Taking Humanism Back to the Bedside
Jennifer Plant, MD, MEd, Michael A. Barone, MD, MPH, Janet R. Serwint, MD, Lavjay Butani, MD, MACM

After attending The Arnold P. Gold Foundation’s “Barriers to Sustaining Humanism in Medicine” symposium in 1996, Steve Miller and Richard Sarkin proposed a Traveling Fellows program for the foundation. The program was approved, and Steve and Rich served as the program’s 2 Traveling Fellows until their untimely death on October 19, 2004. Steve and Rich, both Council on Medical Student Education in Pediatrics presidents known for their creativity and charisma, brought to our collective consciousness the need to promote humanism in our work as clinicians, teachers, and role models. When they died, Steve’s Chair at Columbia, John Driscoll, urged that their memory be honored by devoting time each October to promoting humanism.1 It is in this spirit that COMSEP Perspectives provides the following article.
– Kenneth B. Roberts, MD

WHAT IS HUMANISM?
Reflecting on our journey through medicine, we may recall pivotal moments that re-affirmed our commitment to the values of our profession. These moments may relate to the spirit of discovery inherent in the practice of medicine, to the recognition afforded by society to medical practitioners, or to service toward those who are suffering and in need of care. This last attribute, which encompasses a spirit of sincere concern for the centrality of human values in every aspect of professional activity, is referred to as humanism.2 Humanism is a way of being defined by the characteristics of empathy, altruism, and compassion.3 As so eloquently stated by Sir William Osler, “it is much more important to know what sort of person has a disease, than to know what sort of disease a person has.”4

WHY PRACTICE AND TEACH HUMANISM?
The literature demonstrates that patients cared for by humanistic clinicians have better outcomes,5 increased satisfaction,6 and improved adherence to an agreed-upon plan of care.7 When coupled with the observations highlighting the decline of empathy among learners8 and the missed opportunities for demonstrating empathy among practicing physicians,9 it becomes essential for us to consciously role model and teach humanistic values to learners. Fortunately, the medical literature provides supporting evidence that the construct of humanism can be learned and taught.10

ATTRIBUTES OF HUMANISTIC TEACHERS
Today’s health care environment poses challenges to a practice founded on humanism. Exponential advances in medical technology, documentation demands, and an increasing emphasis on the clinical productivity and the business aspects of medicine have the potential to distance physicians from their patients.11 Recognizing the potential impact of these challenges, we, as educators, need to maintain the focus on humanistic practices. In 2014, Chou et al12 examined the attitudes and behaviors of highly humanistic physicians. Her team found that attitudes of humanism include humility (cherishing the privilege and responsibility that society has bestowed upon us), curiosity (a genuine desire to know about the people we interact with), and a desire to maintain high standards of behavior.
Behaviors that have helped educators maintain these attitudes include self-reflection, seeking connections with patients, a focus on personal resilience and wellness, and teaching and role modeling humanistic care. Intentionally practicing these behaviors and creating an environment with a focus on humanism can hold teachers accountable, help maintain humanism, and ensure that we role model humanism for our learners.

A FRAMEWORK FOR TEACHING HUMANISM

Steven Miller and Hillary Schmidt proposed that the practice and teaching of humanism could be conceptualized by using a framework, similar to the approach for the physical examination or creation of a differential diagnosis. Their article, “The Habit of Humanism: A Framework for Making Humanistic Care a Reflexive Clinical Skill,” posits that humanism can become a habit by practicing 3 steps: (1) identifying perspectives of the patient, the patient’s loved ones, and the health care provider; (2) reflecting on how these perspectives converge or conflict; and (3) choosing to act altruistically by endorsing and understanding the perspectives of the patient and family.13

There are numerous teaching strategies that build on this framework to promote humanism in daily medical practice.14 Many strategies are embedded during the practice of providing care to patients while others can be taught outside of a patient-care setting, as outlined in Table 1.15–19

SUMMARY

A quotation by George Eliot in *Middlemarch* summarizes everyday humanism:

*We do not expect people to be deeply moved by what is not unusual. That*

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<thead>
<tr>
<th>TABLE 1 Teaching Strategies</th>
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<tr>
<td>Clinical Practice Recommendation</td>
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<tr>
<td>Strategies embedded during patient care activities</td>
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<tr>
<td>Encourage learners to incorporate humanism into personal learning goals and individualized learning plans</td>
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<tr>
<td>Promote perspective taking, the act of viewing a situation from others’ points of view, by asking learners to explore the perspectives of the patient, the family, and the health care team</td>
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<td>Heighten learner awareness regarding the potential impact of illness</td>
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<tr>
<td>Incorporate psychosocial aspects of patients’ stories into presentations</td>
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<td>Refer to patients and parents by their actual names, not as their diagnoses15 and not necessarily as “Mom” or “Dad”</td>
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<td>Practice family/patient-centered rounds that include active participation of the patient and family in the discussion and decision-making process</td>
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<td>“Reflect on action” on impactful events as they occur</td>
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<tr>
<td>“Reflect on action” after impactful events have occurred: capture the opportunity to reflect on seminal events by debriefing after patient encounters that have a powerful impact17</td>
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<td>Facilitate end of day/week/rotation reflection</td>
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<td>Structured activities independent of direct patient care</td>
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<td>Engage in experiences with graphic, fine, and performance arts to facilitate “enstrangement” (making the familiar unfamiliar) and viewing what may have become mundane with a keener vision19</td>
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<td>Visit a museum; discuss a piece of art, poem, or video</td>
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<td>Ask learners to take on the roles of the subjects or characters and share their feelings and emotional reactions to the events described</td>
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<td>Debrief on how perspectives may differ from person to person yet all are valuable</td>
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<td>“What did you learn about your patients today?” “Here are the names of our patients that we cared for this week. What did they teach you? What will you remember? What do you recall about these patients as people?”</td>
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<td>“Did that patient have a lung infection? Why do you think she became so emotional?” “What do you think is the patient’s most important current priority? Why?”</td>
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<td>“What do you see as your priority and role?”</td>
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<tr>
<td>“What do you think is the patient’s most important current priority?” “What do you think is the patient’s most important current priority?”</td>
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<td>“Heighten learner awareness regarding the potential impact of illness”</td>
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As Eliot so eloquently states, being empathic can be considered a double-edged sword; while it facilitates the opening of oneself to others’ perspectives and emotions with the purpose of understanding them and caring for them better, it can also lead to our bearing a heavy burden. There should remain little doubt, however, that empathic actions are a core part of the virtue of humanism and must be practiced and taught, both implicitly and explicitly. Our hope is that by using Miller and Schmidt’s framework on the “habit” of humanism and the various educational strategies outlined here, a great clinical teacher can channel his or her innermost humanistic attributes as a role model and overcome perceived barriers. Such actions could only further improve the care we provide and foster humanism in our learners.

ACKNOWLEDGMENT

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