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Compassionate Practice: A Review and Framework for Integrating Medical Humanities into Pre-Medical and Medical Curricula

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Compassionate Practice: A Review and Framework for Integrating Medical Humanities into Pre-Medical and Medical Curricula

by

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Abstract

The article presents the findings of a comprehensive narrative literature review aimed at addressing the question: What are the current frameworks of the medical humanities discipline in terms of purpose, methodology, curriculum, and student learning outcomes? Thematic analysis and qualitative coding highlighted key themes and areas of concern, including the purpose of medical humanities, methodology, current curriculum, and student outcomes. Recommendations are provided to address disagreements within the discipline, proposing a conceptual framework and definition for medical humanities, alongside advocating for a mixed-method approach as the primary methodology. Curriculum guidelines emphasize the importance of a quality integrated curriculum focusing on narrative medicine, case-based learning, and reflective work to enhance student engagement. The review identifies primary student learning outcomes, such as enhanced professionalism and holistic care, increased empathy, self-awareness, compassion, reduced burnout risk, and improved performance. Further research is needed to establish a consistent conceptual framework, addressing the varied language usage within the field. Additionally, the review underscores the importance of curriculum quality, advocating for research to define it and promoting techniques like narrative medicine and case-based learning in integrated programs. Further, publishing program details would facilitate comparison and inspire similar initiatives across institutions.

Keywords: Medical Humanities, Pre-Medical, Medical Education, Compassion, Professionalism, Holistic Care

Introduction

Medical education is a constantly evolving field. As new research and needs arise, the type of care that providers are expected to deliver also changes. Presently, individuals are impacted by much more than illness alone, with many factors coming into play, such as human connection and cultural values or impacts. Overall, providers need to be more adept at caring for the individual as a whole. The field of medical humanities seeks to address this.

Medical humanities have been defined in a multitude of ways. In summary, these viewpoints offer an interdisciplinary approach to patient care and a deeper understanding of the meaning of health, illness, disease, and their social, psychological, and cultural impacts (General Medical Council, 2013). Medical humanities are rooted in the combined study of arts and humanities as a way to generate meaningful interactions with others and to value the human condition. Notably described by Shapiro et al.:

> “Essentially, the humanities focus on the study of those subjects that lead to a better understanding of the human condition. Medicine necessarily engages with almost every aspect of the human condition. In this respect, the humanities are not additive to medicine, which implies that medicine has somehow become deficient.” (Shapiro et al., 2009, p. 194)

Other terms are sometimes used interchangeably with medical humanities, such as "health humanities." However, "health humanities" applies to the broad field of health and social care professionals, whereas medical humanities refers more specifically to medical practitioners (Crawford et al., 2015; Macnaughton, 2023). Medical humanities first became a distinct field of study in the U.S., where the term originated in 1948 (Sarton & Siegel, 1948). At this time, the prominent thinking was still that something could not be both medical and humanities focused (Fixter, 2022). Now, although it is more broadly expected, there is still a struggle to integrate the two fields. For the sake of clarity, this article refers to the field using the term "medical humanities," as the focus of the study is on pre-medical and medical education programs.

The field of medical humanities is described as crucial to developing the skills necessary for medical professionals to become "clinically excellent, creative, and critically reflexive practitioners" (Carr et al., 2021). It seeks to develop a set of qualities and behaviors in practitioners that foster a sense of

professionalism and person-centered care. These qualities include "tolerance of ambiguity and anxiety, observation of one's own thinking, emotions, and techniques, recognition of and response to cognitive and emotional biases, and integrating judgment from multiple sources, including the scientific, the clinical, and the humanistic" (Shapiro et al., 2009, p. 195). In other words, it has the general aim of creating compassionate, thoughtful practioners that can analyze and account for all aspects of wellness.

Presently, many more factors impact an individual's overall wellness beyond physical ailments alone. This concept is often described as the social determinants of health. These are nonmedical factors related to an individual's living environment that may also impact their health. They often fall into five domains: economic stability, education access, healthcare access, neighborhood and built environment, and social and community contexts (U.S. Department of Health and Human Services, 2023). The arts and humanities have often been utilized to understand and interpret the human experience at various points in time. From this, they have the power to help navigate the cultural entanglements that impact overall wellness. Medical humanities most directly addresses the social and community contexts wellness, by creating a meaningful and supportive interaction in the patient-provider relationship. But it can also aid in looking at the root cause of illness and entagling the affects of the other categories. Further, it can provide a lot of the critical analysis skills that are necessary in understanding the affects of various social determinants of health.

The field of medical humanities has recently come to the forefront of medical education, as many have declared the medical field to be in a state of "compassion crisis" (Brownlie, 2023; Ong, 2021). In other words, medical providers today, despite being well-educated and focused on evidence-based practice, lack the level of compassion on which the medical field was founded (Kidd & Connor, 2008; Ong, 2021). In recent years, there has been a much larger presence of study in the field of medical humanities. While the curriculum has been integrated into medical programs for some time, there is little guidance on how it is best taught due to the field's relatively recent development. Hence, the "compassion crisis" has highlighted the need for a consensus on effective teaching methods.

The lack of consensus in the field regarding purpose, research methodology, curriculum, and student learning goals is one of its most prominent critiques. Furthermore, the lack of a conceptual framework gives the impression that the field does not fully understand itself (Carr et al., 2021). It is currently theorized that there is an "overarching theory of practice," though it is established through brief stints of research (Moniz et al., 2021). Therefore, guidelines must be established to align the educational experience of medical humanities. Guidelines allow for comparability between programs and to better assess the application of the field. Further, it is a way to ensure that all students are receiving the same adequate training in the area, so that patients are more likely to recieve the same standard of care no matter where it is accessed.

In response, the following article conducts a narrative literature review, summarizing discussions in the sectors of Medical Humanities Purpose as a Field, Methodology of the field, current curriculum and techniques, and student learning outcomes. Following thematic analysis in these areas, a conceptual framework and curriculum guidelines will be proposed to address the highlighted concerns. Thus, the following review seeks to answer the question: What are the current frameworks of the medical humanities discipline in terms of purpose, methodology, curriculum, and student learning outcomes? Through this exploration, a concentrated effort will be made to establish consensus within the discipline and propose a conceptual framework alongside guidelines for an integrated medical humanities curriculum.

Methods

A narrative review was conducted to analyze and summarize the current discussion around the discipline of medical humanities. Unlike other review types, such as scoping or systematic reviews, a narrative review does not strictly adhere to methodological review criteria and the analysis of the ‘quality’ of articles (Green et al., 2006). This approach allowed for a broader scan of the literature and a more comprehensive summary of the conversation at hand. The narrative approach facilitated careful reflection during the data extraction process, enabling the refinement of guiding questions and methods as a stronger understanding of the literature was gained.

For the literature search, the Web of Science Database was utilized, and articles were accessed through the Portland State University Database as well as publicly available titles. The Web of Science Database provides one of the most accessible services where publications can be searched using key terms. Search terms including “Humanities,” “Medical Humanities,” “Education,” and “Health Humanities” were used. The resulting articles were then manually scanned for relevance to the study based on the publication title. If deemed that the article may present relevant information to the study, article abstracts were scanned following this initial screening. From this process, fifteen articles were selected for in-depth thematic analysis.

The articles included within the study varied in format from literature reviews to qualitative or quantitative studies, to mixed methods studies, and editorial-based essays. The inclusion of various article forms is useful in reflecting the scope of discussion and research in the field of medical humanities. The study also chose to include articles that refer to the medical humanities with synonyms such as ‘health humanities’ or described the integration of arts and humanities curriculum with medical education. Articles were also included based on their focus on the population of medical and pre-medical students and curriculum. Articles applying to the broader field of health and social care professionals were excluded. Some other sources were used as supplementary material to provide definitions and context but were not included or analyzed as part of the narrative review article set.

A thematic analysis was performed on the fifteen articles using an inductive coding process. This involves a ground-up approach where topics emerge from the dataset and are grouped into larger themes. The guidelines of themes and categories are provided by Rossman and Rallis: “Think of a category as a word or phrase describing some segment of your data that is explicit, whereas a theme is a phrase or sentence describing some subtle and tacit processes” (Rossman & Rallis, 2016). It is also interesting to note that this was done manually. During which, each article was printed and manually highlighted and sticky noted for themes using a scanning and analysis method of humanities origin. This method is known as ‘scasi’ which stands for ‘setting, character, action, style, ideas.’ This is a method I learning very early on in english courses that is useful for interpreting and analyzing various text types to help with

understanding. Thus, the study acts as a real life example of the application and utility of humanities. Using this method, four primary themes were identified. The themes identified are as follow: Medical humanities purpose as a field; methodology of medical humanities; current curriculum and techniques; and student learning outcomes.

Thematic Analysis

Medical Humanities Purpose as a Field

As described previously, a major critique of the field is its lack of a conceptual framework. Medical humanities have generally been described as an interdisciplinary field with the intent of providing a more complete understanding of health, illness, and disease within social contexts (Carr et al., 2021; General Medical Council, 2013). It is a field that incorporates the teachings of the arts, such as visual arts, performing arts, and music, and the humanities, such as history, literature, narrative, ethics, and philosophy, to better instill levels of compassion and empathy in care providers (Carr et al., 2021).

While there is some consensus on what medical humanities is, its application can almost be described as 'anarchic.' This observation was made by Kidd and Connor (2008) in their article “Striving to do Good Things: Teaching Humanities in Canadian Medical Schools,” where they surveyed medical educators at Canadian medical schools about their medical humanities programs. The study found that most of these programs were developed based on the individual interests, experiences, and passions of the educators. However, the study still aligns with the purposes outlined in other articles, such as providing a humanistic foundation to the field of medicine through the teaching of humanities.

Another article, “Exploration and Practice of Humanistic Education for Medical Students Based on Volunteerism” by Chen et al. (2023), equates the purpose of medical humanities with humanistic education. Through this approach, it is intended that students will better understand their own morals and value systems, as well as those of other cultures, acting with reverence toward all living things (Chen et al., 2023). Overall, medical humanities currently lacks a single conceptual framework due to the breadth of the field. However, one can be developed that encompasses various purposes such as promoting humane care, increasing provider self-awareness, and fostering compassion and cultural competence.

The work of Jill Gordon (2005) in the article “Medical Humanities: To Cure Sometimes, to Relieve Often, to Comfort Always” is frequently referenced throughout the literature. Gordon was one of the first to articulate the value of medical humanities, describing it as explicitly intending to “promote a humane approach to patient care” (Gordon, 2005, p. 6). Rather than allowing physicians to fall into an overly technical or dogmatic approach, medical humanities prompts self-reflection for both practitioners and the health system itself (Gordon, 2005).

Another article that clearly iterates the intention of the field is Shapiro et al.'s (2009) “Medical Humanities and Their Discontents: Definitions, Critiques, and Implications.” Shapiro et al. (2009) offer a review of the primary critiques of the medical humanities curriculum, made by students and instructors, which fall under the categories of content, teachers and methods, and placement. They describe that medical humanities serve a significant moral function by following two conditions. The first condition is its interdisciplinary methods, concepts, and content to “investigate illness, pain, disability, suffering, healing, and other aspects of medicine and health care practice” (Shapiro et al., 2009, p. 192). The second is the employment of this curriculum in teaching health profession students critical reflection, with the intent to become self-aware, humane providers (Shapiro et al., 2009). Through these goals, medical humanities aim to produce providers who grasp the complexities of illness, personhood, and related areas and apply their understanding in refined responses in clinical settings. In this sense, they serve a purpose as applied academia compared to a traditional theoretical basis.

The purpose of medical humanities as an applied field is significantly supported throughout the discourse. Kirsty Brownlie (2023) discusses her personal experience with the discipline in “A Penny for Your Thoughts: Promoting Compassionate Medical Practice Through Reflection,” a reflective piece on her teaching experience with medical humanities. The article details various instances in Brownlie’s life, as well as in the lives of her students, where medical humanities have provided them with the tools to be stronger providers. The most impactful experience for Brownlie occurred when a patient directly called her out for not addressing her as an individual but only as a condition. The patient, Latika, noted, “How can you say you understand how I feel? You didn’t even bother to remember my name” (Brownlie, 2023,

p. 390). This provoked reflection and shame in Brownlie's practice, as she realized that "in doing so, [she] wasn't treating her as a person, but as a thing to be fixed" (Brownlie, 2023, p. 390). Brownlie (2023) describes how reflective practice has fostered more person-centered, compassionate care (Brownlie, 2023), highlighting the applied utility of the field.

The article "Forming Physicians: Evaluating the Opportunities and Benefits of Structured Integration of Humanities and Ethics into Medical Education" by Eno et al. (2023) discusses additional skills that can be acquired through medical humanities education. Eno et al. (2023) argue that although the current medical education system is comprehensive in biomedical knowledge, it does not prepare students to care for suffering beyond the biological body (Eno et al., 2023). Thus, not integrating medical humanities into traditional medical curricula comes at the expense of valuable skills, including compassion, empathy, and interpersonal skills.

Similar to the argument articulated by Eno et al. (2023), Zhao et al. (2023) focus on the purpose of medical humanities within medical education in their article "Role of Narrative Medicine-Based Education in Cultivating Empathy in Residents." The article describes the function of medical humanities as making the curriculum complete. A curriculum that focuses solely on medical technology and clinical practices does not teach the medical profession as a whole, as it ignores the care for the patient as a complete social person (Zhao et al., 2023). The social aspect of care is equally important as the physical, and medical humanities have shown great potential in integrating this social dimension. In other words, since the field of medicine is person-centered, it makes sense to teach person-centered care.

Lastly, an article by Jane Macnaughton (2023) offers intriguing insights into the potential capabilities of medical humanities. In the article "Does Medical Humanities Matter? The Challenge of COVID-19," medical humanities is described as having the power to translate culture, specifically 'COVID-19 culture,' in understanding the human experience and cultural interactions during the pandemic. Macnaughton (2023) proposes that culture is constantly being produced and reproduced, and medical humanities have the potential to make sense of these cultural entanglements. She theorizes a

further subdivision of medical humanities, termed critical medical humanities, which responds directly to calls for more direct engagement with current health research.

Methodology of Medical Humanities

Regarding the methodology of medical humanities, research styles vary widely. This is a main critique of the field, as offered by Carr et al. (2021). Their scoping review found a variety of methods in this area, ranging from mixed methods to purely qualitative approaches (Carr et al., 2021). A similar finding emerged in this literature review as well. When discussing the conceptual framework and purpose of medical humanities, scoping reviews, literature reviews, and personal essays are the most common forms. Articles by Carr et al. (2021), Chen et al. (2023), Jill Gordon (2005), Jane Macnaughton (2023), and Shapiro et al. (2009) all contribute to the conversation through the articulation of theories and the proposal of guidelines or further methodologies. Essays by Kirsty Brownlie (2023) and Barend Florijn (2020) offer personal experiences and reflections on the field. For researching the outcomes of medical humanities programs, methods vary. Quantitative studies generally aim to measure student improvements resulting from the implementation of the medical humanities curriculum, while qualitative studies typically aim to articulate the types of improvements that can occur through such programs.

A study by Huang et al. (2023), "The Quantified Analysis of the Correlation Between Medical Humanities Curriculums and Medical Students' Performance," conducted a cohort study to assess the correlation between the quality and quantity of medical humanities courses. Using quantitative data such as clinical curriculum scores, clerkship performance, and weighted average marks, the study found a positive association with the number of medical humanities courses taken (Huang et al., 2023). However, more significant to the learning outcomes was the quality of the medical humanities courses. The study also found that "students who [took] more than five medical humanities courses performed worse than those who [took] fewer" (Huang et al., 2023). Thus, it concluded that the quality and quantity of courses must both be appropriate to the curriculum (Huang et al., 2023). This study demonstrates the type of knowledge that quantitative research aims to achieve in the field of medical humanities.

Similarly, some have quantitatively measured empathy using the Jefferson Scale of Empathy (JSPE) (Thomas Jefferson University). In the study "Role of narrative medicine-based education in cultivating empathy in residents," Zhao et al. (2023) implemented narrative medicine-based education with 230 neurology residents. The residents were randomly assigned to study and control groups, and pre and post-empathy scores were compared. An increase in empathy scores was observed in the study group, along with a rise in professional neurological knowledge, although not statistically significant (Zhao et al., 2023). Another study conducted by Eng Koon Ong (2021) utilized quantitative data to assess the feasibility and acceptability of a medical humanities program. This study also evaluated empathy using the Jefferson Scale of Empathy (JSPE) and the modified-CARE (Consultation and Relational Empathy) measure. Ong's (2021) article, "A Pilot Program Using Humanities to Teach Junior Doctors Empathy in a Palliative Medicine Posting," determined the program's acceptability and feasibility through a Likert-scale questionnaire and a completion rate of at least 80%. An increase in empathy was also noted, indicating the program's effectiveness (Ong, 2021). Both studies by Zhao et al. (2023) and Ong (2021) exemplify the kind of contribution quantitative data aims to provide regarding program outcomes.

Qualitative data aims to elucidate the various types of student outcomes attainable through medical humanities programs. In the study "Forming Physicians: Evaluating the Opportunities and Benefits of Structured Integration of Humanities and Ethics into Medical Education," conducted by Eno et al. (2023), qualitative data is employed to comprehend the student perspective and experience of medical students at Creighton School of Medicine. Student essays, end-of-year surveys, and semi-structured interviews illustrated student engagement with the curriculum, as well as the attainment of learning objectives. These objectives were assessed by the incorporation of the learning outcomes in student essays (Eno et al., 2023). Moreover, relevant humanities topics were chosen, and the discussion and identification of these topics within student essays indicated the achievement of the learning outcomes. Overall, Eno et al. (2023) found that students perceive engagement with medical humanities as an opportunity to reflect and connect with classmates. Additionally, the data revealed an expansion in students' perspectives regarding medicine and the role of a physician, suggesting personal growth (Eno et

al., 2023). The study itself acknowledges that "it highlights the value of robust qualitative data collection and analysis in describing the outcomes of the humanities and ethics curriculum" (Eno et al., 2023).

Another study, "Striving to do Good Things: Teaching Humanities in Canadian Medical Schools," by Kidd and Connor (2008), utilized qualitative data to comprehend the types of curriculum in place and the perspectives of educators. The study conducted telephone interviews with fourteen Canadian medical schools regarding their medical humanities curriculum. The primary focus was on "instructors' stated goals, approach, and vision, rather than on teaching outcomes" (Kidd & Connor, 2008). Kidd and Connor (2008) discovered that programs are primarily shaped around instructors' interests and that the boundaries of the discipline vary widely among individuals and are dependent on personal “interests, experience, and passions.” Here, the value of qualitative data in understanding the development of various aspects of medical humanities and its curriculum is demonstrated.

Lastly, these methods can be very effective in conjunction, as demonstrated in the article "The Role of Humanities in the Medical Curriculum: Medical Students’ Perspectives," by Petrou et al. (2021). The study administered a mixed methods survey to medical students concerning their perspectives on assessment, engagement, delivery, and purpose. From the collected data, students strongly expressed that humanities subjects should not be assessed but are necessary for engagement, and the majority felt they should be more incorporated into the first three years of the program (Petrou et al., 2021). No consensus was found on whether medical humanities courses should be delivered as electives (Petrou et al., 2021). Mixed methods provide the benefit of both quantitative and qualitative data, offering substantial numerical data while still articulating student outcomes and types of medical humanities curricula.

As demonstrated, there is little consistency in the methodology used to research medical humanities and its curricula. However, literature review, quantitative, qualitative, and mixed methods each have their value in the field. The purposes of implementing medical humanities education are diverse, and the methodologies of the field are equally varied. Rather than limiting the field, this diversity uniquely positions medical humanities to both measure and investigate the social aspects of health and apply these insights to practice.

Overview of Curriculum and Techniques

Current Limitations of the Curriculum

Another conversation heavily present throughout the literature pertains to the type and delivery of the medical humanities curriculum. Again, this is a large area of critique due to the high level of variation in this sector. Shapiro et al. (2009) cover this most explicitly in the review article "Medical Humanities and Their Discontents: definitions, critiques, and implications." Here, the most prominent questions raised about the medical humanities curriculum are whether the content being taught is relevant or consistent; who should be instructing or facilitating medical humanities coursework; and where it is appropriate to offer it within the course of a medical program.

The first critique toward the relevance and consistency of the curriculum arises from the broad range of arts and humanities content that medical humanities span. Furthermore, nearly every institution has a different definition of what constitutes the medical humanities. The next critique, regarding who should be teaching medical humanities, stems from a similar area, as many medical humanities courses are taught by clinical faculty or science instructors with a ‘side’ interest. In other words, content is often chosen and taught by instructors with personal interests in the subject matter as another field of study or hobby of theirs. As much as students trust these instructors since they have an understanding of clinical realities, it brings up the question of whether or not they are qualified to teach in the humanities subject area (Shapiro et al., 2009).

In the current medical education system, there is a level of distrust toward non-physicians, with details indicating that "there is a widespread perception that non-physicians do not comprehend clinical realities. [Hence,] students object that humanities instructors lack professional training or experience in medicine" (Shapiro et al., 2009, p. 193). So although they are trained to teach in the discipline of humanities, students tend to feel that "medical humanities teachers seem to talk the talk without walking the walk" (Shapiro et al., 2009, p. 193).

Lastly, disagreement occurs on where the medical humanities curriculum is best implemented into the existing medical school curriculum, as the workload is already intense. Furthermore, it seems there is

no right workload for medical humanities content itself. If it's too much, it overwhelms students, and if it's too little, it's criticized as not adding value to the curriculum (Shapiro et al., 2009).

These questions are often raised by students and perpetuated by the current state of the curriculum as an unpredictable ad-hoc (Shapiro et al., 2009). Medical humanities programs are highly variable across many colleges, as they aim to follow the minimal guidelines offered by the American Association of Medical Colleges (1998) and the General Medical Council (2013). The American Association of Medical Colleges provided four main objectives in that physicians should be "altruistic, knowledgeable, skillful, and dutiful. In order to achieve these objectives… medical schools [should] initiate curriculum reform in order to train students to "be compassionate and empathetic in caring for patients… [to] understand the history of medicine [and] the meaning of patients' stories" (Kidd & Connor, 2008, p. 46). The General Medical Council describes that doctors must be able to "adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social, and cultural factors), their views, and values" (General Medical Council, 2013). Thus, both organizations, overseeing the United States and Canada, and the United Kingdom respectively, provide minimal but critical guidelines that necessitate the teaching of medical humanities.

Jill Gordon (2005) describes in her review, "Medical Humanities: To Cure Sometimes, To Relieve Often, To Comfort Always," that many programs are offered as electives and are frequently optional. Others are short-term interventions for research purposes, some are discrete course offerings, and some are briefly integrated into clinical instruction (Gordon, 2005). This type of delivery contributes significantly to the impression that medical humanities teaching is irrelevant and an unnecessary add-on to the core science curriculum.

Conversely, to the ad-hoc nature of many medical humanities programs, Carr et al. (2021) conducted a scoping review that included only programs with an integrated approach. Most programs in the study spanned anywhere from four weeks to a year. The study aimed to find comparability between similar programs by setting clear parameters. However, there was still too much variation in the field to adequately compare the effectiveness of different programs (Carr et al., 2021). This analysis is significant

because it only included programs that could be described as integrated and sought to establish a framework for evaluating medical humanities curricula.

The article "The Role of Humanities in the Medical Curriculum: Medical Students' Perspectives" by Petrou et al. (2021) addressed several areas presented by Shapiro et al. (2009) through a survey administered to students in a six-year Bachelor of Medicine, Bachelor of Surgery program at Imperial College London. The survey was a mixed-methods questionnaire that collected data on student demographics, viewpoints, and the integration of humanities into the medical curriculum. The topics were addressed using a mix of multiple-choice, ranking, and free-response questions. For example, "students could select multiple years that they thought the course should be included into and give free-text answers for the reasons behind their choices" (Petrou et al., 2021).

The survey highlighted that students generally wanted more medical humanities courses to be incorporated into the program, specifically during the first three years (Petrou et al., 2021). No consensus was found on whether medical humanities courses should be delivered as electives, and junior medical students ranked the skill of empathy higher than senior medical students (Petrou et al., 2021). Furthermore, students strongly felt that humanities subjects should not be assessed but saw them as necessary for engagement (Petrou et al., 2021). Unfortunately, no opinion was offered regarding who should be instructing the medical humanities curriculum.

However, as elucidated by Huang et al. (2023), the curriculum can only go so far. In a retrospective cohort study, the correlation between the quality and quantity of medical humanities courses was assessed. The study analyzed a dataset and performed multiple regression analyses of students' learning records, which included demographic information, weighted average marks, clinical curriculum scores, scores of medical humanities courses, and the number of medical humanities courses taken (Huang et al., 2023). A positive association was found between the number of medical humanities courses taken and students' clinical curriculum scores, clerkship performance, and weighted average marks, up to a certain extent (Huang et al., 2023). When students exceeded five courses, their performance actually decreased. The quality of the medical humanities courses was found to be a more impactful factor, with

the learning quality of medical humanities courses displaying a more significant positive correlation with the same variables (Huang et al., 2023). Thus, the study demonstrated that more is not always better, and both the quantity and quality of the courses must be appropriate (Huang et al., 2023).

Teaching Techniques

Medical humanities teaching is delivered in many forms, such as reflective writing, narrative works, and other types of engagement with the arts and humanities. This variety suits the context of humanities study itself, as human expression is broad and all-encompassing. However, in terms of synthesizing a formal medical humanities curriculum, this diversity can be a drawback, contributing to the varied nature of the field. All of the methods presented can be described as forms of active and transformational learning, requiring engagement with one's value system, beliefs, attitudes, and behaviors (Carr et al., 2021). In contrast, conventional learning methods such as lectures, tutorials, and laboratory sessions are described as passive and informational (Carr et al., 2021).

The study "How are the Arts and Humanities Used in Medical Education? Results of a Scoping Review" by Moniz et al. (2021) offers the most comprehensive description of intervention methods. These methods include literature, reflective writing, narrative medicine, other types of writing, visual art, theater and drama, film and television, music, comics and graphic novels, philosophy, history, religion, visual thinking strategies, and other art forms (Moniz et al., 2021). Generally, these areas are all categorized under "arts and humanities," but in reality, they represent various subfields.

Narrative medicine is a prominent teaching technique in the field. As elucidated by Moniz et al. (2021), there is a lack of clear definitions for each technique and how it specifically functions. It is sometimes defined or referred to with adjacent terminology such as narrative competence, narrative reflective practice, and narrative medical writing (Moniz et al., 2021). An essay by Barend Florijn (2020) exemplifies this type of work. Florijn (2020) describes how self-narratives help make sense of one’s lived experience and invite a physician to join the story. This provides an opportunity for further understanding and empathy with an illness narrative—an account of the illness and its effects on an individual’s

life—which is complementary to evidence-based medicine when formulating a clinical response (Le et al., 2017; Florijn, 2020).

An article by Kirsty Brownlie (2023) briefly touches on narrative medicine in terms of its use as curricular content. In Brownlie's (2023) article, a technique called 'case-based learning' is implemented in regular sessions over a year. 'Case-based learning' involves presenting a clinical case to students, who then discuss the issues that may arise from it in various fields (Brownlie, 2023). Sometimes, the case presented is a patient narrative, as Brownlie has done herself when facilitating these sessions.

In doing so, Brownlie encouraged reflexive work, another prominent technique within the field. Reflexive work also has varied definitions and is described using adjacent terms such as reflective writing, reflective practice, and reflection (Moniz et al., 2021). Generally, this consists of written or discussion-based reflections on one's own experience as a provider or student, or reflecting on the experiences of the patient. Brownlie has found reflexive work to be valuable for both students and herself but cautions against its assessment, as it would be detrimental for students to 'fail' at their own personal reflection (Brownlie, 2023).

An entirely new perspective and technique was proposed by Chen et al. (2023). Chen et al. (2023) propose volunteer work as a way to achieve similar outcomes to those of the medical humanities curriculum, describing that "volunteering helps [students] have more opportunities to bond with people and provides a platform to learn about humanities." Further, medical personnel must connect with the service they are providing to society and understand the value of their work: "Most medical students choose to participate in volunteer service activities in order to help others and society by showing their own value, which is exactly the manifestation of humanistic care in volunteer service" (Chen et al., 2023). Thus, it is described as a technique that can help to develop the 'humanistic spirit,' as is done and sought after in medical humanities.

The methods utilized in the medical humanities curriculum encourage individuals to engage with their value systems, beliefs, attitudes, and behaviors, whether through narrative medicine, case-based learning, reflective work, or volunteering. Each method aims to provoke a level of transformation and

self-awareness through active engagement and exposure to differing perspectives. Thus, quality medical humanities coursework must provoke a level of engagement and fundamentally function in an active and transformational manner.

Program Examples

Lastly, various articles have outlined the specifics of their programs. Eng Koon Ong's (2021) article details a short-term intervention method, as is prevalent in the field. In this method, two small group sessions occurred where "literature and other art-based" materials were presented to junior doctors at the Division of Supportive and Palliative Care at the National Cancer Centre Singapore. Another study by Zhao et al. (2023) utilized a similar method spanning two months. A subgroup of the residents at the First Affiliated Hospital of Xinxiang Medical University received a narrative medicine curriculum in the form of classroom lectures, discussions, films, readings, and analysis of narratives in one-hour sessions per week (Zhao et al., 2023).

Shapiro & Rucker (2003) published an article detailing the Medical Humanities program at the University of California, Irvine, which is more integrated and long-term. This program includes elective and required courses across four years of medical school and a required curriculum in residency. The program employs humanities and art-based teaching in horizontal coherence and vertical complexity structures. Horizontal coherence refers to related subjects being integrated with core biomedical subjects, while vertical complexity refers to the progressive increase in content difficulty and depth as schooling continues (Shapiro & Rucker, 2003). For example, Year 1 students use "prose and poetry to study in greater depth patient care issues and topics covered in the five modules of the Patient-Doctor course that integrates physical examination with communication skills and a range of psycho-sociocultural patient-related issues," demonstrating horizontal coherence (Shapiro & Rucker, 2003, p. 955). While Year 1 medical students "focus on topics such as anatomy, interviewing, and the physical examination," Year 3 students cover "topics such as socialization into clinical medicine, breaking bad news, and death and dying," demonstrating vertical complexity (Shapiro & Rucker, 2003, p. 955).

Furthermore, the program is primarily led by clinical faculty, another area greatly debated throughout the literature. Faculty who work within the intersection of medicine and humanities and are willing to operate within a medical program are rare. Shapiro's program has invested in faculty development and training them in the relevance of medical humanities so that the program may eventually become 'self-generating' (Shapiro & Rucker, 2003).

The article presented by Eno et al. (2023) details a similarly integrated program spanning all four years of medical school. During this period, the related curriculum is presented as a 'track,' cohering to the organ system of study (Eno et al., 2023). The curriculum involves large and small group sessions, as well as service learning in the later years (Eno et al., 2023). Both Shapiro & Rucker (2003) and Eno et al. (2023) present highly integrated approaches to the medical humanities curriculum.

Student Learning Outcomes

Lastly, various student outcomes have been proposed to arise through the implementation of medical humanities, specifically benefiting the type of care provided as well as student and physician wellness. The medical humanities curriculum has benefits in the areas of professionalism and holistic care, fostering traits such as increased empathy, self-awareness, compassion, decreased risk of burnout, and improved student performance. All of these contribute to demonstrating the utility of the field in terms of measurable student gains and personal development.

Often, these benefits are encompassed in the betterment of professionalism. Shapiro and Rucker (2003) describe that their home university program was developed to enhance professionalism in aspects such as "empathy, altruism, [and] compassion" (Shapiro & Rucker, 2003, p. 953). Professionalism generally describes the competencies needed to be successful in a role (Merriam-Webster, 2024). In the case of a healthcare provider, this includes the qualities described by Shapiro and Rucker (2003). Petrou et al. (2021) note that medical humanities education extends beyond the reach of standard medical education by promoting "professional values and behaviors, including professional identity formation" (Petrou et al., 2021). These traits are synonymously described in the discipline as 'humane practice' or 'humanism.' Carr et al. (2021) note that half of the studies covered in their review focus on the

enhancement and support of the knowledge of humanism (Carr et al., 2021). Chen et al. (2023) describe this outcome as a ‘humanistic spirit and behavior’ that exhibits "the care and reverence for the life of all living things," as well as "the pursuit and aspiration for value and meaning," and that the "humanistic spirit guides the moral level of humanistic education" (Chen et al., 2023). In other words, Chen et al. (2023) use the term ‘humanistic spirit’ to describe the care, empathy, and value that a provider should hold for human life and the pursuit of meaningful interactions with others.

Medical humanities education also aids in the development of a more holistic perspective for students and providers. A significant aspect of humane medicine is the concept of seeing the ‘whole’ patient. In doing so, providers acknowledge and take into account not only the ailment that an individual is seeking treatment for but also the larger social contexts that affect illness. Thus, the ‘whole’ individual is perceived as a person existing within a broader context and is treated as such.

Eno et al. (2023) detail the medical humanities curriculum at their home college, Creighton School of Medicine. Through their qualitative study, students themselves described the outcome of "seeing the whole patient," explicitly stating how medical humanities "taught them that patients are more than illnesses/ailments or corporeal beings and have emotions, experiences, and a life outside the exam room" (Eno et al., 2023). This forms the basis of patient-centered care, which has been recognized as a result of medical humanities teaching. As noted by Jill Gordon (2005) and Carr et al. (2021), medical humanities work to develop skills associated with patient-centered care, such as seeing the whole patient. Kristy Brownlie (2023) also describes how she encourages her students to "see each person as an individual rather than a condition."

Increased empathy is one of the most commonly detailed benefits of medical humanities education among students and providers. A brief essay by Barend Florijn (2020) provides an example of narrative medicine that urges physicians to think with patient stories rather than purely about them, as it may provide a greater capacity to empathize with patients. Another study by Eng Koon Ong (2021) measured this outcome in a study among Junior Doctors at the Division of Supportive and Palliative Care at the National Cancer Centre Singapore. After two small group sessions, students exhibited an increase in

empathy scores from pre to post-Jefferson's Scale of Physician Empathy (JSPE) and the modified-CARE (Consultation and Relational Empathy) measure (Ong, 2021). Zhao et al. (2023) found the same result after administering medical humanities education to a group of resident students at the First Affiliated Hospital of Xinxiang Medical University. Comparing a control group and a study group, the empathy scores using the Jefferson Scale of Empathy-Medical Student (JSE-MS) version were higher in the study group (Zhao et al., 2023). Carr et al. (2021) touched on this similarly, stating that medical humanities target the empathetic response (Carr et al., 2021). Petrou et al. (2021) interestingly found through a survey among all year groups of students in the 6-year Bachelor of Medicine, Bachelor of Surgery course at Imperial College London that junior medical students ranked empathy as a more desirable attribute compared to senior medical students. The study acknowledges this as a learning outcome of medical humanities, but the varied conceptualization of the trait can be attributed to cultural differences among year levels (Petrou et al., 2021). Senior students experience a change in priorities as they inevitably approach final exams and their careers. At this point, senior students operate in a more survivalist manner toward their educational experience and may feel that focus on non-clinical skills cannot be afforded (Petrou et al., 2021). Thus, senior medical students ranked empathy as a less desirable trait compared to clinical skills such as patient management.

Self-awareness and compassion are also detailed as outcomes of medical humanities teaching. Shapiro et al. (2009) detail that medical humanities serve a moral function by teaching critical reflection to form more self-aware practitioners. This is achieved by encouraging a meta-level of questioning regarding how and what doctors should be doing. Additionally, the Association of American Medical Colleges (1998) prescribed in their guidelines for medical schools that "physicians must be compassionate and empathetic in caring for patients." Kristy Brownlie (2023) describes how her students developed a greater understanding of the meaning of compassion in healthcare through the reflective practice of medical humanities. Furthermore, she argues that compassionate patient engagement can also promote provider well-being.

Another benefit experienced by students and providers as a result of medical humanities teaching is a decreased risk of burnout. The skills taught within the curriculum provide tools to better process the schooling and practicing experience. Kristy Brownlie (2023) points to reflective work and compassionate-based care as preventative measures for burnout. As elucidated by the previous positive results of medical humanities teachings, the healthcare field requires a fair level of moral and emotional involvement. During this, providers are put at risk for experiencing "moral distress or moral injury; a state of psychological suffering caused by violating one's intrinsic personal values" (Brownlie, 2023, p. 392). Petrou et al. (2021) articulated this similarly, stating that medical humanities can provide an outlet for physicians and students at risk of experiencing burnout. Gordon (2005) notes this as well, describing that the medical humanities curriculum is instrumental in counteracting professional burnout by providing the skills necessary to process moral challenges that are not addressed otherwise within standard medical education.

The most measurable result of medical humanities teachings is increased student performance. Alongside the increase in empathy, Zhao et al. (2023) also observed a rise in test scores among the study group on the neurological professional knowledge exam. Another study by Huang et al. (2023) found that appropriate medical humanities courses, in terms of quantity and curriculum quality, were positively associated with clinical curriculum scores, clerkship performance, and weighted average marks. A significant finding of the study was that students taking more than five medical humanities courses actually performed worse than those taking fewer (Huang et al., 2023). Therefore, it is not to say that more is necessarily better, but an appropriate quantity along with quality medical humanities courses has a positive impact on student performance. Carr et al. (2021) also note this as a result of medical humanities teaching, with twenty out of the twenty-four articles included in the review describing medical humanities as an intervention method aimed at developing and mastering skills.

Discussion: Recommendations & Proposals

Conceptual Framework

A major critique of the field has been the lack of a conceptual and theoretical framework in the discipline of medical humanities. As described by Carr et al. (2021), this absence gives the impression that the field does not fully understand itself. However, upon review, there seems to be more consensus on the purpose and framework of medical humanities than the discipline acknowledges. The more prominent challenge is the varied language used to describe this framework. As an interdisciplinary field, its broad expanse is a benefit, and it is characteristic to have no exact 'textbook' definition of medical humanities. With the roots of the field in the humanities discipline, it is only reasonable that many authors have an innate love for language and will naturally use it in a varied and expressive manner.

To this end, it is not necessary for the field of medical humanities to have a word-for-word definition of its purpose and intent. Rather, a summary or set of parameters defining what qualifies as medical humanities is more appropriate for maintaining the characteristic breadth of the field. Additionally, much of the purpose of the field is to act as an applied discipline, in contrast to more traditional academia which may focus purely on content. Its intent is to promote critical outcomes within providers, particularly a humanistic foundation. From the review, it can be concluded that medical humanities content is a form of teaching that incorporates the arts—such as visual arts, performing arts, and music—and the humanities—such as history, literature, narrative, ethics, and philosophy—into the medical curriculum to better instill compassion and empathy in care providers (Carr et al., 2021). Furthermore, the purpose of the field can be encompassed by the intentional promotion of humane care, increased provider self-awareness, compassion, and cultural competence. Thus, a theoretical framework is proposed as follows:

> *Medical Humanities* is an interdisciplinary field where the teachings of the arts—such as visual arts, performing arts, and music—and the humanities—such as history, literature, narrative, ethics, and philosophy—are integrated with the medical curriculum to promote a humanistic foundation in providers. This foundation supports the promotion of humane care, increased provider self-awareness, compassion, empathy, and cultural competence, among other benefits.

This can serve as a functional definition of Medical Humanities, describing its nature as an interdisciplinary domain that combines the teachings of the humanities with the principles of medicine within medical education. The goal is to foster a more compassionate practice of medicine, benefiting both the patient and the provider.

Methodology

Regarding the methodology within the discipline of medical humanities, both quantitative and qualitative methods provide crucial functions. Quantitative methods measure student improvements following the implementation of medical humanities curricula, while qualitative methods articulate the types of improvements that can occur. Each provides critical information that can support the argument for incorporating medical humanities curricula. However, both are needed to adequately frame what the curricula are accomplishing. Thus, quantitative and qualitative methods are most effective when used in conjunction. As the field is interdisciplinary, its methods must be as well. A mixed-method approach allows for the most comprehensive understanding of the field's application, integrating both the traditional 'scientific' approach of quantitative data and the more humanities-based approach of qualitative data. The diversity in methods uniquely positions the field of medical humanities to both measure and investigate various aspects of health and apply these insights to practice. Therefore, the methodology of the discipline is proposed as follows:

> *Medical Humanities*, as an interdisciplinary field, should primarily utilize a mixed-method approach.

Curriculum Format

Many critiques have been made by both students and instructors about the current medical humanities curricula offered at many institutions. The guidelines necessitating the teaching of medical humanities come from the American Association of Medical Colleges (1998) and the General Medical Council (2013). These guidelines detail that physicians should be “altruistic, knowledgeable, skillful, and dutiful” and that doctors must be able to “adequately assess the patient’s conditions, taking into account their history (including symptoms and psychological, spiritual, social, and cultural factors), their views,

and values" (American Association of Medical Colleges, 1998; General Medical Council, 2013). These minimal guidelines have produced a variety of programs at different institutions.

The first critique concerns the theoretical and conceptual framework of medical humanities, noting that every institution has a different definition (Shapiro et al., 2009). While it is natural for this type of discipline to use a variety of words to describe its purpose, for clarity, the proposed framework from this article will function well as a definition for medical humanities, as it encompasses the primary intent and function of the field.

The second critique pertains to who is teaching the medical humanities curriculum. Students often distrust non-physicians, perceiving that "there is a widespread perception that non-physicians do not comprehend clinical realities," and that typical humanities instructors "talk the talk without walking the walk" (Shapiro et al., 2009, p. 193). Therefore, it is crucial that medical humanities instructors are skilled in both areas. Shapiro and Rucker's (2003) program addresses this well by investing in humanities training for clinical faculty who often end up leading these programs. Thus, it is essential for this interdisciplinary field to be taught by instructors with an interdisciplinary background, and if one does not already possess this background, it is possible to train individuals in its relevance and value.

The last major critique is that of workload. Students argue that if the workload is too much, it is overwhelming with the already intense medical school curriculum, but if it is too little, it's criticized as not adding value (Shapiro et al., 2009). The most viable solution to this argument can be found in the research by Huang et al. (2023), which found that negative associations in student performance occurred when the workload of the courses increased beyond a certain extent, in this case, five courses. Below this extent, positive associations were found between a mildly increased level of medical humanities coursework and student performance (Huang et al., 2023). From this research, it was found that delivering the curriculum in the appropriate quality and quantity would be most impactful for students. Thus, a lower workload of medical humanities coursework is complementary to the existing medical education, but it must be of high quality.

Another critical factor of the medical humanities curriculum is student engagement. Due to the nature of the curriculum, students benefit more from strong engagement with the material than from an assessment of it. Petrou et al. (2021) highlighted this point in their survey, in which students indicated their preference that humanities subjects should not be assessed but are necessary for engagement.

Lastly, it is imperative that institutions take an integrative approach to the implementation of medical humanities curricula. More often than not, these curricula have been implemented in an ad-hoc manner, particularly in the context of research. Shapiro and Rucker's (2003) program at their home university serves as an exemplary model. Their approach employs humanities and art-based teaching in horizontal coherence and vertical complexity structures. This means that the medical humanities curriculum is paired with relevant medical coursework and increases in difficulty as the years progress.

Regarding the learning techniques used within these programs, the most pivotal are narrative medicine, case-based learning, and reflective work. These are the fundamental teaching techniques in the discipline of medical humanities and encourage individuals to engage with their value systems, beliefs, attitudes, and behaviors. Many other teaching types can be included in medical humanities education, such as literature, other types of writing, visual art, theater and drama, film and television, music, comics and graphic novels, philosophy, history, religion, visual thinking strategies, and more. However, medical humanities programs must include narrative medicine, case-based learning, and reflective work as the basis of their curriculum, as these are the most prominent and common techniques in the field. All other forms of medical humanities coursework may be considered supplementary beyond these core facets. Volunteer work can also serve a great purpose in developing a humanistic foundation, but until further research is available, it is not necessary to include it in the base curriculum.

Furthermore, it is crucial that all learning techniques take an active and transformational approach. In contrast to traditional passive and informational learning techniques such as lectures, tutorials, and laboratory sessions, the core teaching methods of medical humanities aim to provoke a level of transformation and self-awareness through active engagement and exposure to different perspectives (Carr et al., 2021). Thus, guidelines for a medical humanities curriculum are proposed as follows:

> *Medical Humanities* should be defined by the previously proposed conceptual framework. As an interdisciplinary field, it should be taught by faculty with backgrounds in both applied health and the humanities. The curriculum workload should be appropriate in both quantity and quality; the most complementary approach would involve a lower workload that focuses on high-quality student engagement and does not necessitate assessment. The medical humanities curriculum should be highly integrated into the existing medical curriculum by adopting a horizontal coherence and vertical complexity approach that spans the medical education experience. Lastly, the curriculum should function in an active and transformational manner, rooted in the learning techniques of narrative medicine, case-based learning, and reflective work.

Student Learning Outcomes

Lastly, the utility of the field has been demonstrated through various student outcomes. These include the enhancement of professionalism and holistic care, fostering traits such as increased empathy, self-awareness, compassion, decreased risk of burnout, and improved student performance. These outcomes also contribute to the conceptual framework of the field, providing substantial benefits that students will experience through the implementation of the medical humanities curriculum. This further supports the argument for medical humanities as an applied field, as many of these are measurable, application-based outcomes. There are many other results found in the teaching of medical humanities, but the listed outcomes are the most prominent in the literature, with supporting data. Thus, the student learning outcomes of medical humanities are proposed as follows:

> The *Medical Humanities* curriculum fosters the prominent student learning outcomes of improved professionalism and holistic care, increased empathy, self-awareness, compassion, decreased risk of burnout, and improved student performance.

Limitations

Potential limitations of the review include incomplete coverage of relevant information, which may have resulted from the limited set of fifteen articles that were thoroughly reviewed. The use of a single database, in conjunction with articles accessible through Portland State University, may have further contributed to the scope limitation of the review. It is also possible that relevant information was missed in the search process or erroneously excluded during the selection process. Given that medical humanities is a newly growing field, there is potential for reporting bias from the articles used, as authors may seek to promote the field. Another limitation pertains to the thematic analysis process, which

involved interpreting the findings reported by the articles, potentially leading to misinterpretation. Although the inductive coding process was employed to mitigate potential bias and misinterpretation, it may still pose a limitation to the review. Lastly, the time constraints of the project may have contributed to the limited scope. Furthermore, some sources may be outdated, though they were included to provide a more historical and comprehensive view of the discussion in the field. Overall, these potential limitations are minor in contrast to the thorough and comprehensive review process that was performed.

Conclusion

The findings of this review address the significant claim that there is a lack of a conceptual framework in the field by highlighting consensus in the conversation and proposing an inclusion framework and definition. It also evaluates the methods used throughout the discipline, which, although varied, provide a comprehensive view of medical humanities. Thus, a mixed-method approach is well suited to the field. The current curriculum is equally varied, but a few program examples stand out as the most adept integrations of medical humanities content into medical education. The programs of Shapiro and Rucker (2003) and Eno et al. (2023) provide in-depth examples of well-integrated curricula. From the review, it is proposed that a quality integrated curriculum should utilize the core teaching techniques of narrative medicine, case-based learning, and reflective work, with a strong focus on student engagement. Lastly, the review identified primary student learning outcomes from teaching medical humanities as an applied field. These include enhanced professionalism and holistic care, increased empathy, self-awareness, and compassion, a decreased risk of burnout, and improved student performance.

Further research is needed in the development of a conceptual framework for the discipline. Although this review proposes a functioning definition, there is still little consistency within the field. A prominent contributing factor is the discipline's tendency to use varied language. As an interdisciplinary field, there is value in a literary approach, and this is not necessarily a drawback. However, to establish a comparable curriculum, consensus on what constitutes medical humanities and acceptable synonyms is necessary.

Additionally, the review found that curriculum quality is a more impactful factor than previously acknowledged in the literature. Thus, more research on what constitutes a quality medical humanities curriculum is necessary. This review suggests that quality likely includes the teaching techniques of narrative medicine, case-based learning, and reflective work, as they promote student engagement with their personal value systems and the broader social systems at play. If it exists, it would be a considerable contribution for other institutions with integrated medical humanities curricula to publish details of their programs. This would provide more examples for comparison across the discipline and inspire integrated programs at more institutions.

Overall, the article conducts a narrative literature review, summarizing discussions in the sectors of Medical Humanities Purpose as a Field, Methodology, Current Curriculum and Techniques, and Student Learning Outcomes. Using thematic analysis in these areas, the authors proposed a conceptual framework and curriculum guidelines to address the highlighted concerns. The review successfully addressed the question: What are the current frameworks of the medical humanities discipline in terms of purpose, methodology, curriculum, and student learning outcomes? The existing frameworks were identified, with the content consolidated and relayed into working guidelines that can help further the integration of medical humanities content into pre-medical and medical programs.

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