

Virtual Mentor

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POLICY FORUM

Expanding Humanities Training beyond Medical School

Nicholas Kluesner, MD

Working in the emergency department of a busy tertiary care center, I am afforded a vantage point for encountering the behaviors and attitudes of my resident colleagues at their most challenging times. Contributing to their mounting list of consultations and providing a steady stream of admissions, I add to their already clinically overwhelming and emotionally exhausting workloads. Thus, it is no surprise when I receive a long-winded sigh or a standard dose of admission “push-back” on the phone. I would like to present an example of this daily reality—the case of Dr. Fish and Arlene—and submit a perspective on how this came to be and what we might do about it.

Arlene was a 72-year-old native of small-town Iowa, known to her community as the retired librarian. Her husband had long since passed away from the typical diseases of a farmer (coronary artery disease and chronic obstructive pulmonary disease mixed with stubbornness-delayed medical care). Arlene came to the ED in acute pain after church one morning. Following the necessary imaging, labs, and ED management, we consulted attending physician Dr. Fish about admitting her. For all the familiar reasons, what ensued was a circus of brainstorming other consulting services who might take the admission instead and rustling up medical comorbidities to justify a primary medical admission before the obligatory long sigh and acceptance. All the while Arlene sat on the ED stretcher, floating between doses of opioids, wondering who was who, what the plan was, and why she had not moved in three hours. This demonstrates how Samuel Shem’s classic work *The House of God* [1] has become an unfortunately true portrayal of medical training rather than a sour satire.

To better understand Dr. Fish’s disposition in the ED, one must first understand the “hidden curriculum” that has trained him. In their seminal work, Hafferty and Franks expose the socialization process within medical education that teaches students (largely without their knowing) to regard the patient and their medical colleagues as “objects of work and sources of frustration, and antagonism” [2]. In this process of indoctrination, even the most virtuous and rightly resolved student succumbs to a culture that facilitates or even rewards Dr. Fish’s practice in the ED. This indoctrination does not absolve Dr. Fish of his personal responsibilities; rather he is the “canary in the coal mine,” calling attention to our diseased training process and culture.

Hafferty and Franks clearly and correctly identify this problem, but only start to develop a solution. They recommend a top-down acknowledgement, understanding, and correction of our professional culture as physicians (or at least of faculty physicians). And while their ten-page work makes great strides in the first two steps, it does not suggest exactly how to effect that change in our culture. Many advocate that exposure to various aspects of the humanities during the medical-school years is the next step needed to move this cultural shift along.

In 2014, Boudreau and Fuks, in reviewing the historical trends of humanities in medical education—which have largely been peripheral and extracurricular until recently—resurrected an Aristotelian concept of *phronesis* (φρόνησις) [3]. This characterization of practical wisdom as combining “disposition, reasoning and action” in the development of a particular moral actor may offer a framework for understanding the role of humanities in physician education. Alasdair MacIntyre’s important work in moral theory, *After Virtue*, argues that through “practicing” activities—be it history, ethics, or even poetry or portrait painting—that exercise positive attributes, values, or virtues, physicians habituate these personal qualities in a more integral way [4]. And, to their credit, medical schools have responded to calls for integration of the humanities into medical education with restructured curricula, mentoring, and expectations to encourage and reward humanist values of honesty, integrity, justice, social awareness, and patient-centered medical care.

Now, close friends may identify this as my dry sarcastic humor surfacing, but what I have concluded from these reflections on medical education and personal virtue is that the first, necessary step for addressing the case of Dr. Fish may be for him to take up poetry, portrait painting, the study of ethics, or some other similar “practice,” to use MacIntyre’s term. But that is too little, too late for Arlene—and maybe even for Dr. Fish. Exactly what specialty Dr. Fish practices and what disease process Arlene has are irrelevant and intentionally ambiguous, because what I believe is most important is that Dr. Fish and I had the same medical school education. We attended the same “patient-based learning” small groups and the same course on ethics and had the same narrative essay assignments—all in a curriculum designed to counteract Hafferty’s “hidden curriculum” and imbue MacIntyre’s habituation of virtuous practices. So what is different about Dr. Fish’s training? There are really only two times at which Dr. Fish’s development could have been changed—premedical education and graduate medical education.

Growing political and economic pressures have resulted in initiatives to promote undergraduate study in science, technology, engineering, and mathematics (“STEM”) [5]. While few if any have called for a reciprocal de-emphasis on the humanities, the effect of this pressure is obvious. There has been a clear increase in STEM majors—with a rise in engineering majors, for example, of roughly 57 percent over the last decade [6]. Furthermore, undergraduate curricula largely allow students to select whichever courses suit them after basic core requirements are satisfied. While this allows for a wonderful diversity of experience and opportunity to explore new interests, it also allows undergraduates to select coursework with

their GPAs rather than educational goals in mind. The observational research on STEM statistics demonstrates clear trends between the larger economic and job pressures and students' majors since the 1970s [5]. And this is not a new trend—I myself was advised out of an advanced philosophy course with a not-so-subtle allusion to the fact that the grade I received in this difficult advanced course could hurt my application to medical school. I was viewed as quite unusual on the interview trail when I ultimately added a major in philosophy. Thus, the components were available in the undergraduate curriculum for all students to engage in personal and professional development, if premedical educators were to follow medical schools' lead and incorporate those components into the premed curriculum.

But even then, study of the humanities in the premed years would not suffice. I would like to blame a difference in our premedical foundations in humanities as the difference between Dr. Fish and me, citing my intentional training in humanities which introduced me to a virtuous, patient-centered practice of the medicine I had yet to learn, contrasted with his “cake” classes and ambivalent checking-off of requirements. But the truth is Dr. Fish and I are not different at all. In fact, I *was* Dr. Fish just a few months ago while rotating off service, and I embarrassingly do not know anything about Arlene's personal story. I continue to wonder, as I reflect on my undergraduate and medical school educations which so keenly integrated the humanities, how could that have come to be?

The answer lies again in the insidious and robust hidden curriculum. Interns and senior residents are just as susceptible—perhaps more so—to unspoken institutional cultures and pressures. As residents become more specialized and advanced in their training, they become all the more likely to assimilate to their environmental influences. In other words, it is much easier for an emergency medicine resident to say “that isn't an emergency” than it would be for the undifferentiated medical student who only sees a patient in pain. (In fact, this is what has led the medical student section of the American Medical Association to serve as a “moral barometer” for the General Assembly.) What these examples show us is that something critical happens after medical school to adversely affect our moral characters as physicians. This is the hidden curriculum of what we call residency.

Yet, while residents may be all the more vulnerable to the hidden curriculum pressures, few residency programs can boast a robust, integrated training program in the humanities that develops their residents' virtue beyond medical knowledge and technical skills—despite the Accreditation Council for Graduate Medical Education's having listed “professionalism” and “interpersonal skills and communication” as required core competencies for all residency training programs [6]. Yet, using our emergency medicine residency program at the University of Iowa as a representative example, only this year—after training emergency physicians for more than 11 years—did we develop a dedicated, intentional curriculum in medical ethics beyond didactic PowerPoint presentations on the Emergency Medical Treatment and Labor Act (EMTALA) and the “four principles.” And while this is an important step for us, it remains stridently away from the emerging medical school

standard of integrated humanities training to promote the development of empathy, social awareness, honesty, and patient-centered medical practices. Certainly mentorship from our fantastic faculty core can be cited as the primary mechanism for professional development, but this overlooks two objections: first, role modeling, while important, does not have the integrating power of habituated practices for moral development, and, second, if our faculty are themselves products of this medical training culture, how can we expect anything other than the same “hidden curriculum” mistakes?

In conclusion, while we may be seeing an explosive proliferation of literature and programs on integrating the humanities into medical school education, its presence in the training of premedical students and resident physicians is minimal and possibly even decreasing. Medical school is only one step on the developmental continuum of training the virtuous physician. If our understanding that medical training as a process of moral enculturation is correct—and I believe it is—then we must now expand our efforts to develop the integration of humanities training (not just teaching) into the premedical and graduate medical education spheres.

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Nicholas Kluesner, MD, is chief resident in the Department of Emergency Medicine at the University of Iowa Hospitals and Clinics in Iowa City. He did his premedical training at the University of Notre Dame, studying biology and philosophy, and received his medical school education at the University of Iowa Carver College of Medicine with distinctions in service and global health. He is a member of the Iowa Medical Society’s Committee on Law and Ethics and the University of Iowa Hospitals and Clinic’s Ethics Subcommittee.

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