

Naïve we are not, at least when it comes to how students approach experiences in the humanities and social sciences in the midst of their medical education. While we have had countless students who viewed these experiences with enthusiasm and humility, we also have had direct experience with students who have shown a lack of interest, condescension, and even hostility toward the content and methods of such inquiry. When faced with illness narratives instead of hard clinical data, poetry instead of teaching rounds, short stories instead of surgical electives, a number of students make it clear that these experiences are a waste of time, which is, after all, their most precious commodity. We also have years of direct experience observing fourth-year students post-match, students who are understandably ready to cruise through the remaining months of medical school, given the trial they have just completed and the one facing them in July. They arrive at this juncture feeling that they have “met the requirements,” as evidenced by the fact that they have successfully matched for residency training.

What were our goals, then, for the gift we’d been given of the entire month before graduation to be spent with our near-graduates, and the freedom to build a curriculum from scratch? Actually, the primary goal was quite daunting: to engage students in critical reflection on the meaning of the work they were about to pursue in training and careers in medicine. Our hope was to move students beyond their usual quest for certainty to engage them in the posing of questions that cannot be answered from the standpoint of knowledge - questions philosopher Hannah Arendt believed we cannot refrain from asking. For Arendt, “Thinking amounts to a quest to understand the *meaning* of our world, the ceaseless and restless activity of questioning that which we encounter. The value of thinking is not that it yields positive results that can be considered settled,

but that it constantly returns to question again and again the meaning that we give to experiences, actions and circumstances” (n.p.). That is, we wanted to encourage in our students a lifetime of asking questions, and answering them with provisionality.

In particular, we wanted our students to think about who they wanted to be, and what they wanted to strive for in their relationships with their patients, their profession, and their communities, along with themselves and those they loved. For this reason, we entitled the course, *On Professing*. We carefully avoided the word *professionalism*, for reasons we will discuss later, and chose instead to focus the students’ attention on what they intended *to profess*, that is, how they intended to express their values in their medical work. We emphasized as we opened the course what it means *to profess*, both in the sense of stating something publicly, as well as its meaning in the most ancient sense of the word, of making a promise or taking a vow. Our intent was to ask our students to reflect on the commitments they were willing to make; our hope was that they would keep those commitments alive during residency and beyond.

The Curriculum

The course met 3 times per week for 3 or 4 hours each time, with a mixture of large group (all 115 students) and small group (12 students per group) sessions. The large group faculty/moderator was one of us (JZ), a clinical faculty member and hospital administrator with long ties to the medical school and a familiar person to most students. The small group faculty were a combination of clinical, basic science, and community health faculty.

Readings, which averaged about 4-5 per week, included a wide range of genres, including short fiction, essays, journal articles, and poetry. During the first week we looked at physicians and patients through a variety of lenses. We heard from patients legendary and obscure: Dax Cowart, one of the most important figures in patient autonomy debates in twentieth-century North American medicine, spoke to our students, along with “Chet,” a recovering drug addict whose life was turned around with the help of a compassionate physician who refused to give up on him. We read Anatole Broyard’s provocative “Doctor, Talk to Me” and Jerome Lowenstein’s “Can Compassion be Taught?” alongside poetry by John Stone, all selected to position the physician-patient relationship from a variety of perspectives.

The readings for the second week’s examination of physicians and self/family included several pieces of fiction, such as Susan Mates’ “Laundry” and Richard Selzer’s “Imelda,” along with a *New York Times Magazine* essay about an alcoholic physician called “Did You Hear About Doc Ogden?” We also included a provocative essay by Brian Castellani and Fred Hafferty called “The Complexities of Professionalism,” which suggests that one may “choose” from a variety of orientations to professionalism depending on one’s values and life goals. Several panels were scheduled for that week, one with physicians addressing the search for balance in their lives, the other with physicians in addiction recovery.

The third week found students exploring physicians and community/culture, and included Perri Klass’s “Snap Judgments” along with an excerpt from David Hilfiker’s memoir, *Not All of Us Are Saints*. We planned for the entire class to watch the film, *Crash*, which fell apart for reasons we will discuss below.

The final week was an examination of physician and profession, with particular attention given to the issue of medical errors, as well as the relationship between the medical profession and the pharmaceutical industry. *Health Affairs'* outstanding feature, "Narrative Matters," which are first-person narratives on issues of concern to public policy, provided much of the reading for our students. These narratives included Carol Levine's essay, "Life But no Limb," which discusses medical error from a family perspective, and Howard Brody's "A Matter of Influence," a persuasive treatise on the negative presence of drug company reps in residency programs. A panel of attendings willing to discuss making, and living with, their own mistakes evoked significant discussion among students, and John Stone's personal reading of "Gaudeamus Igitur" provided what we thought was meaningful closure to the course and to their medical school experience.

In addition to mandatory attendance, students had to complete three writing assignments that were due at various points in the month. These assignments were presented to the students as follows:

- (1) A reflective essay on how your medical education has fostered and hindered your conceptions of altruism, compassion, and respect for patients. (2-3 pages double spaced)
- (2) A "personal oath statement" on what you profess, describing the kind of professionalism to which you aspire, and the values and commitments you are willing to promise to yourself to consistently uphold to the best of your ability. These commitments should be described in the context of the four organizers of the course, i.e., your relationship with patients; your relationships with self,

family, and significant others; with the communities and cultures you serve; and with other physicians and healthcare professionals and the profession itself. (2-3 pages double spaced)

(3) A “Letter to a 3rd Year Student,” which may include what to expect, what you’ve learned, what you wish you’d known or been told, and so on. These letters can be in actual letter form, or can take the form of a poem, dialogue, or list (with explanations for each item), or other creative forms. These letters will be bound and presented to each rising M-3 student. (1/2 to 1 page single spaced, but can be longer)

Discussion: What went right and what went wrong

Given the stated goal of the course, one would think that we would have been quite pleased with the evaluations. Eighty-five percent of the students said they agreed (53%) or strongly agreed (32%) with the statement, “The course provided me with opportunities for critical thinking and self-reflection on my experience in medical school.” Over two-thirds of the students similarly responded to statements about the four organizers of the course, i.e., they agreed that the course increased their awareness of relationships issues between physician and patients, physicians and self/family, physicians and community/culture, and physicians and the profession. Finally, two-thirds of the class agreed with the statement, “The course was a valuable experience.”

The writing assignments appeared to be taken seriously by most students, and in many instances, students wrote poignant and meaningful reflections on their experiences and their hopes for their careers in medicine. The letters written to their M3 colleagues

covered a broad range of advice and observations, and when compiled, became a wonderful bound volume that was presented to the rising M3 class during their third year orientation.

Why, then, did *we* feel the course was not as well received by students as we had hoped? Why did we feel as though too many of them were going through the motions of this last requirement before graduation? And why, among a vocal minority, was there such open hostility toward the course itself? We have some ideas offered below that will guide our planning for next year's capstone course.

Student weariness with talk of professionalism Over the past decade, the professionalism discourse has leaked into all aspects of medical education from admissions through graduate medical education. Even before they learn the local institutional meanings of the word, not to mention its larger academic and accreditation significance, students are inundated with professionalism talk, and sometimes even evaluated for its presence or lack. Students in their fourth year of medical school are frustrated with the continued references to professionalism that well-meaning faculty often confuse with simple rules of decorum and common decency, and thus use to "yell at them" for misbehavior. That is, students report that professionalism is equated almost exclusively with issues such as appropriate dress, punctuality, and other behaviors associated with "good manners," all the while talk of virtues such as respect, compassion, integrity, excellence, and accountability is kept in an ethereal state of abstraction only to be found on end-of-clerkship evaluation forms. And while being on time and showing respect for patients via one's dress are indeed one aspect of professionalism in medicine,

they only nick the surface of a larger ongoing discussion of a life in medicine marked by the virtues cited above.

In addition, students recount that earlier in their medical education they are subjected to what one of our students referred to as “preaching from the pulpit of professionalism.” Later, when they don their white coats and enter the clinical arena, they struggle to develop their professional identities while facing repeated contradictions of that very preaching in the way professionals actually behave in the real world of medicine. Throughout their third year clerkships they receive multiple written evaluations of their professionalism on the end-of-clerkship assessment form, along with checklists of their development in certain areas. When they received the syllabus for the capstone course “On Professing,” it was likely that many of them *perceived* it to be the institution’s last inundation in that arena. One student—a particularly kind, cordial, and reflective student not prone to complaining—wrote the following in one of the assignments:

When I read about this assignment to write about how my medical education has affected my altruism, compassion, etc., I actually became angry. How can one become angry about this topic, which is normally so jolly? I will tell you how. This class is a great example of how this topic has been shoved down our throats too many times. I can no longer take it and I am exploding. . . . From day one when we all entered medical school, and for some earlier, we were required to attend professional classes which tried to teach all the concepts mentioned above. I will say that the first couple of them were good to attend. It allowed me to see examples of professionals and I would eventually use those models to mold myself as an upcoming physician. The only problem with our medical school is that they did not stop there. . . .

In addition, and perhaps most relevant for this discussion, is the fact that a rose by any other name would smell as . . . sweet, or possibly unpleasant, depending on one’s affinity for roses. Here as elsewhere, the medium for professionalism efforts in the

formal curriculum is often humanities based, using cases, essays, short stories, or film to illustrate many of the common aspects consigned to professionalism. In fact, as one of us (DW) has written elsewhere, we may be witnessing the phenomenon of renaming what was once called “medical ethics” as “professionalism” (Wear & Kuczewski, 2004); this is also the case with using literature piecemeal in the curriculum to illustrate various professionalism issues we want to address with students. Thus, when talk of compassion arose in class using a case, poem, or essay, many students’ eyes began to glaze over, and we got the feeling that they were thinking, “Here we go again with the ‘P’ word” Actually, when any topic deemed by students to be synonymous with “professionalism” was addressed via stories/narrative/cases, the message, the medium, and the messenger were sometimes confused.

Perceived “liberal bias” of humanities faculty/curriculum Several curriculum experiences during the capstone month evoked strong negative responses among a small group of students. The first was the presentation by Dax Cowart. After watching *Please Let Me Die*, the documentary about Dax’s accident and subsequent refusal of physicians to allow him to go home to die, Mr. Cowart spoke to the students and answered many of their questions about his case and more recent issues surrounding end-of-life treatment, particularly the Terri Schiavo case. In the days that followed, word from several small group faculty was that some students were unhappy with the course directors’ “liberal bias,” as evidenced by a “right to die” speaker, without providing an opposing viewpoint. (We were later reassured, despite these vocal concerns, that in the course evaluation, 91% of the class agreed that this session was thought provoking and/or instructive.) As criticisms continued to mount, we reconsidered our decision to present the film, *Crash*,

which we selected as a provocative treatment of race in the United States. We regarded this as a topic no one can avoid—even doctors who publicly profess to treat *all* their patients with compassion. When additional reports of students' objections came our way, we chose to cancel the film, a decision we later regretted. In fact, a number of students subsequently expressed their unhappiness over the cancellation as well.

The “practical” versus “theoretical” argument. This is not new to the medical humanities, or to the humanities in general. The fact that we were talking about “ethereal” subjects rather than having students learn or practice essential skills required of them in the residencies looming ahead was a topic that arose in more than one small group. In fact, one of the groups went so far as to compose a long list of topics that *they* felt were more relevant to a capstone experience and forwarded the list to us; not one of the topics, content, or methods involved narrative or bioethics. Clearly at this juncture, students have an understandable level of anxiety about their upcoming residency training, and they crave practical knowledge and skills to arm themselves against the rigors of internship. Time spent on more humanistic or reflective topics is seen as distracting and misplaced, and some are thus resentful of their exposure to it. This leads to our final point, which is that it's all about timing.

The timing of narrative- or any humanities-based capstone courses. We are tentative here, unsure if we really believe the following statement: It may be that the last month of medical school is unfit for this kind of inquiry. Students' minds are not to be captured, much as we'd like them to be, by the kind of thinking, reflecting, and puzzling that the topics, readings, and discussions should hopefully evoke in young doctors ready to leave the protective fold of medical school for the ever-increasing and awesome

responsibility of patient care. Many students were passionate in their written evaluations about what they would have liked from a capstone experience that the medical curriculum hadn't provided or hadn't provided enough of, most of it skill-based or "practical" tips regarding medical error, "practical" tips on delivering bad news, or other "practical" tips for survival during residency. Our class on medical error involved discussion of readings (e.g., Atul Gawande's elegant essay, "The Learning Curve") followed by a panel of attendings and a resident who discussed their experiences, particularly how it felt and how they dealt with it. And while this particular class was highly rated by students, some students indicated in the comments section of the course evaluation that there wasn't enough "how-to" in it, specifically how to maximize one's chances of making as few errors as possible.

There may be other issues going on here too that make the last month of medical school not the best place for the kind of inquiry we planned. Medical students are post-match, and have almost nothing at stake in their classroom performance at this time; indeed, the only thing they have to worry about is a "pass" in this pass/fail course. Their minds and hearts are elsewhere: their residencies, moving plans, housing to be secured, and weddings for some. Successfully completing medical school and matching into residencies are major hurdles they have already jumped, and many don't believe there's much more we can teach them, or in our case, at least engage with them in the domains that formed the course. For many of them, this decidedly non-didactic course still felt didactic, that even raising the issues described above was beating a dead horse; they'd heard it all before at various junctures in the medical curriculum, and *enough!* Finally, many students saw the focus of this course trying to make them more humanistic,

compassionate, or altruistic, and they strongly objected on the grounds that if they hadn't already achieved these objectives through their education to date, it was too late.

Lessons learned

At the Northeastern Ohio Universities College of Medicine we have been extremely fortunate that, from its inception, the College has encouraged and made possible humanities inquiry in the curriculum. At present, the humanities are included in all four years, primarily in a required four-year longitudinal course that culminates in the *On Professing* course. We also have had a major infusion of professionalism as a concept, expectation, and area of student assessment throughout the school curriculum and overall environment during the past decade. Indeed, professionalism is common parlance everywhere, at all levels. To the extent that we have had the opportunity to use the humanities to encourage meaningful reflection among our students upon the work they will pursue in service to the suffering, we believe that these domains can be consequential to professionalism inquiry.

We remain encouraged that a majority of our students are still receptive to these teaching strategies, and find meaning in the activities they provoke. It is, however, incumbent upon all of us as educators to remain mindful of the lived experiences of our students, and to better attempt to practice our own "narrative medicine preaching" by better understanding and operating in *their* particular narratives. Medical educators must continue to rethink the "professionalism push" that has overtaken the medical education community. It is critically important that young physicians develop a clear understanding of their professional obligations, and physicians undoubtedly need to continue to be held

to the highest standards of the profession. But if the professionalism message is allowed to become synonymous with simple codes of conduct or rules of common decency, and then used inconsistently as a system of discipline against students who don't always meet such conduct expectations, students may progressively close their minds and hearts to the essential commitments that reside in the privileged relationship between themselves and their patients.

In addition, efforts to provide both practical educational material along with the more "meaning-making" experiences are likely to engage the naysayers more positively. For example, during our sessions on medical error, as well as in the more theoretical readings and the panel cited above, we may want to engage students in some role playing, or with the literature on how, when, and under what conditions to tell patients that errors have occurred, and how this relates to them as residents. Further, we must reevaluate the appropriate quantity and timing of this type of content in the curriculum. Finally, as faculty, we must become more broad-shouldered and accept the rejection of our capstone course curriculum by some students with a degree of hope that these concepts are meaningful to a significant number of our graduates.

Training the next generation of doctors is a sobering responsibility. We believe we are obligated as medical educators to prepare our graduates well for what they will *do* as doctors, as well as how they will *be* as doctors. In addition, we believe that there is value in engaging these soon-to-be residents in meaningful reflection on just how profound the work is that they will be called to do in service to the suffering. It is our hope that such reflective practice will make them more conscious in their caring, and thus, more competent in their care.

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