also helps them link this attitude with Ms. Q's perception of his behavior, which occurs in a societal and medical context in which obesity and "med-seeking behaviors" are heavily stigmatized and pathologized, often through gender and racialization. In another example, HP could be applied to help students recognize signs of burnout in themselves as well as individual and systemic contributors to and interventions for burnout. It is thus possible that HP as a framework may support medical student well-being and agency, potentially combatting some of the dehumanization of medical training.

HP creates an opportunity to move beyond the "cultivating empathy" framework for health humanities education, which is limited with respect to the breadth and content of health humanities learning and focused largely on feeling rather than action. Instead, HP allows us to move toward a framework in which a capacity for empathy is assumed but the practical application of it is not self-evident. The frame of HP can prompt students to identify when an expression of empathy towards a patient is called for *and* how to enact it in the clinical encounter or treatment plan. Take, for example, a student interacting with a patient who is "nonadherent" with a recommended specialist referral. When the patient discloses that this is related to having experienced racism from doctors at that clinic, empathy as a disposition may primarily prompt the student to listen compassionately and suspend judgment. HP, on the other hand, could guide the student to synthesize empathy with their knowledge of medical racism to validate the patient's concerns and join the patient in

Table 1 Humanistic Practice Rubric

HP Element	Beginning	Early	Progressing	Advanced	Aspirational
Notice when a situation requiring a humanities response is indicated and describe the core humanities issue.	The student does not notice that a situation calls for a humanities response.	The student notices that there's a situation that requires a humanities response.	The student accurately describes the situation within broad or general categories of humanities.	The student pulls from humanities knowledge to describe a specific humanities situation in a clinical context.	The student pulls from humanities knowledge to describe multiple interrelated humanities topics in a specific clinical context.
Create and implement (if possible) an action or care plan for responding to the humanities issue.	The student is unable to create a practical and concrete plan for how to *use* the humanities knowledge.	The student generates a superficial plan that is not explicitly informed by humanities tools.	The student draws from their broad humanities knowledge to formulate a general or preliminary plan.	The student applies specific humanities knowledge and contextual factors to formulate a targeted solution to the clinical problem.	The student applies specific humanities knowledge and context to formulate multiple targeted solutions to the clinical problem and identifies the solution that is optimal for that specific scenario.
Evaluate the plan. NOTE: this criterion is essential in real life clinical activities, but not realistic for paper cases. We keep it the rubric to help us remember that *action is vital to humanistic practice!*	The student superficially describes the outcome of the (intended or carried out) plan without linking it to humanities concepts.	The student engages in deliberate assessment about whether the humanities plan helped solve the problem.	The student engages in deliberate assessment about whether and how the humanities plan helped solve the problem.	The student engages in deliberate and iterative assessment about whether and how well the humanities plan helped solve the problem.	The student draws from their deliberate and iterative assessment of the outcome from the humanities plan to explore broad themes in humanistic medicine.
Identify One Big Thing (OBT) that you will take away from this encounter and consider how the OBT will inform your developing professional identity.	The student identifies OBT that has no connection to the humanistic elements of the case.	The student identifies OBT that is grounded in the humanistic elements of the case, but not in self-reflection on professional identity.	The student describes how their OBT reflects who they are, and what kind of clinician they want to be.	In addition to Progressing level, the student identifies one way in which the culture/practice of medicine may interfere with their OBT.	In addition to Progressing and Advanced levels, the student identifies one way in which being a human may interfere with the OBT.

concrete problem-solving. In shifting the emphasis to action, HP becomes knowledge for practice.

Additionally, HP transcends and synthesizes the traditional content domains of health humanities education. When confronted with an end-of-life dilemma, for example, the process of HP would invite students to enrich their compassion and empathy for the parties involved with a deliberate and intentional application of knowledge about surrogate decision-making, grief and loss, and medical trust and mistrust among marginalized communities. After a simulated or real encounter to apply their humanities training, students consider the encounter, weighing which components they would like to integrate (or not) into their future professional identity.

Due to its multi-level focus, HP aligns with models of professional identity development that describe how a person's developing professional identities intersect with and are shaped by the culture of medicine (R. Cruess et al. 2015; R. Cruess, S. Cruess, and Steinert 2018; R. Weaver et al. 2011). In other words, HP asks students to make overt a process of professional development that is often covert. In this way, HP, like professional identity formation, can be thought of as a career-long process.

Additionally, HP has the potential to generate novel strategies for assessing the outcomes of UME health humanities curricula. In our experience incorporating this construct into a 22-week course for first-year medical students, which included content on ethics, narrative medicine, critical consciousness, and the patient as person, we found that the model of HP helped students appreciate the clinical relevance of their humanities learning and generated a template by which educators and students could assess students' approach to clinical vignettes over time. In addition, preliminary data suggest that the assessment of HP can be accomplished, at least in part, with a well-accepted qualitative humanities method—the reflective essay. Calibrated to self-assessment of where learners fall on an HP developmental rubric, the reflective essay allows learners to evaluate their own progress over time as well as to provide a context for external perspectives through mentored conversations. Table 1 represents our initial conceptualization of a rubric for learner self-assessment of HP. We are currently in the process of evaluating, refining, and validating this rubric through qualitative research.

Thus, HP holds promise as a measurable outcome that can focus humanities curricula in UME and perhaps medical training more broadly, utilizing traditional foci like empathy and resilience but also assessing sensitivity to humanities-oriented problems, an action orientation that calls on humanities knowledge and reflective practice.

There is obviously much that remains to be explored regarding the new concept of humanistic practice. What are the stages of HP development? How can medical educators cultivate HP in their learners? What is the most effective way to evaluate the outcome of HP? Could the framework of HP productively translate to graduate medical education settings or perhaps even baccalaureate settings? Our early experience suggests that it is possible to cultivate HP in the UME classroom and that evaluation using a developmental rubric such as the one provided in Table 1 is effective; however, empirically studying these questions—and many others—is needed.

What we find so enticing about HP is that the construct may help to address some of the foundational problems in health humanities outcomes research. HP transcends the traditional diverse content domains in the health humanities, can link patient and provider experiences, and may bridge the divide between the additive, curative, and intrinsic epistemic positions of humanities to medical education (Dennhardt et al. 2016). Above all, HP is a behavioral competency—and, as such, it matches the medical education goal to align behaviorally defined learning objectives with measurable assessments. In a sense, the

construct of HP suggests that students can be taught to navigate clinical scenarios by generating a humanities "differential diagnosis" and treatment plan, leveraging the humanities knowledge and skills they've acquired. HP therefore aligns with the cognitive process students are taught for clinical decision-making and emphasizes the ultimate endpoint of any medical education intervention: improvements in clinical practice. Perhaps most importantly, HP encompasses the myriad educational outcomes in the humanities that have been proposed in the literature to date and thus promotes standardization of curricular outcomes.

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