POETRY FOR PHYSICIANS:
DEVELOPING AN INTEGRATED MEDICAL HUMANITIES CURRICULUM

I. SLIDE 1 – TITLE; personal introductions (**Johanna, Desiree, Elizabeth**) 5 min

II. SLIDE 2,3,4 – Poem "Doctors" read and discuss (**Desiree**) 5 min.

III. SLIDE 5 - GOALS AND OBJECTIVES I (**Johanna)** 5 min total
By the end of this seminar, participants will be able to do the following:
   A. State the relevance of medical humanities curriculum to medical professionalism, including
      1. self-awareness
      2. empathy
      3. communication skills
      4. patient and family-centered care
      5. ethical decision-making
   B. Identify key components of an integrated medical humanities curriculum
      1. Horizontal coherence
      2. Vertical complexity
      3. Graduated application to patient care
      4. Required (baseline) as well as optional (in-depth) components
   C. Construct appropriate medical humanities courses and course components, including how to:
      1. Select useful and relevant readings
      2. Develop discussion guides
      3. Link medical humanities to patient care

IV. SLIDE 6 GOALS AND OBJECTIVES II (**Johanna**)
   A. Have ideas about how to instigate humanities-related faculty development
   B. Plan successful implementation of a medical humanities curriculum, including
      1. Start-up and administrative buy-in
      2. Core faculty
      3. Student involvement
      4. Funding and legitimacy
   C. Develop systematic and innovative evaluation strategies for new and/or existing medical humanities courses

V. RATIONALE 10 min total
   A. SLIDE 7 - Theoretical: Why teach medical humanities? (**Elizabeth** – mini-discussion) 3 min.
      1. Appreciation for other perspectives and points of view through careful attention to language, tone, details
      2. Understanding of illness within the context of the lived life of the patient
      3. Ability to listen as well as talk to the patient
      4. The capacity for empathically imagining the patient's experience

B. SLIDE 8 – Description of needs assessment survey (**Johanna**) 4 min.total
   1. Two needs assessment surveys administered to medical students, family medicine clerkship preceptors, and family practice residents
   2. Surveys focused on uses of literature in medical education, either alone or in relation to other innovative methodologies like EBM and CAM
   3. N=312; overall response rate 68.3% (faculty 50.0%; 3rd yr students 89.8%)

C. SLIDE 9 – Results of survey (**Johanna**)
   1. Overall interest in medical humanities could be described as moderate (4.34-5.60 item means on a 7 pt Likert scale) with students expressing slightly more interest than residents and faculty
   2. Students were more uncertain of the usefulness of medical humanities when compared to both EBM and CAM
   3. Both learners and teachers identified "hard-to-teach" areas of clinical competency, such as death and dying, cross-cultural medicine, and chronic diseases as appropriate areas in which to introduce medical humanities curricular material

D. SLIDE 10 - Philosophical/pragmatic issues (**Desiree**) 3 min.
   1. Content: literature vs. visual and performing arts
      a. Personal preference
      b. Research supporting value of writing as a therapeutic and meaning-making tool (Pennebaker)
   2. Structure: elective vs. selective vs. required
      a. Pragmatic: key institutional faculty wanted to participate
      b. Philosophical: emphasis on integration rather than separation

VI. SLIDE 11 Sir Luke Fildes The Doctor

VII. SLIDE 12 - OVERVIEW OF MEDICAL HUMANITIES CURRICULUM – (**Johanna)** 5 min.total

A. Horizontal coherence
   1. Linking medical humanities material by theme and content to existing courses within a given year
   2. Current: Within PD courses, to be relevant to topics currently being discussed
   3. Future: Involve additional courses such as anatomy in first year, examination of the patient in second year, additional clerkships in 3rd year

B. Vertical complexity
   1. Organizing medical humanities material over the course of trAIning so that it progressively introduces concepts and methods of greater depth and compexity
   2. Current:
      a. PDI superficial exposure to patient point of view
      b. PDII in-depth exposure to patient, then physician, then family points of view, as well as final integration of all three
      c. PDIII switches focus to reflection on interaction with actual patients
      d. Residency – applications of insights into managed care setting

        e. Practicing physicians – emphasis on antidote to burn-out, cynicism
    3. Future:
        a. Family medicine clerkship – supplementary readings and journaling
        b. PDIV – reintegration of humanistic skills; refresher course on patient-as-person
C. Graduated application to patient care
    1. First two years – more hypothetical, speculative, or based on historical experience, tag-alongs
    2. Third year – the initial patient encounter; the student as empathic listener and intermediary
    3. Residency – medical complexity vs. bureaucratic responsibilities vs. humanity
    4. Practicing physicians – reinforcing and rethinking attitudes and habits toward patients

VIII. SLIDE 13 – REQUIRED COURSES (**Johanna**) 5 min. total
- A. Medical student (PDI, PDII, Clerkships – IM, Peds, FM)
- B. Residencies (FM, PM & R)
- C. Faculty (PDII faculty development)

IX. SLIDE 14 – ELECTIVES (**Johanna)**
- A. Medical student (PDI and II)
- B. Residents (FM – resident-as-teacher)
- C. Faculty
    1. PDI – workshop
    2. PDI, II, III, residencies – modeling, co-teaching
    3. All day symposium

X. SLIDE 15 ANCILLARY ACTIVITIES (**Johanna**)
- A. Teaching (FNPs post-Masters program; honors undergraduates)
- B. Special projects
    1. Plexus – journal
    2. Medical Humanities Performing Arts Program
    3. Reading/writing program for cancer patients
- C. Academic links
    1. COM Alumni Association
    2. Humanities Center
    3. School of Arts

XI. SLIDE 16 - SPECIFIC COURSES AND COURSE COMPONENTS: WHAT MEDICAL HUMANITIES LOOKS LIKE AT UCI (**Johanna)**

XII. SLIDE 17 – VAN GOGH PIETA

XIII. Presentation of PDI – (**Elizabeth**) 5 min.
- A. SLIDE 18 –OVERVIEW OF COURSE

B. SLIDE 19 – REQUIRED HUMANITIES COMPONENT
    a. Module readings (example)
    b. Two pov writing assignments (example)
    c. Faculty development – workshop and discussion guides

C. SLIDE 20 – ELECTIVE COURSE
    d. Description of how linked to modules
    e. Description of structure and content
    f. Evaluation (qualitative and quantitative)

XIV. Presentation of PDII – (**Desiree**) 5 min.

A. SLIDE 21 – OVERVIEW OF COURSE

B. SLIDE 22 – MODULES (Required humanities components)
    a. Readings and discussion for each module (example)
    b. Required pov writing for each module (example)
    c. Faculty development – orientation, faculty development sessions, discussion guides
    d. Evaluation (random assignment; professionalism and communication)

C. SLIDE 23 – ASSESSMENT

D. SLIDE 24 – INTERSTATION

XV. SLIDE 25 REQUIRED HUMANITIES COMPONENT PDIII – (**Johanna**) 5 min. total

1. 2 sessions, 3 hr. each
2. Readings and discussion
3. Creative projects (example – Bill)
    a. literary
    b. artistic
    c. performance

XVI. SLIDE 26 QUANTITATIVE EVALUATION (**Johanna)**

A. Subjects 92 3rd year medical students

B. Design – pre-post-post

C. Assessed attitudes toward the value of humanities in helping them to increase understanding of the culture of medicine and enhancing their empathy for patients, self, and colleagues

D. Results: Students showed significantly more positive attitude toward the humanities after participating in the creative project, but no difference after participating in reading discussion groups. Personal creative experience may have a more powerful effect that simply reading the works of others

XVII. SLIDE 27- QUALITATIVE EVALUATION (**Johanna**)

1. Emphasis on student point of view, patient point of view, and combination
2. Students employed a range of tone, including reflective, humorous, ironic, tragic, and empathic/compassionate

3. They tended to focus on some common themes, including the medical education socialization process, the doctor-patient relationship, and the topic of death and dying and the limits of medical intervention

XVIII. SLIDE 28 – MEDHUM BEH SCI COMPLETED MODULES (**Johanna**) 5 min. total

XIX. SLIDE 29 – DESCRIPTION OF MEDHUM BEH SCI SESSIONS (**Johanna**)

A. Structure – informal, noon hour
B. Format – on-site readings
C. Discussion
   1. Basic orientation questions
   2. Message and reaction to message
   3. Encouragement of differences of opinion
   4. Expression of feelings/exercise of imagination
   5. Take-home message for clinical practice

XIX. SLIDE 30 EDVARD MUNCH THE SICK CHILD

XX. SLIDE 31 - START-UP AND IMPLEMENTATION (**Johanna**) 5 min. total

A. Small is beautiful: initial 1st-2nd year elective course
B. Administrative and powerful-other buy-in bottom-up
   1. Pioneering and supportive faculty colleagues
   2. Faculty in positions of influence (course directors, clerkship directors)
   3. Support of chair of department, senior associate dean for medical education, other senior faculty
C. Critical mass
   1. One person can teach an elective
   2. To have an integrated program, need a dedicated core

XXI. SLIDE 32 – START-UP AND IMPLEMENTATION II (**Johanna)**

A. Student involvement
   1. Importance of student advice and participation
   2. Student-initiated projects: Plexus; student interest group, selectives (in development)
B. Funding and legitimacy
   1. Real and symbolic importance of funding
   2. Legitimacy conferred by respected inside others and by nationally recognized outside others – conference

XXII. SLIDE 33 - THE KEY: FACULTY DEVELOPMENT (**Desiree**) 5 min.

A. Informal – getting together/email and sharing enthusiasm, books, ideas
B. Reading group
C. Role-modeling – co-teaching
D. Workshop – either independent, or part of standard orientation

E. All-day conference – external legitimacy

XXIII. SLIDE 34 - THE OTHER KEY: EVALUATION (**Elizabeth**) 5 min.

A. Importance of both systematic and creative methods of evaluation
B. Without data, medical humanities will wither
C. Quantitative –
    1. Well-designed trials of educational interventions
    2. Identification of relevant valid and reliable measures (empathy, values, communication skills)
    3. Word analysis (Pennebaker)
D. Qualitative
    1. Open-ended interviewing
    2. Focus groups

XXIV. SLIDE 35,36,37POEM: THE KNITTED GLOVE (**Elizabeth**) 5 min.

XXV. SLIDE 38 QUESTIONS? 15 min.