Humanism and the Physician

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Understanding Humanism in Medicine

What Is Humanism in Medicine?

In the daily practice of medicine, physicians apply scientific principles with varying levels of evidence to enhance the health and wellness of fellow human beings, that being their patients. Physicians must wrestle with and ultimately reconcile the subjectivity of human relationships with the objective detachment of science in order to optimize the effectiveness of their work. The potential for tension between these two domains has been apparent since the earliest days of medicine: even ancient philosophers who lived in a world before modern science recognized the existential dangers of an imbalance between the two [1, 2]. The physi-

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cian is often the singular embodiment of this tension, sometimes struggling in a tug of war between two professional identities, trying simultaneously to preserve their own humanity, connect meaningfully with patients, and keep pace in an increasingly complex scientific and technological world.

Did You Know?

Humanism in medicine has been defined as "the application of scientific knowledge and skills with respectful, compassionate care that is sensitive to the values, autonomy and cultural needs of individual patients and their families" [3].

Humanism is an approach to patient care that acknowledges both the importance of *scientific* knowledge of the patient's disease process and *biographical* knowledge of the patient's social environment, values, and goals [4]. Biographical knowledge requires getting to know one's patient as a *person*, unique in their identity, context, illness experience, and determination of meaning. Humanism is rooted in the core values of empathy, compassion, relationship-based care, and professionalism [5]. A humanistic approach recognizes that physicians use the "lived-body" and the "lived-world" as foundations for understanding the human condition and thus, the patient experience [6]. A physician must have a scientific understanding of the "biological body" as well as a humanistic understanding of the embodied nature of each patient's illness experience [7]. A humanistic grounding allows the physician to understand the impact of illness on patients' lives, "not just as a secondary effect of the biological disease, but as a primary phenomenon" [8].

While humanism has long been recognized as a core philosophical value of medicine, it was only recently articulated as a core clinical competence for residents and practicing physicians, likely as a response to numerous challenges and flaws in contemporary medical practice [9]. Physicians and patients must both contend with powerful dehumanizing forces that comprise the daily realities of medicine. These include an increasing depen-

dence on technology, a diminishing amount of time spent directly with patients, growing financial pressures, and intensifying bureaucracy in medicine. Yet, the more enduring inspiration for the campaign to restore humanism is recognition of its role as a countervailing force acting alongside science that enables physicians to address patients' needs for wellness, healing, and alleviation of suffering.

Did You Know?

*The terms "**health**" and "**wellness**," although often used interchangeably, are distinct concepts. As per the World Health Organization, health is an objective "state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" [10]. Wellness is an active, dynamic, and holistic process that is subjectively perceived and self-directed; it relates to decisions of intentional healthy living and optimizing potential [11].*

*There is an important distinction between "**disease**" and "**illness**"; disease is a biomedical abnormality that is physiological or psychological in nature; illness is experiential, the lived human response to disease (also referred to as "**illness experience**").*

*There is a difference between "**curing**" and "**healing**"; curing is the elimination of all evidence of disease, while healing involves the promotion of wholeness and wellness. Even when curing is not possible, physicians have the ability to promote healing through a humanistic approach to practice.*

Limitations of the Biomedical Model

Rapid progression of scientific knowledge has created and sustained the biomedical model of disease, which has become the dominant paradigm in medical culture, education, and healthcare policy [12]. This model of disease emerged in the 1950s alongside swift developments in medical science, including the dis-

covery of specific disease processes and disease-causing agents. Biomedicine "assumes disease to be fully accounted for by deviations from the norm of measurable biological variables" [6]. In other words, the biomedical model posits that any given disease can be aptly described by its underlying biological, chemical, and physical mechanisms. Knowledge of the parts is sufficient to explain the whole.

There are three main problems with the biomedical model of disease that humanism seeks to redress. The first is that biomedicine is reductive. Molecules, transmitters, and receptors are seen to represent the most valid level of knowledge, presumed to be the best way to understand and explain disease. Within this framework of understanding, there is no weight given to the psychological, social, and behavioral dimensions of illness; as such, this approach fails to view human disease as primarily a human experience [13]. For example, understanding the physiology of vasodilation in flushing, the pathways leading to catecholamine release in tachycardia, or the receptors responsible for increasing sweat gland activity in diaphoresis, is meaningless unless one understands the underlying human causes: embarrassment, anxiety, and nervousness.

Second, the biomedical model of disease is "exclusionistic"; in other words, symptoms and processes that are not understood by current biological explanatory models are excluded from the field of medicine [14]. The result is that "patients with vague complaints and non-localizable lesions are relegated by biomedical reductionism to a netherworld of hypochondriacs and malcontents" [15]. Through this method, biomedicine has a way of filtering patient complaints into only those problems that can be medically recognized and addressed based on current knowledge. This is discouraging for patients and undoubtedly inspires the caricature of the out-of-touch doctor, as well as the recently trending twitter hashtag "#doctorsaredickheads." When the extent of a doctor's tools to treat disease were entirely contained within a small black bag, the simple value of the supportive, empathic presence was perhaps more apparent.

Finally, biomedicine is incapable of recognizing the limits of science's applicability to humans. In recent years, scientific

and technological discoveries have even obscured the boundary between life and death. Through mechanical ventilators, extracorporeal membrane oxygenation (ECMO) machines, and pacemakers, humanity has been forced to accept that neither brain activity nor the ability to oxygenate and circulate blood are sufficient descriptors of human life. A thousand other smaller scale interventions have given us the ability to prolong life to a point that may no longer be considered meaningful. Biomedicine alone cannot distinguish a life worth living; it can sometimes answer the question of "what," but it can never answer the question of "why." Instead, a patient's values, goals and spirituality, their very concept of a meaningful life, and how much they are willing to suffer to achieve and preserve it, are the most relevant factors. (For further details, see Chap. 16.)

Certainly, the application of scientific models to human health has provided a window to more fully understand disease. As physicians, we can use the explanatory power of the physical sciences to understand some aspects of human function and disease, right down to the most basic anatomic and molecular parts. These parts appropriately become targets for interventions and treatments. We cannot, however, abstract meaning about the human experience from information about the biological parts. If we fail to acknowledge the limits of science, we risk inflicting suffering on the whole person through treatment of the parts [16, 17]. This is the gap that humanism seeks to fill.

Refer to Fig. 1.1 for a representation of the dual importance of the biomedical and humanistic paradigms for effective medical practice.

Case Study I

Aisha, a medical student, hears a patient desperately calling for water one afternoon on the medicine ward.

"Water! Water!"

She notices that the rest of the members of the healthcare team are busy performing other tasks. The patient is old, frail, and bed bound. The loud pleading continues.

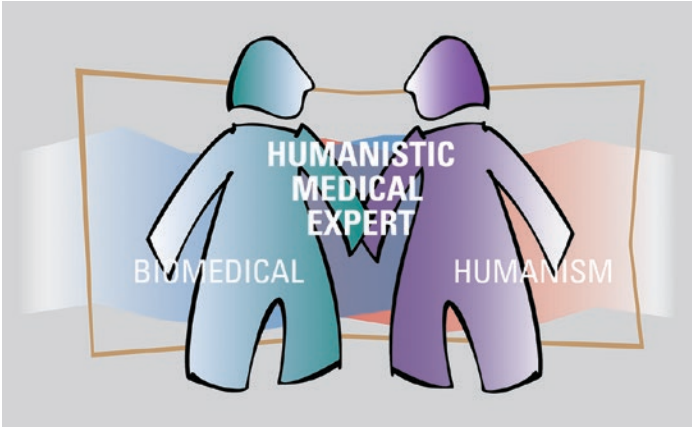

Fig. 1.1 Humanism and the biomedical model in medical practice

Although the patient is unknown to Aisha and not being cared for by her team, she feels compassion and is unable to walk by his room without helping. She finds the kitchen and fills a Styrofoam cup with the appropriate ratio of ice and water and delivers it to his bedside.

The patient is grateful and settles, and Aisha feels an immediate swell of satisfaction. Although her medical knowledge is limited at this point, she is delighted to have made some small difference to a patient's hospital experience.

Aisha leaves the room without noticing the sign above the patient's bed reading "FLUID RESTRICTION < 1.5 L."

Coincidentally, later that night Aisha reads about the role of fluid restriction in management of the syndrome of inappropriate antidiuretic hormone secretion (SIADH).

Question 1. **In Aisha's development as an effective physician, it will be important for her to build competence in which paradigm(s) of care?**

A. **Humanistic**
B. **Efficient**
C. **Biomedical**
D. **Both A & C**

Answer: D ✓
Both the humanistic (A) and biomedical (C) paradigms of care are integral to effective patient care. In this case, Aisha acted generously and with compassion toward the patient, importantly demonstrating a humanistic approach in helping to alleviate suffering. In spite of her best humanistic intentions, however, she was not able to apply optimal medical knowledge and clinical assessment skills to the situation, in addition to being unaware of the value of team communication. This case illustrates the importance both humanistic and biomedical expertise combined for optimal medical care. Although developing efficiency (B) without compromising quality of care will be important as Aisha progresses through her medical training, this is not a paradigm or model of care.

Question 2. **Had Aisha known about SIADH and this patient's fluid restriction, how could she have maintained her humanistic approach to care while still respecting the medical recommendations?**

A. **Taking time to talk with the patient about his understanding of the condition and care recommendations**
B. **Empathizing with the patient about the discomfort of thirst**
C. **Exploring options for oral care with the team**
D. **All of the above**

Answer: D ✓
Even when a physician is unable to meet all of a patient's hopes and needs, a humanistic approach to care can still provide comfort and promote well-being. If Aisha had known that providing water was not an optimal medical response to this patient's request, she would still have been able to develop a connection with the patient, provide education (A), empathic support (B), and explore ways to enhance comfort (C). A physician is never without options when it comes to applying humanism in medical care.

Key Points

- A solely biomedical approach to the practice of medicine is inadequate due to three main limitations:
  - Reductionism precluding understanding of the whole patient and their experience
  - Exclusion of that which is not understood or explained based on current scientific knowledge
  - Inability to address essential human concerns of meaning, value, and connection [13–17]
- Humanism in medicine values the human connection between patient and physician, and an understanding of the patient's experience of illness, context, health, and meaning.

The Humanistic Practitioner

There is a great deal of agreement on the philosophical foundation of humanism. The humanistic physician has an understanding of nonscientific disciplines, which they use to better understand and connect with patients' human context. For example, "the performing arts can 'stretch' perception; ethics can 'exercise' reason; philosophy can 'fine-tune' critical analysis; literature can 'trigger' perspective-taking" [18]. A humanistic physician develops cognitive capabilities that go beyond an understanding of the pathophysiology of disease. The humanistic physician has faculties of the mind which sharpen their ability to reason, judge, remember, emote, contextualize, and imagine.

Yet, medicine is fundamentally a task-based profession. The daily routine of ordering tests, reviewing labs, dictating, and documenting—all tasks without patient interface—seems to obscure the relevance of humanism. It is increasingly apparent that physicians spend a disproportionately greater amount of time with a computer screen than with a patient [19]. (For further details, see

Chap. 3.) So, while we can describe what humanism *is*, it can be harder to define what a humanistic physician *does* in a practical sense.

Attempts to describe the habits and behaviors of humanistic physicians quickly devolve into a "word salad." Humanistic physicians are empathic. They are compassionate. They treat their patients with kindness. They are curious about their patients' context and values. They approach clinical decisions with cultural humility and an alignment with patients' goals and preferences. They practice medicine in a way that values the physician-patient relationship. They view their actions not only in the curative frame of medicine but also in the frame of healing. Humanistic physicians are humble. They engage in mindfulness, self-reflection, and perspective-taking on both their technical performance and the nature of their interactions with patients. They are self-aware [3, 5, 20]. (For further details, see Chap. 5.)

In efforts to promote and sustain humanism in medicine, organizations like the *Gold Foundation* for *Humanism* have developed methods to study and measure humanistic characteristics [21]. Some have pointed out that such measurement risks subjecting humanism to the reductive forces that underpin the biomedical paradigm, noting that the quantification of humanism has potential to destroy what it seeks to measure [22, 23]. Others suggest that regardless of the integrity of the measurement schemes, as in the case of other human endeavors, one will know a humanistic physician upon seeing one. Table 1.1 summarizes characteristics associated with humanistic physicians.

Did You Know?

In keeping with the field of medicine, there is even a helpful mnemonic for humanism! Developed by the Gold Foundation for Humanism, I.E.C.A.R.E.S. represents the attributes of the humanistic healthcare professional: integrity, excellence, collaboration and compassion, altruism, respect and resilience, empathy, and service [24].

Table 1.1 Characteristics of humanistic practitioners

Humble	Recognizing and cherishing the privilege that is bestowed upon physicians to engage with other humans in their most vulnerable state. Acknowledgment and acceptance of personal limitations and receptivity to input from others.
Professional	Striving to uphold the highest standards of professional behavior and doing what is ethical and in the best interests of the patient.
Curious	Possessing a genuine desire to understand the patient's context, hopes, fears, and wishes.
Self-reflective	Developing the capacity to critically assess one's own behaviors, beliefs, and interactions in order to better care for patients, and doing so regularly.
Connection-seeking	Understanding of the importance of developing a relationship with patients that transcends merely the "doctor-patient relationship" into a person-centered professional connection.
Purposeful	Making intentional and deliberate decisions to pursue meaningful clinical and life experiences that sustain humanistic attitudes and mitigate risk of burnout (e.g., teaching, mentoring, volunteering abroad, working with vulnerable populations, finding a "balance" between the personal and professional domains of life).

Adapted from Chou et al. [3]

Importance of Empathy in Medicine

Empathy is the ability to comprehend the experience of others and is considered essential to forming an effective patient-physician relationship wherein the physician is able to convey a deep understanding of the patient's situation [25–27]. This is important because patients who feel understood are more trusting of their physicians and thus, more willing to disclose concerns [27, 28]. Through this trust, physicians validate and normalize patient concerns, thereby reducing feelings of isolation, worry, and distress [27, 29, 30]. In this regard, it has been suggested that patients are more adherent to medical advice and more satisfied with their medical care when they perceive empathy from physicians [27, 31]. Clinically, physician empathy has been associated with fewer disease complications in patients

Key Points

- Sympathy refers to understanding another's feelings of sadness or loss.
- Empathy is a deeper experience than sympathy, referring to the ability to share emotionally in the experiences of another person, to be able to identify with them and put oneself in their shoes. Empathy involves coming alongside and facing the same direction together with another.
- Compassion goes beyond empathy to include the presence of a reaction to suffering with intent to relieve it [36–39]. Compassion and its importance will be explored further in Chap. 15.

with diabetes mellitus, significantly shorter and less severe episodes of the common cold, and with a more robust immune response [32–34]. Despite these benefits, empathy has been shown to decline during medical training [27, 35]. The decline in empathy has been attributed to a number of factors which will be considered in this chapter.

Patient-Centered and Person-Centered Care

Patient-centered and person-centered care are key components of a humanistic approach to medical practice and are terms often used interchangeably. Patient-centered care refers to that which "includes principles such as shared accountability, mutual respect and trust, shared decision-making, communication, advocacy, access to care, avoidance of unnecessary tests, and alignment of health facilities and services with patient needs" [40]. Both terms involve moving beyond a solely biomedical model toward a more holistic approach, focusing care toward the patient. This includes a broad understanding of and respect for patients' social context

(culture, race, spirituality, sexuality, relationships, and resources), ideas, values and goals related to health, wellness, and medical care. Some have suggested that the term "person-centered care" moves the "locus of power" from the physician to the patient for defining what constitutes care, and more clearly emphasizes patients' resources and problems as *they* experience them, not only as health professionals define them [40]. From the lens of a humanistic approach to medicine, both concepts highlight the importance of knowing and valuing the patient, their story, and their preferences.

Skill-Building Exercise: The Humanistic Physician

Consider a humanistic physician with whom you have worked.

What qualities and behaviors did they demonstrate to give you that impression?

Consider your own experience in caring for patients and identify a time when you approached your work in a humanistic manner.

What particular aspects of your care demonstrated humanism in this situation?

Importance of Positive Role Models

Role modeling is often considered the most effective way to learn about the humanistic aspects of medicine [27]. One way to optimize the learning environment and perhaps mitigate a decline in empathy is to seek out positive role models who exhibit humanism in medicine. Students and residents identify most closely with faculty who are not only clinically competent, but who also show passion for their work [41]. A study of surgical residents' perceptions of humanistic faculty found that those who exemplified humanism showed "humility, responsibility, and a desire to live up to a high standard of professional behav-

ior" [20]. The shared habits important to sustaining these attitudes were "self-reflection, finding deep connections with patients, maintaining personal and professional relationships, having fun at work, and paying forward to surgical trainees" [20]. A prior study with internal medicine residents identified similar attitudes and habits [3]. Both studies highlight the importance of positive role models in the development of residents as humanistic practitioners.

Faculty who model empathy in the context of patient care are viewed as inspirational, thus encouraging students to develop empathic skills themselves [42]. For example, residents adopt empathic phrases from their preceptors and use them in subsequent encounters to enact their moral empathy [27]. Moreover, feedback provided by positive role models has a greater impact when the resident perceives the supervisor as being supportive and having their best interests in mind [41].

Did You Know?

Moral empathy *is the "inner motivation to accept patients unconditionally, commit to understanding patients, and help patients achieve their needs" [27, 43].*

In the natural transition from textbook learning to engaging with patients, the physician in training needs support in understanding their moral and ethical responsibilities. It is ultimately the responsibility of supervising physicians to be proactive in initiating moral dialogue in the clinical setting [44]. Medical training programs need to provide robust faculty development for their attending physicians. Faculty development must be aimed at highlighting the importance of modeling humanistic care, as well as learning the skills to guide trainees through moral and ethical discussions that they will encounter in practice. Finally, it is the shared responsibility of residents to seek out faculty who emulate moral, empathic, and compassionate care. These and other educational strategies to support humanism in medicine will be explored further in this book. (See Chap. 16.)

Moral Development and Professional Identify Formation

Theoretical Framework for Moral Development

Kohlberg describes the sequential stages of moral development from childhood through to adulthood, comprised of three general levels that each represent a fundamental shift in an individual's thinking process and moral perspective-taking: preconventional, conventional, and postconventional [41, 45–47] (See Fig. 1.2). Young children in the preconventional stage can determine right from wrong by avoiding punishment but are unable to generalize this learning to other situations. Later childhood and adolescence fall under the conventional stage wherein individuals can generalize learning and begin to develop a sense of self. At this stage, actions are deemed correct if they are approved by individuals they consider significant, such as parents, teachers, or friends. Receiving approval and demonstrating loyalty mark the beginning of this stage; advancing to higher levels of the conventional stage requires a deeper understanding of abstract concepts, such as roles, sense of duty, and societal norms. By late adolescence

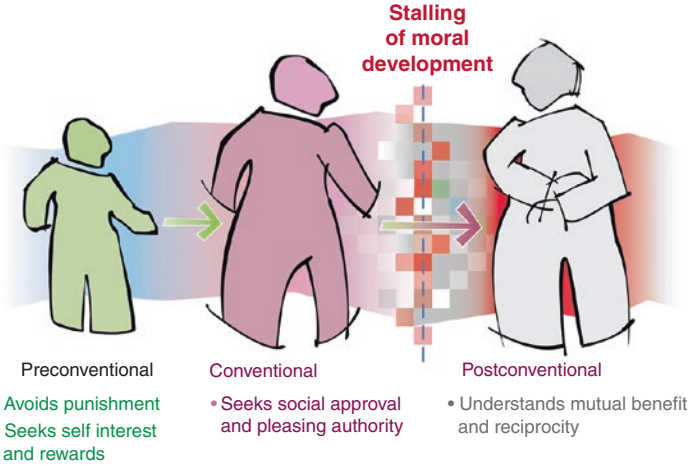

Fig. 1.2 Three levels of moral development

and early adulthood, moral development shifts toward the post-conventional stage. In this stage, individuals define moral principles that guide their behavior beyond both the self and rules of society [41]. Moral development is a lifelong process that begins long before entry into medical school; however, upon entering medical training, the commitment and motivation for moral and ethical development is imperative.

Four distinct competencies have been recognized as key elements of moral development and functioning, as outlined in the "Four-Components Model of Morality" [48]. These competencies are as follows:

(i) *Moral sensitivity:* "the capacity to interpret ambiguous clues in real-life settings" [48].
(ii) *Moral judgement:* "the capacity to analyze moral issues and provide justifications for decisions" [48].
(iii) *Moral motivation:* "the capacity to internalize and give priority to professional values and commitment" [48].
(iv) *Moral implementation*: "the capacity for empathic interaction and problem solving" [48].

Please refer to Fig. 1.3 for an illustration of this model.

Did You Know?

- *Morals are "a person's standards of behavior or beliefs concerning what is and is not acceptable for them to do" [Moral. (2019). In Oxford Online Dictionary. lexico.com/definition/moral]. Morals are personal, helping one to internally determine what is right and wrong. Morals inform ethics.*
- *Ethics are an external set of expectations or rules for behavior and are context-dependent [49].*
- *A physician may demonstrate behavior that is ethical, but that goes against their own morals. Alternatively, a physician may act in keeping with their own moral standards, but in doing so, go against the ethical expectations of an established code of conduct.*

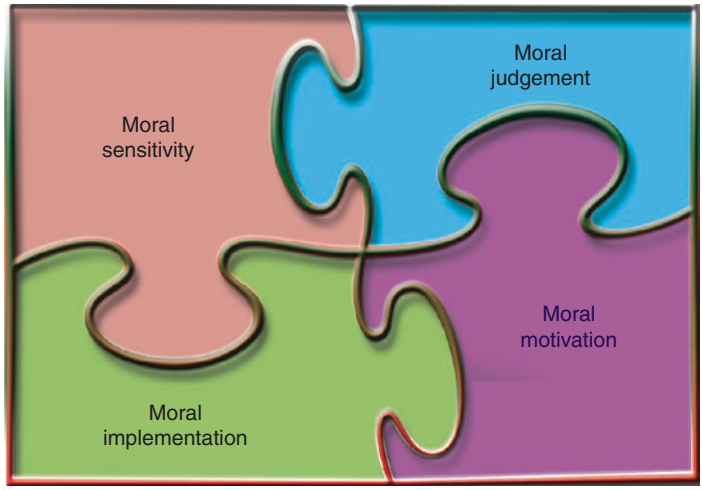

Fig. 1.3 Four-component model of morality

Regarding the previous *Did you know?* section discussing morals and ethics, for example, a physician might not personally agree with pregnancy termination for a number of reasons, such as genetic anomalies, but will provide prenatal screening and subsequent referral for pregnancy termination when requested by a patient, as expected by their medical regulating college.

Alternatively, prior to the legalization of medical assistance in dying in some countries, some healthcare providers have chosen to hasten death for terminally suffering patients upon request, even though it was against the current ethical and legal codes of their profession and country.

It is obviously much less stressful to function as a physician when moral and ethical expectations are aligned, although we know that in the complexity of real-world medical practice, they sometimes are not!

Key Points

- Moral development occurs over one's lifetime, progressing along a continuum defined by three stages: preconventional, conventional, and postconventional [41, 45–47].
- Moral functioning relies on four key competencies which include: moral sensitivity, moral judgement, moral motivation, and moral implementation/character and competence [48].

Skill-Building Exercise: Moral Development

Take a moment to consider your own moral development to this point in your medical training.

- What personal moral beliefs guide your own decisions and behaviors as a physician?
- Consider a recent patient care experience in which you were able to live out your morals in your work as a physician. What made this possible? How did it feel?
- Have you been involved in a patient care experience in which your personal morals were challenged? How did you manage the situation? How did it feel?

Professional Identify Formation

In the context of medicine and clinical practice, a well-developed sense of moral judgement is both important and necessary for the challenging professional practice of "doctoring." There is an expectation that physicians, as professionals, reflect on the moral

basis of their actions and place the best interests of patients before themselves. This ability is realized over time as one develops their professional identity as a physician.

Professional identity formation is influenced by ongoing moral development, and is defined as "a process by which [trainees] incorporate professional values, aspirations, and actions into their identity and develop an increasingly complex understanding of what it means to be a professional" [48]. As one transitions from medical school to residency to independent medical practice, the integration of this growing professional understanding with one's own moral construct supports the evolution of an increasingly complex professional identity. Learning about medical professionalism is a fundamental component of medical education; the goal is to ensure that medial trainees understand the nature of the profession, its obligations, and the importance of internalizing its value system. The ultimate outcome of professional identity formation is a "fully integrated moral self," "one whose personal and professional values are fully integrated and consistently applied" [50]. Equipped with a well-established professional identity, one is more likely to experience success as a humanistic and resilient healthcare professional.

Key Points

- Professional identity formation is "a process by which [trainees] incorporate professional values, aspirations, and actions into their identity and develop an increasingly complex understanding of what it means to be a professional" [50].
- The successful outcome of professional identity formation is a "fully integrated moral self" in which one's "personal and professional values are fully integrated and consistently applied" [50].

Stalling of Moral Development During Medical Training

Moral development can be either positively or negatively affected during medical training. Medical residents often enter training in early adulthood when moral development typically progresses from the conventional stage wherein behaviors are based on the norms and values of those around them, to the post-conventional stage in which individuals identify and attempt to live by their own personal values. However, a number of studies have shown that moral development in medical students remains relatively stagnant [41, 46, 51–55]. It has been suggested that the lack of ongoing moral development in medical trainees is attributable to *moral distress* that arises in part due to hierarchical pressures (i.e., the hidden curriculum) of medical training [41, 52, 54].

Did You Know?

The hidden curriculum is defined as "a set of influences that function at the level of organizational structure and culture," and is sometimes also referred to as the "null curriculum," "informal curriculum," or "silent curriculum." The hidden curriculum is learned implicitly (without awareness), as opposed to from explicit teaching as part of the formal curriculum [56].

The hidden curriculum is a powerful socialization process whereby the trainee experiences a disconnect between what they have been taught (i.e., formal or delivered curriculum) and what they experience or observe of their attending's behavior [56]. Pressures within the hidden curriculum may hinder moral development by forcing residents to think and behave within a set of imposed rules and implicit expectations instead of acting in accordance with their own moral judgments and in patients' best interests. Moral distress is defined as "the negative feelings that arise when one knows the morally correct

thing to do but cannot act because of constraints or hierarchies" [52]. It is experienced by medical trainees when they witness disrespectful behaviors or actions that could negatively impact patient care within a hierarchy of medical training in which they have the least amount of perceived power [53]. If prolonged and pervasive, moral distress can be an important contributor to burnout, low career satisfaction, and erosion of professionalism [51].

Decline in Empathy in Medical Trainees

The majority of individuals enter medical school with an innate empathic capacity [27]. However, events that occur during medical training can either nurture or erode this capacity—unfortunately, it is often the latter [27, 35]. Similar to moral development, empathy also declines from distress brought on by the hidden curriculum in medical training [57]. Additionally, the following have all been reported to contribute to empathic decline: poor role modeling by mentors, mistreatment by superiors, insufficient social supports, high workload, limited direct patient interactions, challenging realities of patient care (e.g., unpleasant patients, malpractice issues, insurance regulations, limited autonomy due to hospital guidelines), hostile learning environment, pressures on time, fear and occurrence of medical error, lack of sleep, and an idealized view of medicine from various portrayals in the media and elsewhere [27, 35, 57, 58].

Skill-Building Exercise: Moral Distress

Think of a time when you experienced moral distress during your medical training.

- What happened in this situation that caused you to feel moral distress?
- What do you think should have ideally happened in this situation?

- What were the factors that prevented this more ideal experience?
- Are there ways you could think of improving similar situations in the future to eliminate or mitigate moral distress?

Humanism Barriers and Enablers

Barriers to Humanism in Residency

Most *undergraduate* medical schools are integrating humanistic teachings into the formal curriculum as a way to counterbalance the scientific domain. However, few *postgraduate* training programs carry this course of study forward, leaving residents to absorb the values and messages of the "hidden curriculum" on their own. Humanistic lessons learned in the pre-clerkship years are sometimes set aside as one advances up the hierarchy and becomes gradually unshielded from the harsh realities of modern healthcare. For example, a resident may be willing to experience the hazard of the open-ended question in a 10-minute appointment slot just a few times before they learn to curb that practice in favor of more directive interviewing.

The block-based residency rotation schedule can interfere with continuity of care and residents' development of longitudinal patient relationships [59]. Although strict work hour restrictions were introduced as a means of addressing the excessive workload of residency, they proved unpopular among some resident groups because of their impact on relational care [60]. For example, surgical residents are often sent home post-call rather than operating on the patients they admitted and cared for overnight. Systemic factors such as these can contribute to a decline in humanistic qualities in resident physicians. (For further details on the importance of sleep, see Chap. 13.)

As discussed earlier in this chapter, residency is an important time for professional identity formation in physicians. In relation

to this process, there are distinct challenges inherent to the role of the resident that make sustaining humanism difficult. First, residents must learn to self-negotiate appropriate professional boundaries. They must find a workable compromise between an empathic emotional investment in patients' lives, while remaining professional and functional in the face of pain and suffering. Failure to do so risks emotional distress and burnout on the one hand, and failure to connect with patients and find fulfillment in one's chosen career on the other hand [61].

Second, residents may struggle to identify and discriminate between performative and authentic aspects of humanism. For example, an empathic approach is often required as a "check box" in simulated scenarios that is easily fulfilled by a simple, rehearsed statement such as, "I'm sorry to hear that" [62]. In real clinical settings, if residents are not able to find the balance between authentic empathy and appropriate professional boundaries, they risk substituting the performative version for the authentic. Recognition as a "humanistic" resident can subsequently drive a pursuit of secondary gain such as esteem among superiors and career advancement [22]. This can easily become another contributor to burnout for residents and undermine the intrinsic value of an authentic humanistic approach [62].

Third, as young leaders of a healthcare team, residents must also manage the tension between empathy and authoritativeness. To engender confidence as team leaders, residents must at times trust their own experience, expertise, and intuition over that of the team, and even the patient, to best guide care [63]. To appear indecisive or uncertain in front of a patient is to risk them asking to see the "real doctor." As a compensatory technique, residents can find themselves failing to properly value input from patients or junior learners, or attending to the relational components of patient care and team function. Fear is also a powerful motivator in residency. The on-call resident alone in the hospital at 3:00 AM is primarily concerned with making correct clinical judgments and decisions in a timely manner so as to avoid negative patient outcomes and medical errors; this can overwhelm the capacity to approach patients in a humanistic way.

On a personal level, the demands of residency are well documented. Residency usually takes place concurrently with many

other important life events and decisions. Residents are often required to relocate far away from family and friends through the algorithmic residency matching process at a time when many of their peers are settling into their adult lives, partnering, buying a home, establishing financial independence, and having children. Residents work long hours, have little control over their schedules, and must incorporate research, self-study, and other career demands outside of the typical 9–5 work schedule, leaving them with less time and energy for nurturing their own needs [64]. They may also be separated from their previously established supports and humanizing pursuits, requiring the development of new connections.

Finally, the relative stakes of failure in the scientific realm are prioritized over humanistic domains. Licensing exams, in-training exams, objective structured clinical examinations (OSCEs), morning rounds, and "pimping sessions" (a teaching technique involving public interrogation of a trainee) are all opportunities to be exposed with a deficient fund of knowledge. By contrast, the humanistic qualities of physicians can be much harder to quantify and rank. There is often no supervisor observing a trainee's interviewing skills, empathic approach, and curiosity toward the patient's context and values. While failure to master the humanistic domain makes one a poor physician, failure in the scientific domain makes for failed licensing exams, remediation contracts, poor regard among colleagues, and other badges of dishonor. Failure in the scientific domain contributes missed diagnoses and avoidable morbidity, whereas failure in the humanistic domain contributes to "mere" patient dissatisfaction.

Table 1.2 lists common barriers to humanism encountered during medical training. These issues will be further explored in Chaps. 3 and 17.

Systemic Barriers to Humanism in Medicine

At times in the practice of medicine, the concept of work-life balance feels so elusive that it becomes more aptly termed "work-work balance" [3]. The demands of medical training and practice can be so overwhelming, compelling, and pervasive that work

Table 1.2 Barriers to humanism in medical training

Systemic factors	
Financial	The focus on clinical productivity, efficiency, and performance metrics leads to decreasing time spent face to face with patients.
Limited continuity of care	An increasing number of specialized clinics, alternate care providers, organizational fragmentation, disjointed and unintegrated technological systems often challenge communication between healthcare silos and the longitudinal patient-physician relationship.
Technological advancement	Reliance on technological systems and increasing documentation requirements has led to a decline in meaningful face-to-face interaction between physicians and patients.
Specialization	Decreasing reliance on generalist care promotes disease-specific care rather than person-centered care.
Residency-specific factors	
Personal	Financial debt, uncertain employment prospects, and geographical distance from support networks contribute to high rates of emotional distress.
Workload	Demanding work hours and workload contribute to professional and personal burnout which leads to feelings of depersonalization and inhibits the formation of therapeutic relationships with patients.
Professional identity formation	The hidden curriculum of medical culture is often at odds with the values of humanistic care.
Incentives	The pressing priorities of exams, performance reviews, and program and certification requirements have potential to distract from resident focus on developing a humanistic approach to the practice of medicine.

invades home life and personal time to increasing degrees. Chapters 3, 8, and 17 will further explore various aspects of this shift toward "perpetual work-mode," along with its link to technological advances in medical practice.

The changing landscape of medicine has also had a major impact on day-to-day practice and the way physicians interact

with patients and colleagues. One author identified overemphasis of biomedical and technical models of care over psychosocial and relational aspects, as well as pressure to compete with others and impress preceptors as additional factors eroding empathy [65]. Lehman and colleagues insightfully point out that "technology need not hamper the sacred space of the patient-physician relationship" [54]. Physicians are taught the importance of evidence-based medicine which attempts to describe people, treatments, and investigations through data. Such evidence is necessary but insufficient in the care of patients and in the maintenance of physician resilience. A similar philosophy of care pertains to the use of technology in medicine. Rapidly advancing technology is extremely important in medical care, but there have also been unintended consequences for patients and their caregivers. Studies have shown that internal medicine residents spend as little at 9–12% of their time with patients and 40% of their time in front of the computer reviewing results, ordering investigations, and charting [66]. The impact of technology on humanism and physician wellness will be explored further in Chap. 3.

Additionally, more time is now spent with the team "rounding" on the computer screen and less time rounding with the patient—who should be considered the most important member of the team [54]. Physicians are spending 25% less time doing bedside teaching which results in the loss of important role modeling opportunities. It is at the bedside where students and residents learn from their teachers about therapeutic relationships, communication, clinical skills, and empathy, all of which are foundational to patient-centered care [67]. As McGee writes, "when learners experience bedside teaching, they tend to prefer such rounds for future instruction, commenting that bedside rounds provide them their opportunity to see teachers interact with patients, learn physical diagnosis, and reinforce the perspective that patients are not abstract diseases or hosts but instead unique persons" [67].

Finally, as medicine becomes increasingly sub-specialized in response to the breakneck pace of evolving healthcare discovery, coupled with increasing expectations in terms of deliverables from healthcare providers and the healthcare system, the essential prac-

tice of "generalism" is threatened. Generalist specialities have the ability to apply a more holistic approach to patient care including an understanding of psychosocial context over time, which both benefits from and promotes humanistic practice. Medicine's trend toward increasing specialization and narrowing fields of practice fosters discomfort with uncertainty and potential disdain for "not knowing." Medical trainees often experience distress with and disregard for clinical uncertainty through the hidden curriculum, if not overtly. Unfortunately, this can make it even more challenging for trainees to develop the skills and ability to successfully approach and manage complex multi-morbidity, undifferentiated, and at times, inexplicable patient concerns. It also risks fragmentation of care, the creation of "silos" of patient care, and diminished continuity of care. All of these can impair patients' and providers' experiences of humanism in the healthcare system itself, regardless of the approach of individuals within the system.

Case Study II

Fatima, a first-year medical resident, has just started her emergency medicine rotation and is having a busy shift in the ED. She has not worked previously with her current attending physician.

A young female comes into the ED alone and tearful. The patient is settled into a room and determined by nursing to have stable vital signs, following which Fatima begins her assessment. The patient is pregnant at 10 weeks gestational age, a first pregnancy that was desired and took over a year to conceive. Today the patient started to experience cramping, followed by spotting. Over the past several hours, the cramping has become more severe and the bleeding much heavier. The patient is scared and sad. The patient's husband is overseas visiting family and she has been unable to reach him.

Fatima is concerned about the degree of ongoing bleeding. She prepares the patient for a speculum exam, and is able to identify a large blood clot at the cervical os that she gently removes with

ringed forceps. It is a difficult exam due to the patient's distress and the amount of bleeding. While she is in the middle of the examination and providing ongoing emotional support to the patient, her attending appears suddenly in the patient room. He is visibly upset at how long she has been taking for this patient assessment, and without acknowledging the patient, firmly instructs her to hurry up and finish with this case so that she can move on with the lineup of patients accumulating in the waiting room.

Question 1. **What barriers to humanistic practice contributed to this upsetting situation faced by Fatima?**

A. **Inadequate time for workload demands**
B. **Lack of role modeling of humanism by preceptor**
C. **Resident lack of familiarity with ED process and preceptor expectations**
D. **All of the above**

Answer: D ✓

Working in the ED can be challenging for countless reasons: acuity, volume, strained resources (e.g., rooms, staffing, imaging availability), demands and emotions of patients and family and providers (A). Lack of familiarity with a new department and its processes, the healthcare team members, and rotation expectations are common challenges for medical trainees like Fatima (C). Proper orientation and supervisor support are especially important in high stress and high acuity rotations. In this difficult encounter with her supervisor, Fatima was approaching her care of the patient in a humanistic manner, which was not understood, acknowledged, or valued by her supervisor (B). It is likely that not only Fatima, but the patient as well, were negatively impacted to some degree by this interaction. Barriers to humanism in this situation included: (A) time pressures due to patient volume in the ED, (B) differing priorities between Fatima and her supervisor regarding triage of patients and a humanistic approach to care,

and (C) lack of familiarity between Fatima and her supervisor such that trust and clarity of expectations and process had not been well established. Orientation, team relationship-building, and open conversation about patient care and prioritization would all be helpful in mitigating dehumanizing occurrences such as this.

Question 2. **What humanistic approaches to patient care and resident education could the preceptor have role modeled for Fatima, in a more optimal encounter?**

A. **Providing feedback to the resident in a private location**
B. **Acknowledging the patient upon entering the room**
C. **Taking time to understand and validate the patient's experience**
D. **Offering to accompany or assist the resident during the procedure**
E. **All of the above**

Answer: E ✓

There are various ways in which clinical supervisors can role model humanism (or not!) in both patient care and in teaching. Fatima's patient could have benefited emotionally from acknowledgment of her person (B) and her concerns (C) by the staff physician, but instead may have felt dismissed and disrespected. A humanistic approach is more likely to enhance this patient's overall satisfaction with the visit and her follow through with medical recommendations, even as she confronts the grief and fear of her pregnancy loss. A more humanistic approach to teaching could have included a debrief of the case with genuine interest in Fatima's assessment and approach to the patient's care, and provision of feedback in a private location as opposed to in front of the patient (A). Fatima might also have benefited from the support of her supervisor during the challenging examination (D), an opportunity for direct observation, teaching, and enhanced learning. Humanism has the potential to not only benefit patients, but learners and practitioners as well!

Supporting the Development of the Humanistic Resident

Residency training is a stressful time for many residents. Developing healthy adaptive methods to process the complex demands and challenging experiences of residency should be an essential component of training. Programs that support the development of a positive professional identity and personal awareness of the emotional labor of caring are more likely to foster the development of humanistic practitioners. Fostering moral development and empathy during medical training by addressing the systemic elements that contribute to its decline is of paramount importance. Failing to do so risks burnout, compassion fatigue, and overall dissatisfaction among physicians. But as residents, what can one do?

Being in healthcare, residents are generally aware of the importance of self-care (e.g., eating right, getting enough sleep, and exercising) and of maintaining work-life integration as a way to protect against the negative impacts of training. While self-care is important, it is not enough. This type of lifestyle advice falls short of fully addressing the real-life pressures of medical training and can be difficult to achieve amidst the heavy demands of clinical work, busy call schedules, and large patient loads. Modern medicine and medical education are starting to incorporate the arts and humanities as one measure to help protect against burnout and to promote compassion and humanism in medicine. Although this chapter will introduce such ideas, they will be elaborated further in the chapters of Part III section, *Adaptive Strategies to Promote Physician Wellness*.

Role of Arts and Humanities in Supporting Humanism in Medicine

The arts and humanities in medicine and medical education have been gaining momentum and are now widespread. Residents and physicians can now access the arts and humanities in medicine

through a number of journals, courses, electives, programs, and research groups all devoted to medical humanities. Importantly, medical humanities is now more commonly referred to as *health humanities*, as this term is more inclusive of other healthcare professionals; it is defined as an "integrated, interdisciplinary, philosophical approach to recording and interpreting human experience of illness, disability and medical interventions" [68]. The incorporation of health humanities has gained popularity in medical education as a means to address dwindling empathy, increasing moral distress, and burnout. As Skorzewska and Peterkin have pointed out, the health humanities are concerned with two important areas of healthcare: first, humanizing medicine by fostering a deeper understanding of the impact of illness on the patient and those who care for them; second, providing a unique space for critical and self-reflection [69]. By creating the necessary space for such reflection, health humanities hold the promise of fostering resilience and meaning in the work of being a physician.

Did You Know?

"The Art of Seeing™" is a visual literacy program that enhances observational skills, fosters empathic development, and promotes self-care for healthcare providers through the facilized viewing of works of art with guidance from trained facilitators, usually in the creative space of an art gallery [70, 71].

Critical Reflection

Critical reflection and critical thinking are processes that help one make sense of experiences through questioning, analyzing, and evaluating. Through reflection, one can explore thoughts and experiences to gain a new and deeper understanding. The insights gained through this process can be applied to similar subsequent situations.

Critical reflection in small groups using interactive reflective writing has been shown to support professional identity formation, help learners distinguish between positive and negative role models, uncover the hidden curriculum, develop humanistic skills and attitudes, reduce stress, and foster wellness when incorporated into medical curricula [72–74]. In a study by Koo in which urology residents and fellows were asked to reflectively write about a particularly meaningful personal or professional experience during their training, the common emergent theme was that the writing helped trainees find meaning in their work [75].

What is it about reflective writing that leads to critical reflection? Reflective writing creates space to question, analyze, and evaluate one's experiences, along with the thoughts, feelings, and reactions they evoke. Learning by practice alone without reflection is unlikely to result in professional growth [41, 76]. Charon and colleagues have written extensively about the importance of reading literature and reflectively writing about the experience of caring for patients as a means to promote critical reflection and improve patient care [77]. Charon proposes that narrative training in the clinical setting "can introduce students to ways of knowing that allow them to recognize ethical dilemmas, to regard patients holistically, and to feel the emotions of compassion toward patients and themselves" [77]. Furthermore, narrative training can "increase curiosity, strengthen the use of imagination, and develop the creative powers of the students to represent what is seen so as to deepen his or her very perception of that which is before the eyes" [77].

In a busy clinical setting, the tendency is to look for a quick overview or the "bottom-line" when reading medical information. Reading literature and writing reflections cause one to slow down in ways that are unfamiliar to many in the typical harried practice of medicine. When a physician *does* have time to relax and read for leisure, it might well be spent on a mobile device scrolling social media. However, literature can be a rich source of knowledge about the human experience of illness. In an article entitled "Slow Medical Education," Wear and colleagues advocate for thoughtful placement of literature in medical curricula as a means

of helping students understand patients' illness experiences and fostering professional identity formation through a deeper understanding of these experiences [78]. Writing with the intention of reflecting requires more engagement and exploration, a commitment to ideas, sometimes a reliving of the past, and time to reflect on how things could be different in the future [77].

Are there alternative settings to a hospital or clinic for physicians to engage in reflective practice? As it turns out, the answer is yes. There are now a number of health humanities initiatives across Canada and the USA which have incorporated the art gallery and museum as a unique space for medical practitioners to develop skills in reflective practice. There is mounting evidence for the educational value of taking learners into the art gallery [70, 71, 79, 80]. Many of these studies initially focused on the impact of observing art on improving observational skills and diagnostic acumen, as well increasing acuity to nonverbal cues [79, 81]. It turns out that improving visual literacy impacts more than just observational skills. Basic visual literacy techniques can improve perception, critical thinking, communication, empathy, compassion, self-care, and wellness when augmented by facilitated observation, discussion, art creation, and narrative reflective writing [70, 71]. There are now over 40 undergraduate and 11 postgraduate programs in Canada and the USA that have incorporated visual arts into their curricula [82]. These highly experiential programs, which take place in the imaginative space of the art gallery, promote "learning to look and then look again," contribute to professional identity formation, and nourish the qualities necessary to practice humanistic medicine [70, 71].

Mindfulness Practice

We know that empathy declines during medical training, while rates of burnout and distress increase [27]. These trends are of particular concern and importance given that heightened empathy and decreased distress among medical providers have both been associated with better health outcomes for patients and an improved sense of well-being for physicians [27].

In response, a number of medical schools around the world have started to incorporate mindfulness-based interventions (MBIs) into their programs as an effective strategy to manage and decrease stress/distress associated with medical training [83–86]. A 2018 systematic review of mindfulness interventions in medical education by Daya and Hearn found that MBIs were effective in managing and preventing stress and depression in learners [83]. MBIs have also been shown to positively influence empathy and reduce the risk of compassion fatigue and burnout [86–89].

Mindfulness training has been associated with the development of attributes such as curiosity, openness, acceptance, and an ability to focus on the present moment [86]. Thus, training in mindfulness practices can be an effective way to develop the skills necessary to promote more effective and rewarding doctor-patient relationships. The mindful medical practitioner is more likely to engage in attentive listening, develop a deeper understanding of the patient's illness experience, and respond with increased compassion and empathy [86].

Mindfulness can also help combat the negative impact of stressors associated with medical training by fostering self-awareness regarding the types of ruminations that often precede the onset of depression, and promoting the ability to identify and adapt to intense emotions [83, 84]. The mindful physician is more likely make sound judgments during stressful situations and is more apt to engage in self-care activities [85]. (For further details on mindful techniques, see Chap. 15.)

Did You Know?

- ***Mindfulness*** *can be described as "non-judgemental attention to experiences of the present moment, including emotions, cognitions, and bodily sensations, as well as external stimuli" [86].*
- ***Mindfulness practice*** *is defined as "systematic training and practice (of mindfulness), primarily through meditation" [83].*

Skill-Building Exercise: Pause and Reflect

1. In what situations do you find it most challenging to employ a humanistic approach in your practice of medicine?
2. In your development as a humanistic medical doctor, what have you found helpful for nurturing humanism in practice?
3. What new experiences and strategies are you interested in exploring to further develop and maintain your humanism as a medical doctor?

Strategies to promote humanism in residency education will be discussed further in Chap. 16.

Impact of Humanistic Medical Practice

Benefits of Humanism in Medical Practice

As has been noted previously in this chapter, physicians who practice medicine with a humanistic approach experience enhanced job satisfaction [3, 20]. As human beings are wired with a need for emotional connection, it is through relationships that physicians find meaning in their work and lives.

Interestingly, there has been some discussion about the association between a humanistic approach to medical care and the risk of provider burnout [90]. While humanistic physicians tend to have greater job satisfaction, these very physicians may also have a tendency toward altruism, placing the needs of patients and others above their own. If taken to a degree that risks self-neglect, over time this could progress toward compassion fatigue and burnout [90]. It is essential that humanistic physicians remain attentive to their self-care needs to ensure that they preserve their own well-being, which subsequently enables them to provide humanistic care to others [3, 20]. The concept of self-compassion

will be explored more fully in Chaps. 2 and 15, while compassion fatigue and burnout will be addressed in Chaps. 10 and Chap. 18.

Encouragingly, there is additional literature to suggest that a humanistic approach to the practice of medicine can reduce the risk of burnout and enhance physician resilience, as discussed earlier in this chapter [3, 27]. This may be attributable to the ability of humanistic physicians to forge meaningful connections with patients and coworkers, thereby achieving enhanced career satisfaction overall. It may also be that humanistic physicians are more likely to prioritize opportunities for self-care and healthy pursuits beyond medical practice [3].

Key Point

A humanistic approach to medicine has benefits for:

- *Patients*—improved satisfaction with care, increased follow-through on healthcare recommendations, improved health outcomes
- *Physicians*—enhanced career satisfaction, decreased risk of burnout, and increased resilience
- *Healthcare teams*—improved communication and effectiveness

Case Study III

Jorge is a third-year general surgery resident who attends a walk-in clinic one Saturday morning. He is experiencing a personal health crisis related to a recent breakup with his long-term boyfriend. He has been stressed and busy on surgical rotation at the hospital. He had been aware of strain in the relationship, partly due to limited time and energy to invest. But he had not anticipated the breakup, having assumed that circumstances would

improve on upcoming rotations, and even more so upon completion of training.

Jorge is sad and a bit tearful. He is unable to sleep, eat, and concentrate. He has withdrawn socially from colleagues and friends, preferring time alone. He wants to explore medical options to aid sleep as he is finding it difficult to function at work. He also recognizes his need for professional counseling support.

The healthcare provider at the walk-in clinic seems distracted by issues with the computer in the examination room, making little eye contact. Without much inquiry or discussion, he hands Jorge a computer tablet and asks him to complete two electronic questionnaires. One is to assess Jorge's mood symptoms and the other is to assess his anxiety symptoms. Jorge mentions that he is dealing with a situational crisis, and does not feel such questionnaires are applicable to his situation which is acute and has been precipitated by the breakup. The healthcare provider does not appear interested in this perspective and remains firm on the importance of the instruments for assessment. Jorge feels somewhat misunderstood and disconnected from the provider. But given his desire to feel better and return as soon as possible to his previous level of function, he sighs and completes the PHQ-9 and GAD-7.

There is very limited conversation following completion of the questionnaires, with the healthcare provider relying primarily on the electronic information and test scores. Jorge feels further shut down, and although he leaves with a short-term medication trial to help him sleep and with a list of local counselors, he actually feels somewhat worse than he did prior to the medical appointment.

Question 1. **What are the barriers to humanism experienced by Jorge in this medical encounter?**

A. **Limited interest in and exploration of the patient's story**
B. **Over-reliance on a reductive checklist**

C. **Dismissal of patient concerns**
D. **All of the above**

Answer: D ✓
The healthcare provider at the walk-in clinic employed a more biomedical approach to care than a humanistic approach to care, resulting in Jorge leaving the appointment feeling overall less well emotionally than he did prior to the visit. Jorge was somewhat dissatisfied with his medical care, even though he was provided with a sleep medication and a recommendation for counseling, which were his practical goals for the visit. The healthcare provider's limited conversation and exploration of Jorge's situation (A), along with the dismissal of his concern about the relevance of a reductive checklist-based approach to diagnosis (C), and reliance on test scores as opposed to Jorge's experience and story to help guide assessment and management (B), contributed to his feelings of not being heard or understood.

Question 2. **What benefits could Jorge experience with a more humanistic approach to his medical care?**

A. **Increased satisfaction with medical care**
B. **Increased follow through on care plan recommendations**
C. **Improved sense of well-being**
D. **All of the above**

Answer: D ✓
Had Jorge's medical care provider been able to show more interest in who he is and what he is experiencing, it is likely that he would have left the encounter feeling more satisfied with the visit (A) and with an improved overall sense of wholeness and well-being (C). It is also more likely that he would follow through on recommendations for care related to sleep, counseling support, and other aspects of self-care.

Key Takeaways

- At its best, the practice of medicine is a humanistic service to support the overall health and wellness of individuals and society.
- Medicine requires expert knowledge and skill in both biomedical and humanistic approaches to care such that scientific expertise is applied thoughtfully in the lives of patients and their communities with the goal of compassionate care and healing.
- Humanism is an approach to medical care that values the connection between doctor and patient, considers the patient in their broader social context, respects patients' goals and values, and expresses empathy and compassion.
- Humanistic medicine is associated with improved satisfaction and health outcomes for patients and improved career satisfaction for physicians.
- Residents and physicians face many barriers to humanism in medical practice, including time constraints, resource shortages, the role of technology, the hidden curriculum, lack of continuity with patients, hierarchical systems, fatigue, and burnout.
- Moral development, professional identity formation, and empathy are important processes for medical trainees that can be negatively impacted during residency and medical practice.
- Positive role modeling of humanistic medicine and inclusion of the arts and humanities in medical curricula (e.g., reading literature, reflective practice, and art observation) support the development and sustenance of humanistic physicians.
- Many resources are available to support medical trainees in their development and maintenance of humanism and resiliency, while also helping to mitigate the stress of residency.
- Humanism in medical practice is an important contributor to physician wellness and the prevention of burnout.

Additional Resources

Selected resources about humanism in medicine are illustrated in Table 1.3.

Table 1.3 Selected resources for humanism in medicine

Online resources	**Web link**
NYU LitMed Database	http://medhum.med.nyu.edu
History of Medicine & Medical Humanities	https://medhumanities.mcmaster.ca
Bellevue Literary Review	https://blr.med.nyu.edu
The Arnold P. Gold Foundation	https://www.gold-foundation.org
Center for Digital Health Humanities	http://www.centerfordigitalhealthhumanities.com/en/
Graphic Medicine	https://www.graphicmedicine.org
Canadian Association for Health Humanities	https://www.cahh.ca
Ars Medica: Journal of Medicine, The Arts, and Humanities	https://ars-medica.ca/index.php/journal
Intima: Journal of narrative medicine	http://www.theintima.org
Journal of Medical Humanities	https://www.springer.com/journal/10912
Columbia Narrative Medicine	https://www.narrativemedicine.org
BMJ Journals: Medical Humanities	https://mh.bmj.com
MedHumChat	https://www.medhumchat.com
Books	**Brief description**
"In Shock: My Journey from Death to Recovery and the Redemptive Power of Hope" by Rana Awdish, St. Martin's Press; 1 edition, Oct. 24, 2017.	A insightful, compassionate, and critical look at illness from both a physician's and a patient's perspective.

(continued)

Table 1.3 (continued)

"When Breath Becomes Air" by Paul Kalanithi, Random House; 1 edition, Jan. 12, 2016.	A powerful and inspiring, posthumously published memoir about the author's life and illness as a physician and a patient, finding hope and beauty in the face of battling terminal illness.
"Middlemarch" by George Eliot, Alma Classics, Franklin Square, Mar. 20, 2018.	George Eliot's masterpiece; a riveting, timeless novel published in the nineteenth century, emphasizing compassion, generosity, and self-awareness in the shaping of a single life, which transcends time and generations.

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