Bearing Witness to Suffering and Social Justice: A Novel Multimodal Medical Humanities Course That Cultivates Compassionate Health Care

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ABSTRACT

Background: Racism, sexism, ableism, addiction stigma, weight stigma, and imbalanced power structures in medicine threaten human health and well-being. Medical humanities education that addresses positionality and power in clinical care may enhance physicians' abilities to provide compassionate care.

Methods: Sixty medical students completed a medical humanities elective during the 2020-2021 through 2023-2024 academic years focus on suffering and social justice in medicine and completed pre- and post-course surveys.

Results: Post-course surveys showed increases in students' self-assessed knowledge about applying medical humanities practices to provide compassionate patient care ($P < .001$), plans to use medical humanities practices in their future career ($P < .001$), and intent to disseminate or share their medical humanities work ($P < .001$).

Discussion: This novel multimodal medical humanities curriculum exploring suffering and social justice fostered compassionate clinical care skills and intention to continually engage in humanities work.

BACKGROUND

In 2020, the Association of American Medical Colleges (AAMC) published The Fundamental Role of the Arts and Humanities in Medical Education,[1] a call to action to integrate medical humanities coursework as a foundational feature of medical education. Studies have shown that infusing arts and humanities pedagogy into medical training develops competencies such as relationship building, perspective taking, and personal insight that contribute to compassionate health care provision,[1-4] leading many medical schools to implement humanities curricula where none had existed previously.[1,5] Medical humanities teaching activities may include individual and group reading exercises, writing practices, art interpretation, or historical document analysis. These activities can improve comfort with ambiguity, interpersonal and communication skills, and social advocacy.[1]

At our institution, limited opportunities existed for medical students to engage in humanities education prior to 2020, when 2 students approached 2 authors of this paper – clinical faculty who at the time led grassroots medical humanities efforts – requesting introductory course options. The students expressed particular interest in a course centered on compassion, cultural humility, and social and health care justice – emerging yet relatively understudied areas in medical humanities education.[4] The faculty members agreed to build a small team to develop an introductory medical humanities course with 2 goals: (1) engage students in a wide array of medical humanities activities to provide robust introductory exposure to the field and (2) empower students to explore suffering and social justice in medicine through compassionate and humanistic lenses.

We compared students' pre-course and post-course survey responses for evidence of increased self-assessed knowledge about applying medical humanities practices to provide compassionate patient care, their plans to engage in medical humanities practices in their future careers, and their plans to share personal creative work.

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METHODS

Curricular Approach and Innovation

Over 4 academic years (2020-2021 through 2023-2024), we implemented and assessed a 2-week medical humanities elective for third- and fourth-year medical students, using medical humanities teaching strategies to enhance students' understanding of power hierarchies in medicine and how these hierarchies can endanger the patient-physician relationship. To develop and teach this course with minimal existing institutional infrastructure, the 2 faculty members from pediatrics and palliative medicine who were originally approached by students collaborated with 2 additional medical humanities educators from medical history and bioethics and family medicine, all of whom are coauthors on this paper. This multidisciplinary collaboration to allowed incorporation of health care topics across the lifespan relevant to course objectives.

Table 1. Pre-survey and Post-survey Comparison of Student Responses to Statements With 5-point Likert Scale Response Options Using Nonparametric Wilcoxon Test

Survey Statement	Pre-survey N	Pre-survey Mean (SD)	Post-survey N	Post-survey Mean (SD)	*P* value
I know how to apply medical humanities practices in providing compassionate patient care.	50	2.2 (0.8)	31	4.2 (0.7)	<.001
I plan to engage with medical humanities practices in my future medical career.	51	3.7 (1.0)	29	4.6 (0.6)	<.001
I plan to share my personal work in the medical humanities with the medical community or nonmedical community (eg, via publication, performance, public display, live, reading storytelling, etc	49	2.6 (1.2)	30	3.6 (0.9)	<.001

Table 2. Pre-survey and Post-survey Comparison of Dichotomized Outcomes (True vs Unlikely True) Using a Chi-square Test

Survey Statement	Pre-survey Total N	Pre-survey True/Very True[a] n (%)	Post-survey Total N	Post-survey True/Very True[a] n (%)	*P* value
I know how to apply medical humanities practices in providing compassionate patient care.	50	2 (4)	31	26 (84)	<.001
I plan to engage with medical humanities practices in my future medical career.	51	30 (59)	29	27 (93)	.002
I plan to share my personal work in the medical humanities with the medical community or non-medical community (eg. via publication, performance, public display, live reading, storytelling, etc)	49	11 (22)	30	16 (53)	.010

[a]Number of students answering extremely "true"or "very true."

The course required 90 hours of student engagement (20-25 hours in seminars, remainder in independent coursework). Students needed no prerequisite knowledge. Each course offering was capped at 15 students to promote meaningful seminar discussion and interpersonal connection. (Appendix A provides a course overview; Appendix B provides tips for success.)

The course included asynchronous and synchronous components: students completed pre-class readings and creative assignments (Appendix C) and participated in daily virtual 2.5-hour seminars. Instructors possessed group facilitation skills and at least basic skills in guiding analysis of essays, poetry, film, music, visual art, philosophy, or historical documents. An instructor guide was developed and iteratively updated based on student and instructor feedback (Appendices D and E).

Each course-day explored a different theme:

1. Introducing the medical humanities
2. Humanistic approaches to pain and suffering
3. Expressing the inexpressible through art
4. The trauma of not being seen
5. Suffering and structural violence
6. The violence of medicine
7. Accompanying suffering
8. When doctors suffer
9. Seeing past suffering
10. Bearing witness as a call to action

Students completed a project using their preferred humanities-based expression modality (Appendix F). They presented project drafts to classmates and were taught to provide reflective, growth-oriented peer feedback.

Psychological Safety

For successful implementation, both the literature and our experience suggest that psychological safety is crucial for medical students to engage with new learning modalities[6] such as the medical humanities. This may be particularly important at an institution where arts-based medical education has not been the norm. Psychological safety is also essential when discussing complex topics such as suffering, bias, and inequality in medicine.[7]

We used several approaches to cultivate psychological safety in working with difficult topics and engaging in the humanities, an area of study new to many students.[6] First, we discussed strategies such as acknowledging difficult emotions, taking breaks, and reaching out to instructors or university support systems if needed. We set the expectation that participants maintain a respectful, compassionate, nonjudgmental, and confidential environment. We also provided training in respectfully and responsibly representing others' stories when students wished to incorporate patient or colleague experiences.

Instructors redirected students' self-critical comments toward a more nonjudgmental, self-compassionate stance. We emphasized appreciating works for their creativity and their creators for their curiosity and vulnerability. Instructors also explicitly positioned themselves early and often as co-learners.

In addition, instructors observed class dynamics, including which students were prone to unintentionally dominating discussion and which required encouragement to participate. We found that having 2 or 3 co-instructors provided multiple teaching perspectives and supported balanced class dynamics. Instructors met frequently to discuss class dynamics, concerns, successes, and areas for growth.

Evaluation

We administered pre- and post-course surveys asking students to self-assess their (1) knowledge about how to translate medical humanities practices into compassionate patient care, (2) plans to engage with medical humanities practices in their future career, and (3) plans to disseminate or share medical humanities work. All surveys used a 5-point Likert scale (1 = not at all true, 5 = extremely true). Changes were evaluated using a nonparametric rank sum Wilcoxon test. Because surveys were anonymous, pre- and post-course assessments were treated as statistically independent groups. To further characterize responses, we dichotomized them as "true" (extremely true/very true) versus "unlikely true" (not at all true/somewhat true/moderately true). Comparisons between pre- and post-course assessments were conducted using a chi-square test. All *P* values were 2-sided, with $P < .05$ defining statistical significance.

Institutional Review Board

According to an institution-based institutional review board (IRB) quality improvement/program evaluation self-certification tool, this survey met program evaluation criteria and did not require IRB review. In alignment with best practices, students were informed that participation was optional, would not affect their grade and would remain nonidentifiable.

RESULTS

A total of 60 medical students completed the course during the study period. The pre-course response rate was 85% (n=51); the post-course response rate was 52% (n = 31). Analysis demonstrated significant improvements in (1) knowing how to apply medical humanities practices to compassionate patient care (2.2 vs 4.2, $P < .001$), (2) planning to engage with medical humanities practices in future medical careers (3.7 vs 4.6, $P < .001$), and (3) planning to disseminate or share medical humanities work (2.6 vs 3.6, $P < .001$) (Table 1). After dichotomizing responses, significant improvement remained for all 3 measures (4% vs 84%, $P < .001$; 59% vs 93%, $P = .002$; 22% vs 53%, $P = .010$, respectively) (Table 2).

DISCUSSION

These results demonstrated that a novel multimodal 2-week medical humanities elective exploring suffering and social justice may offer important benefits, including improved self-assessed knowledge of how to apply medical humanities skills to cultivate compassionate patient care and increased likelihood of future humanities engagement. These findings suggest the utility of implementing a medical humanities elective at a medical school with limited existing medical humanities infrastructure.

The course represented an innovative way to improve medical student compassionate care, which may be difficult to teach in traditional classrooms.[1] Compassionate care in the context of social injustice and health inequities requires the physician to identify others' emotions and sources of suffering, recognize power hierarchies in medicine and their effects, maintain desire and ability to comfort, and manage their own emotions.[8] This complex skillset involves observation, listening, perspective taking, growth mindset, social awareness, and emotional navigation.[1] Our findings suggest that this course, taught through the lens of suffering and social justice, helped students gain confidence in their ability to provide compassionate care.

Our results also suggest that students who took the course may continue to engage in humanities-based practices in their careers, which may support long-term development of skills that contribute to compassionate health care. Because the complex skills that medical humanities practices develop[1] require continuous practice, our findings suggest that students may now have practical strategies to continue developing compassionate and patient-centered competencies. This expands on the emerging but limited literature on medical humanities impact within institutions lacking robust humanities offerings.[4] Follow-up studies examining how students apply humanities-based skills in clinical practice would be beneficial.

This study has limitations. In addition to limited generalizability due to single-site data and a self-selecting group, our surveys did not allow individual linkage of pre- and post-course responses to assess changes for individual students. The response rate just over 50% and the use of aggregate post-course data may overstate changes when comparing mean scores. However, dichotomized analyses were conservative and still demonstrated significant improvement across all 3 measures. Larger multisite studies would be useful to assess generalizability.

CONCLUSIONS

This 2-week, single-site medical student course provided a novel approach to exploring complex social and emotional dimensions of medicine related to suffering and social justice and offered strategies for integrating humanities-based skills into clinical practice. Our study suggests that medical humanities curricula may be useful for teaching complex skills such as compassionate care provision and offer students practical strategies to continue to develop

these skills. Larger studies are needed to understand generalizability. Detailed course materials are provided to support adoption of these approaches at other institutions.

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Appendices: Available at www.wmjonline.org

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