The Medical Humanities and the Perils of Curricular Integration

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Abstract

The advent of integration as a feature of contemporary medical curricula can be seen as an advantage for the medical humanities in that it provides a clear implementation strategy for the inclusion of medical humanities content and/or perspectives, while also making its relevance to medical education more apparent. This paper discusses an example of integration of humanities content into a graduate medical education course, raises questions about the desirability of an exclusively integrated approach, and argues for the value of retaining a discrete and coherent disciplinary presence for the medical humanities in medical curricula.

Keywords

Medical humanities; integrated curriculum; medical curriculum; psychosocial aspects; teaching and learning

The Medical Humanities and the Perils of Curricular Integration

Introduction

The concept of integration is now well-established in medical education, and integrated curricula are a common feature of medical schools throughout the world. Whether as a consequence of the introduction, during the latter part of the 20th century, of problem-based learning (PBL) as a key educational method in medical curricula, or in response to contemporary educational theory (Petrie 1976), the notion that students learn best when course content is explicitly integrated across disciplinary boundaries in an authentic context seems hard to argue against. However, such developments have not necessarily made the introduction of medical humanities content any easier or less controversial to judge from the number of journal articles still attempting to justify the place of medical humanities in the medical curriculum (Ousager and Johannessen 2010).ⁱ Yet, on the face of it, the integrated curriculum does seem to offer a ready framework for medical humanities (MH) content in the sense that it facilitates the inclusion of many and various disciplinary perspectives around a central theme or context, often in the form of a clinical case or ‘problem’. The integrated curriculum also provides a convenient counter to objections to the inclusion of MH on the grounds of critiques such as that of a ‘crowded curriculum’ (for discussions, see Shapiro et al. 2009; Evans and Macnaughton 2006; Grant 2002), as it appears to obviate the need for a discrete curricular and discipline-based presence for the material to be integrated. However, in spite of these apparent benefits of integration, we see potential problems associated with this curricular approach.

This paper represents our perceptions of some of the implications of integration for the medical humanities. We do not engage here in discussions around the actual content of such programs. Clearly there continues to be ongoing debate over the precise composition of the medical humanities, which in turn influences the related crucial question of where, and by implication how much, it should be located in the medical curriculum. Whether conceptualized primarily in terms of specific content, as vividly depicted in Grant’s (2002, 46) diagram of ‘pressures on the medical curriculum’, or in more expansive terms such as ‘the methods, content and concepts of the humanities disciplines employed toward a better understanding of the methods, content, concepts and context of medicine’ (Shapiro et

al. 2009, 192) or ‘a diverse field with diverse identities, epistemologies, teaching strategies, and goals’ (Wear 2009, 218), the concept of curricular integration seems to offer for many medical educators the greatest hope of acceptance and effectiveness. This perspective is epitomized by Shapiro and colleagues who argue:

A broader context within which to understand medicine, to conceptualize and develop professionalism, to appreciate the narrative, story-making component of illness and its treatment, and to revisit the concept of humanistic competencies *would also logically lead to an integrated curricular role for the humanities.* (our italics) (195)

While remaining in fundamental agreement with their conclusion, our focus in this article is to nevertheless consider the broader consequences of attempting to teach material related to the behavioral, socio-cultural, ethical and/or public health aspects of medicine in a genuinely integrated approach. By ‘integrated’, we mean to teach and locate such material in the medical curriculum in a way which is predominantly determined by contextual rather than disciplinary considerations, especially in an environment where such material remains manifestly, if not explicitly, subordinate to the biosciences.

The trigger for our exploration of issues of integration came as our institution moved to a new degree model, in which generalist undergraduate degrees form the basis of professional graduate education. For our own medical school, this meant a shift from a six-year undergraduate medical degree (the ‘MBBS’) to a four-year graduate degree (the ‘MD’). This obviously involved a major curriculum revision, and one of the key decisions involved in this process was how to reduce 2.5 years of ‘pre-clinical’ content to one year only, particularly challenging in the case of the behavioral, public health and ‘humanistic’ content of the course.

The new first-year subject of the MD, ‘Foundations of Biomedical Science’ (FBS), was structured

around two key elements: a vertical, systems- and case-based integrated structure typical of contemporary, PBL-inspired medical curricula; and simultaneous horizontal strands reflecting the key disciplines which would help organize student learning while informing their reasoning through the weekly integrated cases. This resulted in ten horizontal strands for the subject: eight individual bioscience disciplines, plus psychological sciences, and population health. The proposal for the humanities-related course content previously organized and taught under the banner of 'Health Practice' in the MBBS curriculum was for the relevant elements to be incorporated under the psychological sciences and population health strands and for the remainder to be 'integrated' into the case-based learning component.

As part of the process of curriculum change, a set of graduate attributes across six domains – Self, Knowledge, Medical Profession, Patients, Society and Health Systems – were developed in consultation with key stakeholders, including members of the public. Medical education staff then drew on these attributes to design the new curriculum to help organize and focus student learning of key content and to ensure consistent and systematic development of the graduate attributes throughout the MD. While some attributes were obviously more relevant to the later years of the course, most would be expected to be at least introduced during the first year of the degree, in order to lay the foundations for future consolidation. In this sense, our curriculum adopted a similar approach to the medical humanities as outlined by Bleakley and colleagues who described their own medical curriculum as supporting not only the learning of knowledge and skills but also learning of values and attributes that constitute an identity (Bleakley, Marshall, and Brömer 2006, 198).

From a purely pragmatic perspective, clearly there needed to be a significant reduction of Health Practice (HP) content at first-year level, simply in order to accommodate the shift from two-and-a-half years of content to a single year. However, the proposal to teach this material in a case-based structure reflected a more profound change. In the previous undergraduate medical curriculum, medical humanities content was taught via a series of five sequential, discrete 'Health Practice' subjects which

covered a broad scope of issues, including doctor/patient roles and interactions; the social and cultural factors influencing health, illness and medical practice; epidemiology and evidence-based practice; psychological aspects of medical practice; and clinical and professional challenges of medical practice. These units were taught via lectures and dedicated tutorials (i.e. separate to the bioscience-oriented PBL tutorials) which, while they referenced the PBL case of the week in terms of the patient details and condition, retained an exclusive focus on the psycho-social, cultural and/or public health aspects of the case. Therefore, the move to a more integrated approach to the teaching and learning of medical humanities content also signified a change in pedagogical approach, not simply a reorganization of the material.

Medical humanities and the concept of integration

The concept of integration of traditionally separate content in a case-based format approach has, as mentioned, become increasingly favored by contemporary medical educators. Without doubt some of this is due to the advent of PBL, one of whose main tenets is an integrated curriculum (usually systems-based) to better achieve one of its key goals of contextual learning (see, for example, Coles 1985; Dolmans and Schmidt 1996; Wood 2003). But the integrated curriculum also sits well with contemporary philosophies of education such as constructivism and 'just-in-time' learning (Beckett, Agashae, and Oliver 2002). Indeed, the extent of integration is nowadays often seen as important indicator of the quality of medical courses (Jones et al. 2001; Prideaux 2009).

Of course, it is important to understand what exactly one means by 'integration'. Earlier theorizing of integration in the medical education context produced a model which distinguished between many different kinds of integration, ranging from 'Isolation' through 'Harmonization' and 'Temporal Coordination' to 'Multi-disciplinary', 'Interdisciplinary' and finally 'Transdisciplinary' (Harden 2000). More recently, Wear (2009, 216) has drawn on the work of Lattuca (2001) to distinguish between informed disciplinarity, synthetic interdisciplinarity, transdisciplinarity, and conceptual interdisciplinarity. While Wear is addressing the potential for interdisciplinarity within the medical

humanities itself, her distinctions, based on the degree to which the various disciplines constrain the students' discourse and understanding, would apply just as well to the medical curriculum as a whole.

Integration has great appeal especially for traditionally 'marginal' subjects, as it offers clearer relevance and legitimacy. Although, as some writers have noted, robust evidence of the beneficial effect of an integrated curriculum is hard to come by (Alleman and Brophy 1993), the underlying philosophy and resultant curriculum seem so intuitively right and the implementation has such high face validity, that the concept of integration tends to be embraced with very little critique. Others, writing from a more explicitly educational perspective, have argued that the greater relevance that an integrated curriculum creates is also more likely to lead to a deeper approach to learning (Prosser and Trigwell 1999).

In the context of medical education, integration of non-science content finds further justification in the fact that medical students have often perceived such content to be uninteresting, marginal and seemingly irrelevant, as exemplified by the following perspective of a teacher of medical ethics:

... [M]edical students learn better when the basic sciences are integrated with clinical case material. The situation is even more critical for the humanities and social sciences. Medical students are notorious for their intolerance of some of these subjects, particularly when taught as separate courses detached from clinical problems. The students learn best when they can bring the particular social science discipline to bear on the solution of a specific medical problem... [M]edical students tend to be pragmatists and to have little patience for theoretical social sciences and even less for philosophy. Therefore, most successful teaching programmes in bioethics for medical personnel appropriately emphasize the use of cases as much as possible, with the theoretical principles derived during a discussion of cases (Glick 1994, 242).

In an environment where the end of course ‘Quality of Teaching’ (QOT) surveys can have major implications for teaching staff, such ‘intolerance’ on the part of students tends to be taken very seriously. A similar phenomenon appears to have influenced our own course committee’s decision to move most of the previous course’s medical humanities-related content into the cases. Despite attempts to make such material more obviously relevant through the design of Health Practice learning activities as through explicit linking to the bioscience-oriented PBL tutorials and modifications to lecture content and presentation, students had continued to complain about the lack of relevance of the content of these subjects, as evidenced by both formal QOT surveys and less formal staff-student meetings.ⁱⁱ A great deal has been written about the role of the hidden curriculum in shaping students’ attitudes to course content (Hafferty and Franks 1994), and it would seem likely that many similar factors lie at the base of such perceptions held by students. However, from a curricular planning perspective for the new MD, such student responses leave an acute impression, and it is hardly surprising if they influence the way course coordinators seek to present their material. While rigorous evidence of the value of integrated courses may be lacking, there is plenty of anecdotal evidence to suggest that, at the level of student satisfaction at least, many students do seem to react positively to integrated curricula, as reflected by the following student in an integrated medical course at an Australian university:

I mean as a clinician – going to be a clinician – you need to integrate everything you learn. You have to do it anyway, whether you do it in the first year or whether you do it in the third year. If I have to do it I’d rather do it in the first year. And start it straight away. That’s why I (prefer) scenario-based learning (cited in Balasooriya, Hughes, and Toohey 2009, 297).

Clearly, the promise of an integrated curriculum is not just based on pedagogical rationale; it has the potential to improve acceptance of what might otherwise be considered peripheral course material.

In the context of our own graduate medical course, then, it was envisaged that medical humanities

material would be taught, save for a few lectures on specific themes, essentially through an integrated learning approach centered around cases. Each case tutorial would present an opportunity to introduce, and where appropriate, emphasize, the relevant psycho-social and cultural aspects of the case. While all other content, including the related areas of population health and psychological medicine, would have a discrete disciplinary presence as well as an integrated one, no such disciplinary base was proposed for the medical humanities-related content formerly taught as part of the Health Practice subjects. Curriculum inclusion and coherence would be ensured, it was argued, through mapping of the graduate attributes across the curriculum.

Review of the curriculum mapping process

In order to support and monitor this process, the authors undertook, at the end of the initial phase of curriculum mapping, a scoping study to identify which of the relevant first-year graduate attributes could be suitably mapped against a horizontal disciplinary strand and which had no such obvious connection. The purpose was partly to assign, where appropriate, a disciplinary framework for the attributes and partly to ensure that these attributes were ‘deployed’ in the appropriate case. Our review of the attributes against the disciplinary strands suggested that, while the majority of the attributes in the domain of Knowledge, Society and Patient seemed to align naturally with the disciplinary organization of FBS, certain attributes appeared to be at risk of remaining ‘isolated’, in the sense that they remained outside the horizontal, disciplinary component of the curriculum. Specifically, eight attributes, dispersed across the domains of Self, Patient and Society, appeared not to align clearly and coherently with one of the component disciplines (see Table 1).

INSERT TABLE 1 HERE

The humanistic focus of these attributes is clear: empathy, compassion, self-care, emotional understanding, patient perspectives, communication skills, cultural competency, professional service

delivery, and more--all concepts that presumably reflect some of the key content of many medical humanities programs around the world. Their value in the curriculum was subsequently endorsed by the curriculum committee, and their connection with a relevant case reaffirmed, or where appropriate, their place in the curriculum re-assigned to the clinical skills subject in first-year or beyond. However, from a pedagogical perspective, the isolated nature of these attributes and the consequent lack of a coherent theoretical framework for contextualizing their study that might have been provided by an embedded discipline appeared to leave them vulnerable to inadvertent under-representation, if not omission. This concern was underscored by the fact that several of our attributes resembled those rated lowest in importance by medical school faculty experts in the study by Satterfield and colleagues (2010), including spirituality and health, understanding the cultural dimensions of integrative medicine, human development, and patient behavior.

While the notion of integrating and presenting these concepts through a clinical context and at the appropriate point in a case might have an intuitive appeal, they seemed to us to be too important to be left to the possibly serendipitous inclusion of appropriate cases alone. Our review of the mapping of graduate attributes against disciplinary strands therefore seemed to point to an unintended consequence of curriculum integration, namely, that the ‘integrated’ content not only remained contingent on the continued viability of a given case and its appropriate facilitation by faculty tutors, but also that the failure to locate all course attributes in a suitable disciplinary base might also reflect their perceived importance. In other words, whatever was gained by increased relevance might have been lost by isolation and possible attenuation of content. We were reminded of the observation attributed to Robert Frost, that poetry is ‘what is left behind in translation’, and we wondered whether the medical humanities, in our context at least, was what was left behind in curriculum ‘down-sizing’ in the face of limited curriculum space and a predominantly, explicit bioscience orientation.

Discussion

It is often reported by PBL tutors that students commonly resist exploring the psycho-social and/or cultural aspects of a case, no matter how much importance they may be assigned within a course (Benbassat et al. 2003). In some cases, the same might also be said for the tutors themselves, especially when they are employed on the basis of an advanced academic background in the biosciences. While a committed and well-briefed tutor can go a considerable way to overcoming this tendency in students, from a curriculum perspective, a disciplinary organizing framework for humanities content seems vital, not only to reinforce the curricular importance of humanities-related attributes but also to provide a meaningful context for the application of the relevant theoretical principles. Mapping course objectives or attributes solely onto cases without an explicit theoretical framework may not result in the intended level of integration, understanding, or acceptance. Rather, the teaching related to each attribute also arguably requires a coherent disciplinary context to support its integration and conceptual basis in the curriculum.

Nor is it enough to simply map medical humanities-related learning objectives, or attributes, against cases to ensure that they are covered. Perspectives which are explored only in the context of cases run the risk of appearing marginal and possibly under-represented in the assessment framework. That assessment drives learning is unarguable, and there is no clearer way of expressing the marginality of content than through absence in the assessment blueprint (Prideaux 2009, 185).

Some writers have challenged the notion of forms of interdisciplinarity, including integrated curricula, as untenable from a scholarly perspective, citing the perceived lack of disciplinary rigor and methodological confusion which such approaches arguably entail. (see Lattuca 2001; Petrie 1976). Our critique is different. We accept the purported pedagogical and professional benefits of integration for undergraduate (or graduate) medical courses, agreeing that any rational method that explicitly and coherently assists students in overcoming the contextual specificity of disciplinary-based knowledge is of great value (Regehr and Norman 1996). But we also believe that effective integration must start from the assumption that all subjects are inherently equal; not necessarily in the sense of equivalent

teaching space, but certainly of inherent value in the context of students' learning. Where this is not the case or where this view is undermined by other forces, such as the hidden curriculum, the very aims of integration are undermined. The following expression of one student's experience of an integrated first-year course is instructive:

Why do we need to know the social issues when we don't even know the basic scientific stuff? I just don't feel that's important at the moment. We're still in Med 1 – we haven't practiced at all. Maybe it would have been useful later on in Med 6 or something (cited in Balasooriya, Hughes, and Toohey 2009, 297).

For such students, there is a clear hierarchy in the value of different components of the medical course, and any attempt at integrating the 'social issues' through cases alone will most likely fail to convince them that all perspectives are equally important at this stage of their medical education.

Value of the medical humanities concept

So, we ask, why was it deemed appropriate for the medical humanities-related attributes to be addressed through integrated activities alone, while the remaining course content had *both* an integrated and a discrete disciplinary structure? The answer to this may ultimately rest on differing conceptions of what is valid as knowledge. The existence of seemingly irreconcilable differences between the sciences and the humanities has been regularly discussed (see, for example, Brockman 1995; Bruner 1986; Gould 2003), and the so-called qualitative/quantitative debate still unsettles many in contexts where the sciences and humanities meet, as ironically suggested by the title of a recent paper, 'Real men don't collect soft data' (Gherardi and Turner 2002). In such contexts, the 'evidence base' for medical humanities is seen as inadequate, and the relative dearth of studies purporting to provide quantitative evidence of the effectiveness of medical humanities in medical education may yet reinforce this view even further (Ousager and Johannessen 2010). However, this is to ignore the fundamentally qualitative nature of educational research as a whole and the politically and socially delicate context which educational activities usually occupy. For this and other reasons, educational

research has been called the ‘hardest science of all’ (Berlinger 2002), and medical humanities in the context of medical education suffers from similar challenges of execution and perception.

This provides another explanation as to why medical humanities content might be so blithely incorporated into a medical curriculum without any explicit or dedicated disciplinary space – the perception that it lacks legitimacy as a discipline. For many, the very idea of a ‘medical humanities’ seems unsatisfactory, if not absurd (Campo 2005; Knight 2006). And yet, as Knight (2006) has demonstrated, many clinicians and medical educators who express a lack of interest in or even resistance to the notion, nevertheless subscribe to its basic underlying principles. Perhaps, as a consequence, many current medical courses, at least in Australia, address medical humanities-oriented content and objectives under ‘safe’ titles such as ‘Health and Society’ or ‘Medicine in Practice’. Such titles, or perhaps ‘euphemisms’ is the correct word, have the advantage of being broad and inclusive while suggesting practical relevance (Evans and Greaves 2002). But if such euphemisms are necessary to ensure the inclusion of medical humanities content in a medical course, then the potential typological confusion seems a small price to pay – as long as the underlying shared content and methodology with the medical humanities is recognized and understood by the educators themselves.

Our experiences of the transition between course structures lead us to express caution about the wholesale and exclusive adoption of an integrated approach to teaching medical humanities content in a medical course. The promise of integration is great: clear relevance to the core medical curriculum and therefore legitimacy; a modeling of a professionally-relevant trans-disciplinary approach, in which the knowledge and methods of the humanities and social sciences disciplines are utilized to support the authenticity and applicability of biomedical knowledge; and an approach to professional education which derives pedagogical justification from notions of ‘just-in-time’ learning, where students are provided the information they need at a time which fits in with overall curricular and disciplinary developmental objectives (Beckett, Agashae, and Oliver 2002). For many who have taught on the margins of curricular relevance, such an integrated approach can appear to be the silver

bullet to reconcile the various competing demands on the curriculum. Yet there is a real danger in sacrificing the coherence of disciplinary self-containment for the lure of greater, or at least more apparent, relevance through integration. Bleakley and colleagues have sounded a similar caution against ‘favouring relevance over meaningfulness in learning’, arguing that this is likely to result in the medical humanities being introduced ‘against the grain’ and constructed as ‘compensatory, never gaining a foothold in the core provision’ (Bleakley, Marshall, and Brömer 2006, 202). The allure of relevance may in fact turn out be an illusion, as an integrated medical humanities certainly does not guarantee an *integral* place in the curriculum.ⁱⁱⁱ

We therefore argue that the inclusion of an identifiable, discrete medical humanities discipline derives its own justification from pedagogical considerations, namely, as a unifying framework for the teaching of a potentially disparate group of attributes which cut across course domains but are ultimately focused on humanistic outcomes. While an integrated curriculum structure may provide medical humanities material with the necessary relevance, this should not come at the cost of sacrificing its claim to core disciplinary presence. The academic discipline of medical humanities offers an explicit, coherent and, by now, well-established framework for teaching, assessing and organizing humanistic content within the medical curriculum. Although such frameworks often go by alternative designations, the explicit link with a body of disciplinary knowledge and method through the ‘medical humanities’ framework is crucial, we believe, to help promote curricular coherence, to contribute to methodological consistency, and to underpin the teaching associated with the relevant desired attributes. Disputes will inevitably continue about which theory or content merits inclusion in the curriculum, but one thing which should not be overlooked is the importance of a disciplinary ‘base’ in the medical curriculum where such material can be explicitly located and against which course attributes can be clearly aligned and coherently taught. This is arguably one of the major advantages which the ‘medical humanities’ can offer a medical course.

Endnotes

ⁱ According to these authors, approximately 30% of published articles on the subject over the past ten or so years could be classified as 'pleading the case' for the inclusion of the Medical Humanities in the undergraduate medical course.

ⁱⁱ It should be pointed out that in staff-student meetings, the opposite view was also occasionally expressed by a minority, usually older, graduate entry students. Unfortunately they are not identified as such in the anonymous QOT surveys.

ⁱⁱⁱ Interestingly, while the medical humanities is commonly criticised for the lack of unequivocal evidence regarding its effectiveness, a similar lack of evidence could be levelled at the increase in curricular time given to science content in the medical curriculum over many years. The link between more science and better medical practice seems to be taken as self-evident and only very occasionally questioned (cf Berguer 2004). In other words, curriculum decisions, whether about science or humanities content, would appear to be very often based on policy rather than pedagogical evidence.

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Table 1: Attributes not based within a disciplinary strand

- an understanding of the principles of empathy, compassion, honesty, integrity, altruism, resilience and lifelong curiosity; the ability to demonstrate them and a recognition of their importance in health care (*Self #1*)
- the ability to recognize and manage emotion in themselves and others (*Self #8*)
- the ability to maintain their own physical, emotional, social and spiritual health and a recognition of the importance of professional support in this process (*Self #9*)
- a recognition of their own personal, spiritual, cultural or religious beliefs and an awareness that these beliefs must not prevent the provision of adequate and appropriate care to the patient (*Self #10*)
- the ability to communicate with patients from diverse backgrounds including the ability to listen to, respond to, inform and understand the patient's perspective (*Patient #2*)
- an understanding of factors affecting human relationships and the psychological, cultural and spiritual well-being of patients (*Patient #4*)
- an understanding of the principles of the care of the dying and a commitment to ease pain and suffering in all patients (*Patient #6*)
- the ability to respect community values, including an appreciation of a diversity of backgrounds and cultural values (*Society #7*)