STUDI DI SOCIOLOGIA, 2023, Special issue, pp. 65-82
Published online November 2023

REFORMING A HEALTH HUMANITIES CURRICULUM: INCORPORATING SOCIAL JUSTICE INTO MEDICAL EDUCATION

Rebecca L. Volpe* - Justen Aprile** - Amanda Cooper***
Katharine B. Dalke**** - Kimberly R. Myers*
Paul Haidet***** - Nancy Adams****** - Bernice L. Hausman*

Abstract. In 2021 the Pennsylvania State University College of Medicine piloted a new Humanities curriculum for entering medical students. The new curriculum permeates the pre-clerkship phase of medical education and focuses on social justice and humanities concepts and skills. This paper outlines the iterative, collaborative curricular development process and describes three new courses and one redesigned course. Coursework includes foundational concepts and frameworks, skill-building in visual thinking and interpretation, the reflexive development of humanistic practice, and a robust conceptual framework for clinical communication. Reflections on the outcomes of the new curriculum include the productive role of theory in course development, challenges associated with deep discussion of difficult topics, and complexities associated with variable learner preparation in the humanities.

Keywords: Medical education, Health humanities, Social justice, Pre-clerkship curriculum.
ISSN: 0039291X (print) 18277896 (digital)
DOI: 10.26350/000309_000176
To link to this article: https://doi.org/10.26350/000309_000176
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* Rebecca L. Volpe, PhD (corresponding author), Kimberly R. Myers, MA, PhD, Bernice L. Hausman, PhD, Department of Humanities, Penn State College of Medicine. Email Volpe: rvolpe@pennstatehealth.psu.edu. Orcid Volpe: 0000-0003-3406-9498. Email Myers: kmyers2@pennstatehealth.psu.edu. Orcid Myers: https://orcid.org/0000-0002-3028-4337. Email Hausman: bhausman1@pennstatehealth.psu.edu. Orcid Hausman: 0000-0002-4535-0405.

** Justen Aprile, MD, Departments of Pediatrics and Humanities, Milton S. Hershey Medical Center. Email: japrile1@pennstatehealth.psu.edu. Orcid: 0000-0001-8131-1094.

*** Amanda Cooper, MD, Department of Surgery, Milton S. Hershey Medical Center. Email: acooper2@pennstatehealth.psu.edu. Orcid: 0000-0003-3975-3897.

**** Katharine B. Dalke, MD MBE, Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania. Email: katharine.dalke@pennmedicine.upenn.edu. Orcid: 0000-0002-7557-8603.

***** Paul Haidet, MD MPH, Departments of Medicine, Humanities, and Public Health Sciences, Penn State College of Medicine. Woodward Center for Excellence in Health Sciences Education. Email: phaidet@pennstatehealth.psu.edu. Orcid: 0000-0002-7527-2065.

****** Nancy Adams, MLIS, EdD, Harrell Health Sciences Library, Penn State College of Medicine. Email: nadams@pennstatehealth.psu.edu. Orcid: 0000-0003-0534-6716.

I - INTRODUCTION

The arts and humanities have existed in United States schools of medicine for many decades; however, their structure and purpose has varied widely. Recently the Association of American Medical Colleges (AAMC) – a nonprofit organization that represents American medical schools and teaching hospitals – established the FRAHME initiative, an acronym that stands for Fundamental Role of the Arts and Humanities in Medical Education. As part of this initiative, the AAMC commissioned a scoping review that examined literature dating to 1991 on arts and humanities within medical education (Moniz et al. 2021a, 2021b, 2021c). The FRAHME initiative published a report, which found that "over the past decade, the vast majority of U.S. medical schools have incorporated arts and humanities to varying degrees, and many have found novel and foundational ways to ensure the arts and humanities are valued and incorporated. The content, pedagogy, evaluation, and degree of integration are highly variable, however" (AAMC 2020: 7).

Humanities have always had a strong curricular presence at the Pennsylvania State University College of Medicine (PSCOM), which is situated in Hershey, Pennsylvania. The college opened its doors in 1967 with the first Department of Humanities in a U.S. medical school, and since that time the required Humanities curriculum has remained amongst the most robust in the U.S. (Klugman 2017). Through various iterations of curricula, the purposes of humanities learning in medical education at PSCOM continue to be remarkably similar. As Hawkins, Ballard, and Hufford wrote of the curriculum in 2003,

> The rationale for our program 35 years ago was to respond to problems brought about by rapidly increasing knowledge and technology in medical science. There was a concern that despite the benefits of such advances, medical technology was tending to preempt medicine's long-standing concern for human values. Today, the rationale behind a humanities component in medical education is even stronger, with the need to reassert the values of the profession in the wake of managed care and its business ethic, the fact that physicians must be able to serve an increasingly culturally diverse population, and the problems posed by technological advances in fields like genetics. The mission of the [Humanities] Department is a function of this rationale: to engender a critical awareness of the values, presuppositions, and methods that undergird medical education and practice; an appreciation for ethical issues in medicine; empathy for the patient's experience of illness; awareness of social values and beliefs that shape the behaviors and expectations of patients, physicians, and research; a critical understanding of one's own capabilities and limitations; and a self-perpetuating intellectual curiosity (Hawkins - Ballard - Hufford 2003: 1002).

In 2020 through to the end of 2021, we revised the Humanities pre-clerkship curriculum[1] to sharpen the focus on social justice and cultural responsiveness. This article

[1] At PSCOM, the pre-clerkship phase of medical school is the first 18 months of curriculum and focuses on foundational biomedical sciences, health systems science, clinical skills, and health humanities. The learning occurs mostly in a classroom setting; however, students are also exposed directly and regularly to patient encounters.

presents an account of where we started and what our goals were, how the new courses were conceptualized and developed, our collaborative process, and challenges we have faced in piloting the new curriculum.

1.1. *Where we started from and where we ended up*

In the later 2010s, medical educators at PSCOM were looking to enhance multicultural and social justice elements of the curriculum, revising problem-based learning case studies, examining learning objectives, and addressing specific instances of discriminatory language and concepts across the curriculum. Summer 2020 was a tipping point. The Covid pandemic had revealed significant health disparities, especially with regard to racial groups in the United States, and the murders of Breonna Taylor and George Floyd, African Americans killed by American police officers, had created a renewed sense of urgency to address structural injustice. This social crisis galvanized medical educators to include more humanities content focused on social justice. We wanted to increase curricular attention to urgent issues of social concern while still engaging students whose primary focus is developing knowledge and skills for professional practice. Because we already had a significant footprint in the pre-clerkship curriculum, we had an opportunity to develop a series of courses that built on one another. Such scaffolding became an important goal of the revised curriculum.

Prior to the recent revision, the Humanities curriculum included the following: five distinct courses in the 18-month pre-clerkship phase, a small-group debriefing course during clerkships, and a required month-long seminar in the students' final year. The pre-clerkship courses included exploration of the doctor-patient relationship, the biopsychosocial model of health, critical thinking, ethics and professionalism, and communication. The courses were led primarily by faculty from the Department of Humanities but operated separately, without explicit attention to longitudinal learning goals across the pre-clerkship phase, let alone into future phases. In the self-study required by the Licensing Committee on Medical Education (LCME, the accrediting body for educational programs at schools of medicine in the United States and Canada), students voiced concerns about redundancy of content and insufficient focus on diversity in the Humanities curriculum.

The newly revised pre-clerkship curriculum now consists of four courses, three offered in the first year and one in the second. In the first year, Foundations of Health Humanities (FHH) focuses on social justice frameworks and health humanities concepts. This 12-week course introduces students to anthropological perspectives on culture, the social construction of reality, and narrative medicine, with attention to race, disability, gender, and implicit bias. The next course, Observation and Interpretation (O&I), is 8 weeks long and focuses on Visual Thinking Skills (VTS), using works of art coupled with clinical images to cultivate skilled observation and evidence-based interpretations of visual details. The final first-year course is Humanities in Context (HIC), a 20-week course that develops students' "humanistic practice" through learning in three content domains – the patient and doctor as persons, power and privilege in medicine, and ethics. In the second year, Communication is a 15-week course that focuses

on patient-provider communication using Epstein and Street's six-function framework for patient-centered communication (Epstein - Street Jr 2007).

1.2. *Our process*

We launched the new curriculum in the fall of 2021. Our curricular renewal process, which began roughly 13 months earlier, was iterative throughout and painstakingly slow at the beginning. We began with a large group of interested students and faculty and then transitioned to a smaller group of faculty and students committed to meeting weekly (hereafter referred to as the "Friday Group"). One outcome of the large-group process was a Humanities Curricular Vision Statement:

> Health Humanities is intrinsic to medical education, developing students' capacities to approach patients as whole persons. Health Humanities learning experiences cultivate knowledge for practice and critical engagement by focusing on content, skills, and behaviors that advance humanism in medicine and society.

From this vision we created six curricular goals:

1. Demonstrate cultural humility
2. Demonstrate critical habits of mind
3. Demonstrate cognitive and affective integration
4. Demonstrate professional and ethical behavior
5. Communicate effectively in interpersonal encounters
6. Develop a humanistic professional identity

The weekly meetings of the Friday Group were conducted on Zoom. Robust and open-ended discussion was the rule at each meeting. The department chair (BH) convened each meeting and took lengthy notes, disseminating them with the agenda for the next meeting. These notes became an important record of our progress as well as areas of disagreement. Disagreements were noted in the meeting minutes and discussed thoroughly. Most of the time the Friday Group was able to come to a consensus. At other times, the department chair steered decision-making more directly.

One such decision involved the second pre-clerkship year. For weeks the group discussed a potential second "foundations" course to begin the second year, followed by the preexisting Communications course. The department chair suggested that since weeks of discussion had not led to a consensus on the question of a second foundations course, we might consider expanding the Communications course so that its goals were not cramped by its proposed 9-week slot in the schedule. Some members of the Friday group agreed with this idea, citing the benefit of purposefully integrating learning from first year Humanities courses to improve communication practices, a move thought to be appealing to students. Those against expansion lamented the loss of key humanities learning goals in the process, including attention to suffering, caregiving, and addiction, a variety of learning activities including live performances and interviews. The decision to expand Communication was implemented, but it was not one that garnered

support from all members of the Friday Group. Continuing curricular discussions are considering how to implement some lost learning objectives in a new post-clerkship course, but this process demonstrates overall the difficulties of removing curricular content that was understood to be meaningful to students.

Discussions in the Friday Group were focused on high-level visions of course outlines and goals. Once these basics for a course were agreed on, the course went to a design team led by the presumptive course directors. Ideally, those teams were responsible for collaboratively developing specific course goals and learning objectives, creating a course proposal and initial syllabus, designing session guides and assessments, gathering all course material, and periodically reporting back to the Friday Group for consultation. In practice, the course directors did the heavy lifting on all these tasks, largely because of time constraints and the difficulty of meeting with larger groups to coordinate specific tasks.

The Friday Group also engineered changes to the evaluations used for Humanities courses at PSCOM. New evaluations for student participation and engagement in small-groups, small-group facilitators, and each course as a whole were created to be consistent with the new curricular goals. Assessments within each course to measure student learning were aligned with the course learning objectives and scaffolded across the curriculum to measure longitudinal development in learners. Each course developed a final summative exam, which was not common in the prior curriculum.

The Humanities department chair updated various stakeholder groups during the entire process, both for informational purposes and for guidance. For example, the clerkship directors offered insight into what students needed to know going into their clinical experiences. This process of keeping numerous groups and individuals apprised of the curricular revision process and the emerging content of new courses was critical to success in the implementation phase, as all those who needed to approve the courses and new curricular emphases had already agreed with and contributed to the overarching need for and purpose of the new curriculum.

1.3. *Where we are now*

At PSCOM, we run between 18 and 22 faculty-facilitated small-group sections for each Humanities course in the pre-clerkship phase. FHH and O&I are both run entirely in small-groups, although in its first iteration O&I included large-group plenary sessions. HIC is a mixture of large and small-group sessions, with plenaries conducted via Zoom while the students remain in small-group rooms. Communication is a mix of two-hour large group sessions and two-hour faculty-facilitated small-group sessions. The demand for so many small-group faculty facilitators means that the pre-clerkship Humanities courses often use clinical educators with little or no disciplinary training in the humanities. Course directors hold training sessions and provide detailed session guides to promote active and engaged learning by all participants. For the most part, faculty are considered learners alongside their students.

II - THE CURRICULUM

2.1. *Foundations of Health Humanities (FHH)*

FHH meets weekly for 2 hours during the first 12 weeks of the first year, after a one-week Transition to Medical School course. The FHH course goals are:

– To utilize and deploy concepts from humanities and social science disciplines in the practice of medicine

– To understand oneself as an individual as well as a member of a group or groups that influence one's values, behaviors, and thought processes

– To develop skills in narrative analysis

– To imagine and act on new ways of thinking and doing that can change health care and social traditions of injustice

– To develop a reflective communication practice in groups

The course focuses on the *social construction of reality*, which includes the traditions, beliefs, values, identities, biases, and patterns of living that are created by people as they live their lives. Exploring issues through the lens of social construction allows productive discussion of three major issues: disability as co-constructed through the experience of impairment in a world that is built for people without disabilities; race as a concept describing social groups that share health outcomes due to racism and structural discrimination; and illness itself, which is explored through its construction in relation to gender and sexuality. Class sessions draw on the processes of narrative medicine, particularly close readings of short fiction, essays, film, and comics.

Small-group discussions actively engage learners in understanding the medical and social relevance of the week's topic. Sessions may include watching a short video or reading a brief essay. All FHH sessions begin with a brief in-class writing.

For example, for the session on "The History of Race as a Concept," students read a comic called "What is Race?" (Taylor 2017) along with an excerpt from an article on Anti-Asian racism during Covid (Perng - Dhaliwal 2022). A comic about Latinx identity (Gil 2017) and excerpts from Trevor Noah's book *Born a Crime* (Noah 2016) are included as optional Go Deeper readings. The first half of class focuses on two learning objectives: (1) Identify historical evidence of race as a social construction and (2) Appraise graphic medicine as a vehicle for the understanding of the social construction of race. A writing prompt asks student to respond to one of the comics. The second half of the class focuses on a third learning objective: (3) Describe how the social constructions of race and ethnicity impact health. Each group watches a 14-minute Ted Talk by Dorothy Roberts, "The Problem with Race-Based Medicine" (Roberts 2015). Discussion prompts address similarities between the way race has been constructed in the U.S. and other places, as well as differences between the concept of *genetic ancestry* and *race*. All groups submit a lingering question about the relationship of race to health.

FHH has three summative assessments of student learning (an essay, an implicit bias project, and a final exam) and an evaluation of student engagement in small

groups. There are also two collaborative essays that serve as formative assessments and preparation for the final exam. Students must meet expectations for all assignments and engagement in the small group to pass the course. Students also write a nongraded self-evaluation that asks them to reflect on one or more elements of the course at which they excelled. These reflective essays provide robust data for the success of the course and a counterpoint to the numerical course assessment data.

Student feedback on the course has been lower for FHH than for the other new courses in the curriculum, garnering a 3.7 and 3.6 out of 5.0 in the first two iterations for overall quality of the course. Scores for faculty facilitators in small groups is higher, with most in the range between 4.5 and 5.0. Narrative feedback indicates that the course provides a necessary context for learning about controversial yet essential topics and for having difficult conversations that emerge in medical practice. The small-group format and course materials were also praised by many students. The primary area students identified for improvement is addressing students' diverse educational backgrounds in humanities and the dialogue space, a problem that is compounded by the relative lack of demographic diversity in our student body and facilitator corps. Underlying these concerns may be learner discomfort with feeling compelled to share personal knowledge based on identity characteristics. Creating a productive dialogue space is challenging due to many factors, including prior experience with feelings of vulnerability in learning spaces, rather than empowering collaborations across difference. To address these issues, the course directors (BH and NA) are leading a series of discussions with facilitators about creating the dialogue space (Herzig - Chasin 2018) and developing strong conversation agreements to facilitate humanities learning. (See Section III for more on this issue)

2.2. *Observation & Interpretation (O&I)*

O&I meets weekly for 2 hours during the 8 weeks of the fall term that follow FHH. The course is based on the understanding that medical decision-making and art interpretation are similar in that they both rely on identification of key pieces of data, recognition of patterns in the data gathered, and interpretation and *re*interpretation of both data and patterns (Shapiro - Rucker - Beck 2006). Physicians are charged with developing a number of skills over the course of their training, not least of which is the skill of meaningful and thorough observation. From the observation of patient charts, lab results, and imaging to the more obvious scrutiny of physical exams, physicians must rely on their observational skills to fully and holistically interpret information and provide patient-centered care and treatment. The goal of O&I is therefore to hone skills necessary for the effective practice of clinical medicine: systematic observation, holistic interpretation, and lucid communication. To meet this overarching goal, students are invited to examine complex works of art as well as clinical images.

The principal conceptual frameworks for O&I are Visual Thinking Strategies (VTS) and Reader Response theory, both of which challenge students to see things that others do not and to see things *differently* from how others see them. Creating a brave space (Arao - Clemens 2013) in which students discuss and grapple with diver-

gent viewpoints in small-group learning provides the initial scaffolding for students' future capacity to appreciate complex and rarely straightforward patients, continually adapt strategies to manage and communicate about disease processes, and comprehend patients' lived experiences.

VTS mirrors the clinical process of formulating a differential diagnosis, then narrowing that diagnosis through explicit reasoning. The first task is to encourage students to identify and discuss multiple, divergent interpretations of visual data. By exploring what various group members experience in viewing a piece of art, all members come to understand that personal perspectives are limited and, by extension, that a patients' lived experiences of illness is unique and personal. The course also emphasizes close listening to others' observations, a practice that enhances understanding and empathy while underscoring the collaboration necessary for effective team-based approaches to patient care.

One example of the small-group experience is observing and interpreting Titus Kaphar's *Analogous Colors*, which appeared on the cover of the June 15, 2020 issue of *Time* magazine (Kaphar 2020). Using a red border highlighting the names of thirty-five Black men and women whose lives were lost at the hands of police, Kaphar frames a picture of a Black mother holding the silhouette of a child. Students identify formal properties of the image (e.g., line, color, shape) to arrive at plausible interpretations of what is happening in the picture and to consider the chosen form. Observing this work in the aftermath of George Floyd's killing by police in Minneapolis, Minnesota, students think critically about how individual parts of the image contribute to interpretations and nuances of the whole. Further, students are urged to go deeper: What elements of a "reading" are congruous with a given "diagnosis" they propose and what does not seem to fit? To what extent should an interpretation be reconsidered if not all the data support that reading?

The course has three formative assessments: a 55-word story, a collaborative interpretation of a work of art, and a short presentation of a work of art. The summative assessment is a final exam essay in which all students independently analyze the same painting. These essays are assessed using a standardized and validated rubric. Students are also evaluated by their facilitators on their engagement and participation in the small groups.

The course received an overall quality score of 4.0 out of 5.0 for both year 1 and 2 of its implementation. Narrative feedback extolled the course for offering "a break" from the scientific rigors of basic science courses and slow, effortful system 1 thinking (Kahneman 2011). Students found an anxious excitement at being forced out of their comfort areas to not only explore art, but come to understand how the interpretation of that art lends itself to patient- and family-centered care. Some students struggled to appreciate this relationship, even though it is one of the course's core learning objectives. This gap reveals an opportunity for more persuasive pairings of visual art and clinical images. Some students found the rubric and grading guide for the practice and summative exams confusing and seemingly subjective. This aspect of the course, in particular, will be a primary point of clarification in the future for the course directors (JA and KM).

2.3. *Humanities in Context*

HIC meets weekly for two hours from January through May in the first year. The course includes both large group plenaries, delivered via Zoom within the small-group rooms, and small-group discussions. Most, but not all, sessions contain a large group component with the balance of the course weighted towards small-group discussion.

The overarching goal of HIC is for students to begin applying humanities concepts to clinical scenarios via a process of *humanistic practice*. The course operationalizes humanistic practice as 1) noticing that a scenario requires a humanities-informed response; 2) applying relevant humanities knowledge and skills to a tailored interpersonal and behavioral strategy; 3) reflecting on the effectiveness of that strategy; and 4) deliberately reflecting on the outcome to guide future practice. The course directors (KD and RV) adapted the concept of humanistic practice from the established concept of ethical sensitivity (Muramatsu - Nakamura - Okada - Katayama - Ojima 2019; Rest 1979; Volpe - Hausman - Dalke; Weaver - Morse 2006). Ethical sensitivity refers to the ability to notice ethical dilemmas in clinical practice and can dramatically enhance the likelihood of an ethically appropriate response. Ethical sensitivity thus offers a model for considering how humanities education changes medical students' approaches to common clinical challenges. While humanistic practice could be applied across a wide range of humanities topics, HIC focuses on applying humanistic practice strategies to understand the experiences of the doctor and the patient within the societal context of medicine. We do this by engaging with three content cores: 1) Patient and doctor as persons; 2) Power and privilege in medicine, and 3) Ethics.

A session on justice and scarce resource allocation during the COVID-19 pandemic exemplifies HIC's integration of theory, practice, and social justice. The learning objectives for the session include: 1) Describe the principle of justice in biomedical ethics; 2) Summarize a multi-principle allocation framework for distributing scarce critical care resources during a public health emergency, and 3) Apply the principle of justice to potential inequities perpetuated by the allocation strategies that were initially used. In preparation, students read our hospital's first pandemic-era policy on allocation of scarce critical care resources and a brief conceptual piece about justice (Velasquez et al. 1990).

A detailed session guide scaffolds the two hours of small-group discussion. In the first hour, students individually write a brief, plain language summary of the hospital policy and analyze how the policy fails or succeeds with respect to justice. The group then discusses the summary and analysis and explores just resource allocation during a pandemic. An exemplar question is, "Should healthcare workers who are essential to the pandemic response receive priority for scarce resources, even if this de-prioritizes other essential workers like police officers and grocery store clerks?". Subsequent discussion topics include questions about prioritization based on vaccination status and co-morbidity.

In the second hour, the discussion focuses distinctly on equity. Students read aloud from a representative critique that challenges the initial allocation strategies, such as the assigned hospital policy, for perpetuating structural inequities (Chomilo - Heard-

Garris - DeSilva - Blackstock 2020). Students then evaluate the most common solution to the problem, an "equity-correction" using the area deprivation index (Center for Health Disparaties Research 2023). The session closes with a discussion question that asks the students to synthesize the session's content with the three course cores.

Learner assessment reflects the content and process goals of the course. Student knowledge acquisition is assessed via two formative quizzes and one final summative exam, all of which are short-answer responses to clinical vignettes and conducted outside of class time. Students' humanistic practice is assessed via small-group participation, two brief essays inviting metacognitive reflection on humanistic practice in their in-class writings and out-of-class clinical shadowing, and a one-on-one meeting with the small-group facilitator.

Students rated the overall quality of the course 4.0 out of 5.0. The most common strengths cited in evaluations included fostering deep discussions in small groups, applicability and relevance to clinical medicine, large-group sessions that included guest lectures or panels, and course directors' organizational skills. The most common areas for improvement included too-dense session activities that interrupted organic discussion, the undesirable timing of a few sessions (e.g., a session on failure the week after a major exam), dissatisfaction with assessments, and lack of depth within sessions and topics.

2.4. *Communication*

The Communication course is the only one that remained from the previous Humanities curriculum, although it underwent a total redesign. The previous course was 11 weeks long and was structured as an hour-long plenary followed by an hour-long small-group session. It provided a tiered conceptual framework moving from the self (three sessions), to the patient-physician dyad (four sessions), to healthcare teams (two sessions) and, finally, healthcare systems (two sessions). It also involved some sessions with paid actors who served as Standardized Patients (SPs) and some sessions of student role-play.

The revised Communication course, now fifteen 2-hour sessions in the students' second year, was designed around a different conceptual framework focusing on patient-provider communication with an emphasis on patient-centered care. This new orientation centers the patient-provider relationship, shifts the focus from the provider to the patient, and adopts Epstein and Street's six-function framework for patient-centered communication: Fostering Healing Relationships, Exchanging Information, Making Decisions, Enabling Patient Self-Management, Responding to Emotions, and Managing Uncertainty (Epstein - Street Jr 2007). Sessions alternate between two-hour large-group plenary sessions about these functions and two-hour small-group sessions with SPs and unique patient scenarios for each session. The SP sessions provide students the opportunity to put into practice the communication function discussed the week prior. The shift to longer small-group sessions accomplished several goals, including spacing learning about each function over two weeks, providing the opportunity for each student in a small-group to practice each function, and allowing for repetition (since each student can see 6-7 other students in their small-group work through

different variations of the same scenario). The SPs are trained on these variations so that the students can develop understanding not only of the functions themselves, but also about how the functions need to be improvised to remain patient-centered with different people. The students record their SP interviews by video in order to re-watch them to develop an awareness of the difference between what they were thinking and the actual words they used with the patient.

Course assessments consist of three formative writing assignments (an email to a patient, a transcript of an SP encounter with an analysis of an interaction, and a plan for using communication skills during clerkships), a summative final exam, and an evaluation by the small-group facilitators. The final exam consists of four essay questions which assess students' mental models of Epstein and Street's six communication functions. Two of the essays ask the students to analyze patient-provider interactions they observed in a video. In the other two questions the students are asked to analyze case vignettes.

Course directors (AC and PH) were pleasantly surprised by how well the structure of alternating large- and small-group sessions worked. Feedback from both small-group facilitators and the SPs suggested students effectively implemented the behaviors taught in the course. Feedback from the final course evaluations was also positive. The students rated the overall quality of the course a 4.0 out of 5.0. Narrative comments were generally positive. One student wrote, "Talking to patients and delving into real, complex cases with them was great exposure to what life will be like as a real doctor". Another commented, "Overall, the course did allow me to develop more of my own doctor style by letting me try out different strategies… I'm thankful to have gone through this course". Finally, one student observed, "Absolutely loved this course and thought that it matched really nicely with everything else we have been learning in our second year of school. This by far was the most helpful for developing my interview style and feeling prepared to speak with patients one on one".

The most common constructive feedback received regarded the optional attendance policy for the large group sessions: "The large group sessions should be made mandatory". Further review of comments to this effect, as well as discussions with class representatives, suggests that some students attended the small-group sessions unprepared and had to be brought up to speed before the group could work constructively with the SP. While making attendance at large group sessions might help in this respect, we are actively exploring ways to further engage students with the content of the course and to develop an assessment system that will empower learners and foster a growth mindset.

All students in the course passed the final exam and the course, with some demonstrating remarkably sophisticated analyses of patient-provider interactions. While the true success of the course will not be apparent until the students have completed their clerkships, course directors observed a higher degree of communication skills from the students at the end of this course than was evident in the prior iteration, perhaps in part due to the narrowed focus of the course to concentrate on dyadic communication, which may have decreased cognitive overload for the students, allowing them to more effectively learn key concepts in patient-centered communication. The second is that the opportunities for reflection provided by the formative assessments likely helped solidify the concepts in the minds of the students.

III - CHALLENGES AND OPPORTUNITIES

3.1. *The role of theory in course development is productive*

A recent scoping review of the arts and humanities in medical education demonstrated that the vast majority of humanities literature is not explicitly grounded in a theory or conceptual framework: "The conversation is characterized by brief, episodic installments, privileging a medical orientation (over, say, an artistic orientation), and largely lacking a theoretical frame to weave installments into a larger story that accumulates both over time and across subfields"(Moniz et al. 2021a). In our experience, this lack of theory exists not just within the published literature, but within courses themselves: humanities courses in medical schools, including our own until recently, tend to comprise lists of (albeit important) topics that are not framed epistemically or otherwise. This may occur for several reasons. First, there is as yet no widely agreed upon theory of practice, although Moniz et al.'s Prism Model has gained some recent traction (Moniz et al. 2021b). Second, educators may anticipate that medical students will have limited tolerance for conceptually challenging humanities learning. Finally, budgetary constraints and institutional limits on faculty expertise influence curricular development as well.

In the PSCOM curricular renewal, we sought to integrate strong conceptual models rigorously into our course development and implementation. For example, the foundational course is grounded in the conceptual framework of the social construction of reality. The course explores the social values, traditions, rituals, and representational norms that structure the experience of race, gender, sexual orientation, disability, and illness, and it strives to connect these concepts to the real-life practice of healthcare. As described above, each subsequent course was similarly grounded in, and asked students to develop for themselves, a conceptual model. This robust theoretical framing is important for several reasons, including opposing the hidden curriculum that humanities are soft or easy; contextualizing social justice issues in medicine; and creating scaffolding to support student retention of skills and dispositions. The strong conceptual grounding was also a boon during course development: when the big picture is clear, it is simpler to determine what fits, and what does not, within the confines of a particular course. Finally, as we continue to work with these conceptual frameworks, in particular the model of humanistic practice, we suspect that they may provide structure beyond the pre-clerkship phase of medical education. Humanistic practice may become a link between the theoretical grounding of classroom learning and the training and professional identity formation that happens in the more clinical phases of medical school.

3.2. *Deep discussion about values is harder than ever*

Our Humanities curriculum explores a wide variety of what might be considered sensitive topics, ranging from racism to abortion to disability. Sometimes the session is overtly focused on the sensitive topic (e.g., a session on abortion in the HIC course), and sometimes the sensitive topic is woven in (e.g., a racist emblem on a t-shirt in O&I).

Discussing these hot-button topics in a sociopolitical environment which included the U.S. Supreme Court overturning the constitutional right to abortion, multiple police killings of unarmed Black people, and ever-worsening political polarization, was challenging on at least two levels: the course overall and the dialogue space of small-groups.

Within the course overall, some FHH students and faculty perceived that a liberal sociopolitical agenda was being promoted. A student said: "At times, it felt as though we were being more or less indoctrinated into the type of thinking that the course directors endorsed without being shown other perspectives on the issue at hand" (2021); "The agenda is progressive, which is fine in and of itself. However, the conversations and mediation of those conversations makes it impossible for those of more conservative views to express their opinions because there is no respect regarding those views" (2022). These students may in fact have a point: the curriculum does indeed advance an agenda, but it is an agenda that reflects common values and current thinking in health humanities scholarship and teaching, where progressive social justice and diversity, equity, and inclusion (DEI) stances are endorsed.

Struggles with values also arose within the small groups. These medical students went to college during a pandemic and within a divisive sociopolitical environment. Some evidence suggests they lack educational experiences that challenge their value systems and that ask them to engage directly with others whose views are different from their own (Miller 2022). In an HIC session on gatekeeping and transgender healthcare, students observed a panel discussion that included two transgender people who work in healthcare contexts and a cisgender social worker from a transgender health clinic. In small-group discussions following the panel, students discussed a case in which a transgender woman, who also smokes, requests a prescription from her provider for estradiol. Students discussed the physician's responsibility to weigh the medical risk of a potential complication from estradiol with the patient's right to make that decision for herself. Student feedback, gathered with the assistance of the LGBTQ+ student group, suggested that numerous students experienced personal and emotional distress during the session. Several students witnessed transphobic, homophobic, or sexist statements, actions, or attitudes and some felt that a more conservative viewpoint was excluded. Of note, students also perceived that any distress from the session was outweighed by the benefits of addressing the topic and were thus in favor of keeping the session.

While the sociopolitical environment and the pandemic were clearly outside our control, it was our responsibility to foster deep thinking and learning about controversial topics even within the difficult context. We have learned that part of what is hard about constructing and facilitating these conversations is integrating the apparently competing needs to allow sufficient space for students to bring their deep, often emotional, beliefs to the table and to provide enough academic background to support the intellectual exploration of complex ideas. Without great care, small-group discussions can devolve into unproductive venting or harmful, polarizing rhetoric (Herzig - Chasin 2018). When unintentional microaggressions or missteps occurred – as they undoubtedly did – students wanted small-group facilitators to step in swiftly and definitively to respond. However, faculty do not necessarily have the sophisticated skills necessary to proficiently respond when conversations go awry.

Nor is it always appropriate for the facilitator to address interpersonal harms that students need practice repairing. As Wasserman and Browne (2021) suggest, "The interpersonal domain… involves not just faculty responsibilities" (Wasserman - Browne 2021: 564). Their approach to "brave spaces" in medical education attends not only to student and faculty responses to triggering material, but to the responsibility of both groups to the civic domain, which requires collaboration to remain focused on learning for social justice. Faculty facilitators must be trained to recognize moments of group disequilibrium, but so must students, as part of their learning process. Responding authentically to acknowledge individuals' feelings and responses, while remaining focused on specific course goals in their institutional and social context, is a challenging balancing act (Wasserman - Browne 2021).

Since the sociopolitical environment, pandemic, and student's past opportunities to practice respectful disagreement are all outside our sphere of influence, our strategy for addressing this challenge focused on bolstering the skills of the small-group facilitators and building course content on cultivating the dialogue space into the curriculum. In the off-season of FHH, the facilitators met monthly for case-based, interactive discussions about best practices for creating a productive dialogue space. Additionally, FHH course directors will create a new session focused on the dialogue space, opening up curricular space by condensing other sessions. In HIC, during the weekly faculty debrief/prep sessions, five minutes is reserved for a respected educational leader to share a teaching tip. These tips include various topics: how to address professionalism concerns in small-group, how to run a think-pair-share, and how to handle a student who is dominating discussion. Finally, we are exploring reducing the number of groups, from 20 to perhaps as few as 14, as this would allow us to focus on cultivating the skills of a smaller group of faculty who we would then hope to retain over time. These steps are in addition to weekly faculty debrief sessions which are held by every course.

3.3. *Student prior experience in health humanities is varied*

For some students, the Humanities curriculum was too elementary. For others, it was their first time encountering certain concepts; for them, starting from the beginning was essential. The level-setting nature of the courses, FHH in particular, can be challenging for all students, given that those with prior knowledge of its concepts contend with others new to the subject matter and the emotional and intellectual demands that it sometimes makes on learners. One FHH student in 2022 commented at length: "Many of the readings were very high-level, and without the background information, it was difficulty for my class to think critically about the material. The instance where the written primer was provided by the course directors was very helpful. Including more of these primers would ensure that everyone in the class has the theory and history needed to have a fruitful discussion". Yet another FHH student in the same cohort stated, "I felt like this was a very basic course and did not provide enough knowledge or discussion about each topic".

In response to this feedback, we have taken several steps. First, FHH, O&I and HIC have added "Go Deeper" resources for many sessions. These materials explore

concepts in a more advanced and/or nuanced way; unfortunately, many, if not most, students do not access these resources because they are optional. What the Go Deeper readings do provide, however, is a response to students who seek greater depth. Additionally, we have trialed some sessions that have a "choose your own adventure" prep-work design. For example, for a session on imposter syndrome in HIC, students are given two options: if imposter syndrome is a new concept, or if the student prefers popular media, we suggest a radio podcast (Opong - Douglis 2021). If imposter syndrome is a familiar concept or the student prefers scientific literature, we suggest a short resource from the journal *Frontiers in Psychology* (Feenstra et al. 2020). The advantage of this model is that it promotes student autonomy and can lead to rich discussions in small groups, where students are teaching each other what they learned; the disadvantage is that the prep material is not assessable due to lack of a common set of reading materials for all students.

IV - CONCLUSIONS

At this writing, the fall courses (FHH and O&I) have run twice. HIC is in the middle of its second iteration, and Communication has run once. All the courses have been well-received by students and interest in teaching them has brought new facilitators to the Humanities curriculum. However, student evaluation scores for some of the new courses are lower than earlier versions. We interpret this data to reveal the challenging nature of course content rather than to demonstrate critical problems in either content or design. We also observe that while student feedback is essential, it is only one measure of the success of a curriculum.

We have noted that our students struggled with the dialogue space of learning (Kumagai - Naidu 2015). This finding has led us to consider what makes humanities learning in medical education distinct from coursework at the baccalaureate or graduate level. The humanities learning context in medical education is focused on learning for professional development rather than content mastery or crafting sophisticated contributions to academic scholarship. Many of our learners with bachelor's degrees in scientific disciplines lack prior educational experiences in which they have had to manage challenges to their value systems in the context of academic learning. Moreover, the rise of social media and self-censorship in the U.S. college classroom mean that direct engagement with others whose views are different from their own may be rare (Miller 2022). These factors reveal considerable challenges to one of our curricular goals – the demonstration of cognitive and affective integration – as well as the need to address the dialogue space explicitly so that the goal is within reach.

This has been a challenging time for us as educators, but we are proud when we step back and see a coherent longitudinal curriculum that supports our learners in their pursuit of the practice of humanistic medicine that is cognizant of the social context and the sociocultural challenges of patients from diverse populations. Our work is not done; the next steps of re-evaluating, revising, and engaging in continuous quality improvement await. We look forward, in particular, to systematic programmatic

evaluation – discovering whether and how our learners are changed by our curricular endeavors.

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