Subcommittee Summary Report

Regarding

Humanistic Practice in Medicine

For

Curriculum Reform

University of Colorado School of Medicine

Committee Leads: Tess Jones, PhD and Read Pierce, MD

Date: June 1, 2018
I. PURPOSE OF THE COMMITTEE

Committee Members: Oliver Bawmann (student), Shayer Chowdhury (student), Jackie Glover, Jeanette Guerrasio, Lauren Heery (student), Tess Jones (co-chair), Juan Lessing, Steve Lowenstein, Jamal Moloo, Abraham Nussbaum, Read Pierce (co-chair), Deb Seymour, Meghan Treitz, and Shanta Zimmer

Our committee was charged with the cultivation of humanism in the graduates of the CU SOM. This charge sparked considerable debate and discussion among committee members for the following reasons:

- "Medical humanism" is a broad often misunderstood term
- It is often conflated and confused with "medical humanities"--a set of disciplines such as philosophy, ethics, literature, art, history, jurisprudence, etc.
- Institutions that we interviewed expressed a belief that students view humanism as less essential to their education and professional development when compared to scientific and clinical learning.
- Humanism, in the traditional understanding of the term, evokes both a specific cultural, historical, and philosophical system of thought and a Western-biased point of view about what is desirable in the habits of physicians.

Thus, the committee spent its first few meetings striving to balance clarification of terms with the concrete implications for education and the learning environment and with the desire to provide space for humanism to be attractive and relevant to all physicians-in-training. The consequence of these conversations was a decision to amend the committee’s title from Humanism in Medicine to Humanistic Practice in Medicine.

This shift in nomenclature emerged from our working definition of humanistic practice that is:

- The continuous and consistent cultivation of virtuous and lifelong habits that inform the practice of clinical medicine and scientific research but extend beyond it to professionalism, wellbeing, leadership, advocacy, diversity, commitment, and curiosity.
- The creation of a culture expressed through attitudes and behaviors that support all elements of appropriate and effective identify formation for physicians-in-training.
- The commitment to both being and doing that is integrated through all aspects of medical education and the daily experience of physicians-in-training as well as all members of the healing professions.
- The transcendent human pursuit distinct from a particular field, methodology, or historical point of view: humanistic practice is and must be an overarching aim and good, in and of itself, in addition to and aside from content in the sciences, arts, humanities and ethics.
Examples of Virtuous Habits:

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<thead>
<tr>
<th>Curiosity</th>
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<tr>
<td>Compassion</td>
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<td>Self-awareness (strengths, weaknesses)</td>
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<td>Growth Mindset</td>
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<td>Resilience</td>
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<td>Humility as an Expert</td>
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<td>Courage</td>
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<td>Service</td>
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II. REVIEW OF BEST PRACTICES OR AT LEAST ALTERNATIVE PRACTICES

A targeted review of the literature and selective interviews with national and international leaders in the cultivation of humanism and humanistic practice enabled the committee to identify several overarching themes in addition to specific best practices. We found that:

1. The most progressive institutions we reviewed strive to ensure that students see humanistic practice as the work of our profession--not a “touchy feely Tuesday,” "another Wednesday morning lecture," an elective, or an interesting side note to the formal and hidden curriculum.
2. Humanistic practice arises from the cultivation of habits rather than the knowledge of certain fields and disciplines.
3. Helping physicians-in-training with ways to view the work of healing through multiple lenses beyond the basic sciences through the arts, humanities, and ethics, for example, facilitates the overarching habits of perspective-taking, rigorous multi-modal analysis, tolerance of ambiguity, reflective practice, and empathy--all of which are vital to humanistic practice.
4. Integration of humanistic practice into and across all domains of the curriculum seems to increase students’ sense of its relevance and seems to be more effective in developing or changing habits when compared to deploying more intensive and specific sites of educational experiences around a related topic such as art in medicine or professionalism. However, integration is markedly more difficult than a silo-based approach.
5. Habit formation is accelerated through frequent, focused, and closely mentored iterative reflective work at both the individual and small group level following a cycle.
6. Selecting students for humanistic habits as part of the medical school application process is helpful in accelerating mastery later in training.

7. Role modeling by faculty is the single most powerful catalyst for habit formation among students-in-training. Having multiple positive examples of role models upon whom to reflect and toward whom to aspire is vastly preferable and more successful than debriefing observed behaviors which are anti-humanistic as a method of teaching the opposite.

8. Humanistic practice is directly linked to professionalism, wellbeing, leadership, advocacy, diversity, inclusion, and commitment to life-long learning (curiosity).

Potential Practices to Adopt for Physicians-in-training

The most impactful vehicle for cultivating humanistic practice is longitudinal small group sessions (6-8 students per group) with a single, highly skilled faculty member who both models humanistic practice and facilitates iterative reflection and growth among all students in that small group. These faculty must be highly skilled in order to make the content extremely relevant and the discussion extremely open, respectful and accessible: if the purpose, insights, or habits under exploration are ambiguous or disconnected, our own student survey data suggest that learners will quickly tune out such activities in favor of preparing for exams on other topics. To note, there are already multiple opportunities to maintain and refine this approach within the existing Foundations of Doctoring; Humanities, Ethics and Professionalism (HEP) Thread; Culture, Health, Equity and Society (CHES) Thread; and Interprofessional Education (IPED). In addition, structures like PBL/TBL, LICs, and ICC provide appropriate settings.

Individual reflection (with or without dedicated faculty coach):

- Clear and directed reflective writing activities that focus on the pursuit and experience of a particular habit and that are submitted to a faculty coach/mentor for review and commentary.
- Standardized patient communication/empathy scenarios with written reflection on the feedback from standardized patients.
- 1-on-1 reflective writing on personal growth goals set quarterly and discussed with faculty coach/mentor.
Small group reflection (oral):

- Balint groups that identify and reflect on a challenging event or experience with a patient, teacher, or colleague (set within PBL/TBL or ICC).
- Appreciative debrief discussion of positive examples of observed humanistic practice in others in any setting.
- Discussion of observations from a scheduled amount of time following other care team members such as pharmacists, nurses, respiratory techs, etc.
- Collective reflections on individual personal growth goals.
- Medical improvisation – active and expert training that anticipates and enacts challenging interpersonal scenarios followed by debrief with peers and coach/mentor.

Small group case discussion (oral +/- written):

- Ethics case conferences based, if possible, on actual cases and reviewed in a clinical setting with a diverse set of experts (ethicists, clinicians, legal counsel, pastoral care) and stakeholders (patients, family members) followed by group debrief.
- Home visits with patients that include a structured exploration and report of a patient’s lived experience with debrief in small group.
- Careful observation, critical analysis and open discussion of film, artwork, music, poetry, community environment, or personal artifact that provokes emotional reaction, promotes perspective-taking, and helps to identify personal and institutional biases.

Integrated course:

- Longer First Course with a strong presentation that this content will receive emphasis as equally important to anatomy, physiology, etc.

Potential Practices to Adopt for Core Faculty Facilitators

National, longitudinal studies suggest that, in order for faculty to engage most successfully in both teaching and modeling humanistic practice, they must have robust support and rigorous instruction themselves to cultivate their own humanistic practice. At least one multi-institutional study reveals that attention to faculty members’ humanistic practice not only positively impacts students but also promotes personal growth, resilience, and wellbeing for faculty—virtues that matter for success in a career in medicine. In addition, regular sessions and scheduled opportunities for faculty to participate in reflective writing workshops, debrief discussions, small group facilitation training, and ethical case analysis is crucial in developing teaching skills, identifying biases, and anticipating difficult conversations with student groups.

Small group reflection (oral):

- Balint groups that identify and reflect upon a challenging event or experience with a patient, teacher, or colleague (could take place during PBL/TBL or ICC).
- Appreciative debrief discussion of positive examples of observed humanistic practice in others in any setting.
- Discussion of observations from a scheduled amount of time following other care team members such as pharmacists, nurses, respiratory techs, etc.
• Collective reflections on individual personal growth goals.
• Medical improvisation – active and expert training that anticipates and enacts challenging interpersonal scenarios followed by debrief with students and instructor.

Small group reflection (written evaluation):
• Regularly scheduled workshops for small groups of faculty to respond to writing prompts, engage in timed writing, share written work, and debrief from the experience.
• Regularly scheduled retreats for faculty to respond individually to actual (de-identified) examples of student reflective writing and then to discuss collectively their different approaches and responses to student work. Such discussions provide opportunities to identify individual biases and to develop constructive and consistent methods for assessing portfolios.

Small group facilitation training:
• Training in basic and advanced facilitation skills to enhance small-group learning sessions and 1-on-1 mentorship
  o Example of skills: asking powerful and open-ended questions; check-in; learner-centered objective setting; learner-centered rules of engagement in small groups; reflective listening; setting joint learning agendas; learner-centered feedback; recognizing and responding to negative emotion with empathy; leading debriefings; coaching for performance; practicing appreciative inquiry; identifying one's own biases and responding accordingly.

III. ASPECTS OF CURRENT CURRICULUM THAT ADDRESSES PURPOSE AND SHOULD BE MAINTAINED

As noted above, there are multiple opportunities already in place to maintain and refine this approach within the existing Foundations of Doctoring; Humanities, Ethics and Professionalism (HEP) Thread; Culture, Health, Equity and Society (CHES) Thread; and Interprofessional Education (IPED). In addition, structures like PBL/TBL, LICs, and ICC provide appropriate settings.

More specific examples include the content and objectives in the HEP Thread. The advisory committee identified eight essential competencies and developed objectives for each including professionalism, empathy, and ethics. Relevant goals to humanistic practice include identify formation, humanism, and wellness; personal, social, moral and cultural dimensions of healthcare through the arts and humanities; appropriate and compassionate care at the end-of-life; and spiritual needs of patients and families. Most of HEP content is delivered in small groups with faculty who are experienced facilitators and includes reflective writing and case-based ethics discussions. In addition is the newly developed CHES Thread which focuses on content and methodologies to address culturally effective medicine, disparities and access. Special attention to identifying and confronting the impact of personal and institutional bias, injustice, discrimination and stigma through reflective writing and facilitated discussion in small groups are in place and are relevant to humanistic practice.

Finally, reflective writing sessions have been developed, implemented and are facilitated by trained faculty currently in the LICs and in the Psychiatry clerkship.
IV. RECOMMENDATIONS

Essential—

1. Humanistic practice should not be confined to a particular curricular thread or educational methodology; rather, humanistic practice should be woven into every component of the curriculum.

2. Healthcare ethics is an especially powerful and relevant vehicle for exploring many components of humanistic practice and should receive dedicated curricular time in every year of education with particular emphasis on case-based discussion.

3. Communication skills training is a second, essential vehicle for enhancing humanistic practice with particular emphasis on narrative competency.

4. Regular reflection—written and explored one-on-one as well as small group discussion—is a third, essential habit for the cultivation of humanistic habits and provides a mechanism for assessment.

5. Formal instruction and on-going coaching on reflective writing and reflective practice are necessary for both students and faculty facilitators.

6. Reflection should focus on actual experiences when possible rather than simulations or fictionalized reality.

7. A small cadre of dedicated faculty teachers/coaches who both model humanistic practice in all aspects of their work and life and are outstanding facilitators in areas of identity formation, communication skills, and conscious/unconscious bias should receive dedicated funding, time, and intensive training to serve as formal guides for all students, longitudinally, throughout medical education.

8. Existing structures for individual and small group learning should be used to cultivate humanistic practice rather than carving out a new thread.

Suggested—

9. When possible, humanistic practice should be cultivated in an inter-professional setting/model.

10. Careful and formal assessment of the barriers to and facilitators of humanistic practice should be part of the implementation-planning phase of curriculum redesign for each element of the existing and proposed new curricula.

11. Formal integration of humanistic practice in curricula focused on leadership and systems of care (including advocacy) to emphasize how humanistic practice extends beyond the individual to teams, communities, delivery systems, and cultures.

V. SUGGESTED OUTCOMES MEASURES / EVALUATION OF PROGRAM

We believe humanistic practice may be effectively measured in several ways. A number of the evaluation methods focus more on structure and process including:

1. Student-developed portfolios consisting of iterative:
   - Self-assessment of humanistic practice as outlined above in the sub-section of "Potential Practices to Adopt for Physicians-in-training" under Review of Best/Alternative Practices Section.
• Articulation of personal/professional goals related to forming virtuous habits.
• Reflective writing on transformative experiences related to humanistic practice and on continual pursuit and adjustment of personal/professional goals (habit practice).
• Outside feedback from teacher, team members, and peers.
• Adjusting personal goals.

Other evaluation methods should focus on outcomes such as the observation of humanistic practice and how it is or is not positively impacting our learners. Opportunities for outcome-oriented assessment includes:

2. Jefferson empathy score measurement for each student (annually).

3. Wellbeing measurement based on the work of Bryan Sexton at Duke University that focuses on burnout, resilience, and thriving scales (twice yearly).

   **Emotional Thriving (1-5 Likert scale)**
   1. I have a chance to use my strengths every day at work.
   2. I feel like I am thriving at my job.
   3. I feel like I am making a meaningful difference at my job.
   4. I am often pleasantly fascinated by things that happen at my job.

   **Emotional Recovery (1-5 Likert scale)**
   1. I always bounce back quickly after difficulties.
   2. I always find a solution when something unforeseen happens.
   3. I can adapt to events in my life that I cannot influence.
   4. My mood reliably recovers after frustrations and setbacks.

   **Focused Burn-Out Scale (1-5 Likert scale)**
   1. Events in this work setting affect my life in an emotionally unhealthy way.
   2. I feel burned out from my work.
   3. I feel fatigued when I get up in the morning and have to face another day on the job.
   4. I feel frustrated by my job.
   5. I feel I am working too hard on my job.

4. 360-degree evaluation (twice yearly) of behaviors that are an expression of humanistic practice (behaviors tied to virtues) for each student with specific consideration for:

   • Creating an instrument based on literature, designed to meet our goals and reflective of our local culture.
   • Using longitudinal small groups as outlined above.
   • Incorporating evaluation into clinical rotations such as LICs.
V. PILOT IDEAS AND NEXT STEPS

Because we believe humanistic practice can and should be embedded in all aspects of the curriculum rather than developing an isolated thread or focused series of lectures/small groups, any pilot projects should rely on a careful assessment of the emerging structure of the new curriculum and an identification of which existing vehicles will remain and which new avenues for teaching will be created. As a result, our pilot recommendations are currently quite focused. We anticipate developing additional pilot ideas with the steering committee, based on discussion at the June retreat regarding structure and function of the new curriculum.

Pilot Idea 1 (AY 19): For the entering medical student class, develop a cadre of dedicated faculty facilitators who will be responsible for all longitudinal small group learning sessions. These faculty facilitators should:

- Be recruited and selected competitively rather than simply relying on volunteers.
- Receive extensive facilitation training before and during this 1 year pilot, as outlined above.
- Receive non-clinical time, via salary support, for their effort: recommend 10% FTE.

Pilot Idea 2 (AY 19): Create a formal assessment system, as outlined above, to determine feasibility of portfolio creation and evaluation, mechanics of 360-small group evaluation, and baseline data on wellbeing and empathy for entering medical student class.

Pilot Idea 3 (AY 19): Develop and implement a dedicated ethics consultation—a real case with diverse experts and stakeholders (as outlined above) working through the case in the room and pausing periodically to debrief what is occurring—with 3rd or 4th year students during existing ICC time. This could be a large group session or a combined large group/small group exercise.

Pilot Idea 4 (AY 19): Embed 2-3 formal home visits with patients/families into a subset of clinical rotations (recommend Pediatrics, Medicine, OB/Gyn, Surgery) with structured reflection on what the visits teach us about systems of care, patient experience, determinants of health, and unconscious bias.

Pilot Idea 5 (AY 19 vs AY 20): Co-develop, with the directors of the new Leadership curriculum, a thread focused on humanistic leadership practices and how leaders can incorporate virtues and habits discussed above to be more effective.

Pilot Idea 6 (AY 19): End every small group session in the SOM curriculum (across all years) with an appreciative debrief, asking all participants to reflect on one thing for which they are grateful during the session.

Pilot Idea 7 (AY 19): Incorporate a stronger focus into First Course on cultivating specific habits that provide access to resilience in medical school including intensive exploration of how each student can identify 1-2 habits at the individual, teamwork, and larger system levels to strive to cultivate during first year.
Pilot Idea 8 (AY 19-20): Identify a small group of students and faculty (10-12) to research the feasibility for developing and implementing an Ethics Lab—a design lab (modeled on same at Georgetown University's Kennedy Institute of Ethics) that uses ethics and design to approach complex moral problems such as developing a protocol for truly informed consent for genome sequencing, creating a campaign to eliminate disposable water bottles on campus, designing packaging to encourage adherence to prescribed antibiotic dosing, and developing an approach for more equitable treatment of transgender people in healthcare.

SELECTIVE BIBLIOGRAPHY


Kumagai, A. "Beyond "Dr. Feel Good': A Role For the Humanities in Medical Education." *Acad Med* 2017; 92: 1659-1660.


REVIEWED INSTITUTIONS*
Case Western University School of Medicine
Cleveland Clinic Lerner College of Medicine
Icahn School of Medicine at Mt. Sinai
Northeast Ohio Medical University
Northwestern University Feinberg School of Medicine
Thomas Jefferson University Sidney Kimmel School of Medicine
University of California, San Francisco
University of Toronto
Vanderbilt University School of Medicine

*Meeting reports available upon request*