TEACHING ETHICS,
THE HUMANITIES, AND HUMAN VALUES
IN MEDICAL SCHOOLS:
A TEN-YEAR OVERVIEW

Edmund D. Pellegrino
Thomas K. McElhinney

INSTITUTE ON HUMAN VALUES IN MEDICINE
SOCIETY FOR HEALTH AND HUMAN VALUES
WASHINGTON, D.C
<table>
<thead>
<tr>
<th>The Joseph and Rose Kennedy</th>
<th>Georgetown University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institute of Ethics</td>
<td>Washington, D.C. 20057</td>
</tr>
</tbody>
</table>

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Gift of

Edmund Pellegrino
The work summarized in this report has been funded under National Endowment for the Humanities Grant # EN-28688-77-1409 to the Society for Health and Human Values, Philadelphia, Pennsylvania. Correspondence relating to the Institute should be addressed to Dr. T. K. McElhinney, Program Director, or Dr. E. D. Pellegrino, Director, c/o George K. Degnon Associates, Inc., 1311 A Dolley Madison Boulevard, McLean, Virginia 22101.
ACKNOWLEDGMENTS

In a decade of extensive and intensive work the Board of the Institute on Human Values in Medicine has enlisted the time and effort of many capable and dedicated people. It is not possible to list all of them, but a few deserve our special gratitude.

First, we must thank Dr. Lorraine Hunt, who from 1970-1974 was our first Program Director and provided invaluable service in the Institute's formative years. Then we would thank those members of the staff of the National Endowment for the Humanities with whom we worked as colleagues for many years -- Dr. Richard Ekman, Dr. Cynthia Wolloch, and Dr. Richard Hedrich.

We owe thanks also to the United Ministries in Higher Education and the United Presbyterian Church in the United States of America which housed the offices of the Institute and assisted its work in other ways. The same is true of the Society for Health and Human Values and its successive presidents who served ex officio as Board members during the terms of their presidencies.

Finally, and most of all, we thank our colleagues in the field -- the directors and teachers of ethics, human values and humanities in the nation's medical, nursing, and allied health schools who gave of their time and capabilities to serve as visiting faculty in our resource visits, as participants in our dialogues between the disciplines, in our fellowship program, and in our conferences.

Not to be forgotten are those indispensable persons -- our secretaries and assistants -- who coordinated all the details of site visits and preparation of reports, without which the extensive activities of the Institute would have been impossible.

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INTRODUCTION:

Development of the Institute

This report summarizes some of the more significant experiences and work of the Institute on Human Values in Medicine which has been assisted for a decade by successive grants from the National Endowment for the Humanities. The report draws on several sources: (1) a decade of annual reports by the Institute to the National Endowment; (2) a recent questionnaire survey of 125 American medical schools; (3) site visits by the Institute staff to 80 medical schools; (4) the "Capstone" Conference held at the Sugarloaf Conference Center in December, 1981, for program directors and teachers in human values, ethics and the humanities in medical schools.

The first half of the report is devoted to the survey results, supplemented by the observations and conclusions derived from personal visits to ongoing programs. The second half summarizes the discussions, conclusions and recommendations of the teachers of human values who participated in the group sessions at the "Capstone" Conference.

The Institute began its work when the National Endowment for the Humanities funded the first two national conferences for medical educators and humanists in 1970 and 1971 to discuss the feasibility of teaching human values in medical schools. The first operating grant was awarded by the National Endowment in 1970. In the succeeding decade, the Institute received three additional grants from the Endowment. The work, described in this report, was supported by the National Endowment for the Humanities from 1970-July, 1982.

From its inception the Institute has been one of the programs of the Society for Health and Human Values. The Society was formally established in 1968 to encourage research, teaching and public interest in questions of human values as they arise in health and medical care. Its members are drawn from a wide spectrum of educators, faculty members and health care practitioners who share a common interest in ethics, human values and the humanities in the health sciences.
While the Institute is one of several program "arms" of the Society, it is organized under its own Board of Directors, with ex-officio membership of the President of the Society. Both the Society and the Institute have concentrated their efforts on education rather than research per se. They have also embraced the intersections of medicine and the humanities as a whole rather than just with ethics. The Institute's great strength lies in the network of relationships it has established with the faculties of medical schools and schools of the other health professions throughout the country. It has in fact been a specialized university without walls, employing a small administrative staff, calling on a nationwide faculty to carry out its programs.

When the Institute began its work, there was in existence a small number of programs dedicated to teaching human values in medical schools. Now, at the beginning of the 80s, almost every school of medicine and many schools of nursing are teaching courses in ethics and, in addition, some other aspect of human values or the humanities. This remarkable, and quite unprecedented growth paralleled the growth of the Institute's programs and activities.

The Institute does not claim exclusive credit for this growth but there is evidence that its involvement with so large a number of schools and faculty members has been instrumental in the establishment of many programs. In some cases, programs were clearly developed as a direct outgrowth of the "resource visit" to a campus or a faculty fellowship granted by the Institute. While a precise quantitative appraisal of the Institute's influence is not possible, it is a reasonable conclusion that both the Society and the Institute have played major parts in the current widespread interest and teaching in human values in health professional education.

From its inception, the Institute has concentrated on three specific programs -- (1) "resource" and consultation visits to medical campuses; (2) a fellowship program; and (3) dialogues between the disciplines. Its work has been published in a series of seventeen monographs and books which have been used by many educational institutions as guidelines in the development of new programs and in evaluating old ones. (1)

In all its programs the Institute has sought constantly to create long-term multiplier effects. That the effort has been successful is evident from constant references to the Institute in reports in the literature by those who had the advantage of assistance from one of the Institute's programs.
At the "Capstone" Conference the influence of the Institute's work was attested to in several ways:

1) Most of the directors of current programs received their first impetus from a fellowship under Institute auspices or were recipients of one of the Institute's faculty and campus resource visits.

2) Many of their scholarly papers resulted from the Institute's fellowship program.

3) Noticeable changes were recorded in faculty attitudes following a resource visit by the Institute.

4) Authorization to hire faculty or expand the scope of a program often followed one of our visits.

5) An increase in the acceptance by faculty, students and administration occurred.

6) The Institute's publications were widely used to design and implement teaching strategies and curricular programs.

Some quantitative estimates of the Institute's impact on medical education is deducible from the following data.

The Endowment's outreach through the Institute has been summarized in several previous reports. The following information updates the figures to June 30, 1981. Institute programs have now directly involved more than 16,600 persons from about 372 schools, professional organizations, and hospitals, and another 75 who did not specifically identify affiliation with a particular organization.

<table>
<thead>
<tr>
<th>Amount of Time Spent in Various Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellowships: 77 awarded, 308 months of training</td>
</tr>
<tr>
<td>Dialogues: 56 members, spent about 626 days in dialogue sessions, plus about 1,800 days in preparation</td>
</tr>
<tr>
<td>Resource Services Conferences: 16 conferences, average attendance 60, equals about 2,000 days of training</td>
</tr>
<tr>
<td>Resource Services Visits: 77 visits, average persons seen 200, about 15,400 persons received one hour of training and more than 36,200 hours of training were done</td>
</tr>
</tbody>
</table>
Directors of Medical Education: 3 conferences with 116 participants receiving 21 hours of class time equals over 2,400 hours of training. About 75 other persons attended at least part of the California conference.

Program Outreach
(totals)

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th># of States*</th>
<th># of schools, institutions &amp; places</th>
</tr>
</thead>
<tbody>
<tr>
<td>77 Fellows came from</td>
<td>24</td>
<td>58</td>
</tr>
<tr>
<td>77 Fellows worked in</td>
<td>30**</td>
<td>81</td>
</tr>
<tr>
<td>176 Applicants not selected</td>
<td>34***</td>
<td>136****</td>
</tr>
<tr>
<td>came from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56 Dialogue Members</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>17 Resource Services Conferences</td>
<td>36</td>
<td>154*****</td>
</tr>
<tr>
<td>77 Resource Services Visits</td>
<td>26***</td>
<td>56</td>
</tr>
<tr>
<td>36 Team Members</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>3 Directors of Medical Education Conferences</td>
<td>26</td>
<td>92</td>
</tr>
</tbody>
</table>

* Includes District of Columbia
** plus 6 foreign countries
*** plus 1 foreign country
**** 7 were unaffiliated
***** 50 persons, mostly health professionals, did not list a formal affiliation and are not counted in this total.

The National Endowment for the Humanities showed a remarkable prescience when it first decided to fund the work of the Institute. At that time, there were only a few pilot programs, all in relatively new medical schools, and of a few years duration. Through its support of the Institute, the National Endowment has contributed significantly to the establishment of the "connections" between the humanities and professional education and practice. The recent Report of the Commission on the Humanities focused its recommendations a decade later on the importance of just these connections between the study of the humanities and everyday life. It underscored particularly how important the humanities are in the education of all professionals who must make so many crucial value decisions in a technological society. (2)
In a very practical and concrete way, the Institute on Human Values in Medicine has been one of the most successful vehicles in fulfilling the Endowment's own mission to improve teaching of the humanities and make them integral to every facet of American life. Through the flexibility in programming encouraged by the Endowment, the Institute has been able to influence a wide spectrum of university administrators, students and faculty members.

We believe that the decade of effort by the Institute will have a lasting impact on medical education. We believe, too, that it will prove to be among the most successful programs sponsored by the National Endowment for the Humanities.
(1) See Appendix A for a listing of the Institute's Publications.

PART ONE

Teaching Ethics, Human Values, and the Humanities in Medical Schools: State of the Art

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>The Institute Survey</td>
<td></td>
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<tr>
<td>Chapter II</td>
<td>Curricular Pediments and Impediments:</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Ten Years of Site Visits</td>
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<tr>
<td>Chapter III</td>
<td>Present Rationale and Future Viability: The Liberal Arts in the Health</td>
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<td></td>
<td>Professions</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER I

Topography of the Programs:
The Institute Survey

During 1980-1981 the Institute on Human Values in Medicine conducted a survey by questionnaire of 125 medical schools in the United States (2 osteopathic schools were included). The purpose of the survey was to assess the extent of the teaching of human values, ethics and humanities, its geographic and administrative locations, the topography of the teaching faculty, and the kinds of courses offered. The survey supplemented the visits of Institute staff to medical campuses and provided a profile of some of the more important characteristics of these teaching programs.

Unfortunately, data on financial details, sources of support, size of budgets, and salaries were not reliably enough reported to warrant tabulation. In view of the real possibilities of declining support in the years ahead, such data are obviously of very great significance. They will have to be collected by a survey designed specifically to elicit financial data.

Previous Studies and Surveys

The first formal teaching programs in the humanities and human values appeared in medical schools in the late 60s. The three earliest programs were those at The Hershey Medical Center of Pennsylvania State University, the Medical School of the University of Florida, and the new Medical Center of the State University of New York at Stony Brook. The most notable period of growth, however, occurred in the early 70s through the encouragement of the National Endowment for the Humanities and a number of private foundations. The growth from 1972 to 1980 was extremely rapid. It was accelerated by the great expansion of public interest in ethical and value questions arising from the rapid rate of medical progress.

In 1972 the Institute was able to publish detailed descriptions of teaching programs in 12 schools. In 1974 the number grew to 19 and then to 29 in 1976. (1, 2, 3) The 1982 edition of Human Values Teaching Programs for Health Professionals contains descriptions of the programs in 65 schools. (4)
In the *Journal of the American Medical Association*'s annual reports on medical education human values interests have twice been surveyed. The first report given in December 1976 said:

Of 113 schools reporting, the curriculum at 63 includes a humanities course such as history, philosophy, ethics, or human values. At five schools courses are being developed, and at 34 schools a separate administrative unit is involved. At all schools, 161 courses are offered, of which 50 are required and 111 elective. (5)

In a second report (6), four years later, 89 schools reported programs. An additional 7 schools reported programs in the planning process. One hundred and three schools offered instruction in human values during the basic science years, 15 during the clinical years. Seventy-seven provided special forums or seminars.

Robert M. Veatch and Sharman Sollitto surveyed the medical schools to learn where ethics was being taught. Their second report, published in 1976 (7), indicated that 95 of 107 medical schools responding indicated some medical ethics teaching. Twenty-six of these schools were teaching ethical issues in courses not primarily identified as ethics. The number of faculty devoting more than 50% of their time to ethics teaching increased from 19 in 1972 to 31 in 1974. The present survey corroborates a continued increase in teaching and shows that in fact it is occurring in some form in virtually every medical school in the United States.

A valuable overview, together with personal reflections and a summary of sources and organizations pertinent to teaching ethics, is provided in the recent report by K. Danner Clouser. Many of his conclusions are similar to those we have arrived at in this report. (8)

Two additional resources of interest are available from the American Philosophical Association and the American Nurses' Association. (9)

**Method**

A questionnaire was mailed to 125 schools. Schools not responding to the first mailing received a second. Schools not replying to either mailing were contacted by telephone up to four times. Most of the information reported here was obtained in an eight-month period beginning in the spring of 1980. The final results contain information on 122 of the 125 schools.
The questionnaire consisted of two parts. Part 1 contained questions about the administrative structure of the programs, their funding, faculty composition, the nature of the courses being taught, and the materials most frequently used in teaching. Part 2 of the questionnaire requested descriptions of the programs. Sixty-five of these descriptions have been collected and reported. (10)

Fifty-eight schools sent the Institute completed questionnaires and additional information including course outlines and other items describing the basic program. Eighty-nine schools completed both Parts 1 and 2 of the survey. Eighteen schools completed only Part 1. Ten other schools sent letters of explanation instead of completing the questionnaire, often containing more information on some points than requested. Five schools replied that at the time of the questionnaire they had no program they felt could qualify under the criteria in the questionnaire.

Some caveats in reviewing the data are in order. For one thing the data were collected in more than one academic term thus raising the possibility that changes in personnel or program content occurred in some schools. The changes, however, are probably not great enough to invalidate the findings. Also, the respondents had different perceptions about what constitutes human values teaching. This is not unexpected in a new field whose boundaries are yet to be precisely defined. Distinctions among programs and courses are therefore not likely to be clear cut. The ample supplementary material often provided with the questionnaires helped to obviate some of these limitations; nonetheless the data should be regarded as estimates -- the best that can be made given all of the materials at hand.

Results of the Survey

1. Administrative Locations

Of the 122 schools that responded to the survey 8 indicated either they had no program or that their programs were in transition. Therefore, the data base for this section is 114 schools. These schools are divided administratively as shown in Table I on the following page.

Only a few units stand as independent groupings within a medical school. These were classified as departments, divisions within departments, or inter-school programs. The majority of "programs" are almost equally divided between those units located within departments (with status less than a division) and those programs under the Office of the Dean.
TABLE I

Administrative Location of Human Values Teaching Programs

N = 114

1) Independent Departments ........... 4
2) Divisions in Departments .......... 4
3) Programs in Departments .......... 35
4) Programs in Dean's Offices ....... 30
5) Interschool Programs ............... 20
6) "Course" in Human Values .......... 18
7) History of Medicine Department ... 3

It should be noted here that a number of programs began under the aegis of the Dean but subsequently became divisions or departments. While 7 schools reported Departments of the History of Medicine, the structure of the courses in four schools led us to classify them in other categories. (11) Approximately half of the programs listed as "Programs in Departments" or "Programs in the Dean's Office" were reported without specific title or designation by their schools.

The wide variety of administrative arrangements is apparent. Only a few schools have placed human values teaching into a separate administrative unit.

2. Faculty

The following figures on faculty are obtained from 122 schools. The total number of faculty members reported to be teaching in human values was 1,064. Several schools reported that "others" cooperate and contribute time to their programs. The breakdown of faculty by rank, degree, salary and time is given in the following table. These data were not reported for more than 250 of the faculty listed by the schools. Faculty members are quite evenly distributed by rank. It is significant that about half are at the level of associate or full professor.

A surprisingly large number of physicians are reported as participating in the programs mostly in informal ways. Almost half of the reported faculty are M.D.s. However, they make up the bulk of the 57% who spend less than 10% of their time in the teaching of human values. The large number of "volunteer" faculty is made up predominantly of these M.D.s. Also, it is very likely that the 250 or more faculty members about whom we have no further data are "volunteer" M.D.s. They function in most programs largely as small group leaders, conference participants, or discussants at ethical "rounds."
TABLE II

Faculty by Rank, Degrees, Salary, Time

1. Rank (N = 756)
   - Professor: 238 (31%)
   - Assoc. Prof.: 168 (22%)
   - Asst. Prof.: 187 (25%)
   - Other: 163 (22%)
   - Plus 308 Not Indicated

2. Degrees (N = 745)
   - M.D.: 347 (47%)
   - Ph.D.: 250 (34%)
   - Other: 148 (20%)
   - Plus 319 Not Indicated

3. Salary (N = 780)
   - Paid: 530-1/2 (68%)
   - Volunteer: 249-1/2 (32%)
   - Plus 284 Not Indicated

4. Time (N = 651)
   - 100%: 68 (10%)
   - 75 - 99%: 16 (2%)
   - 50 - 74%: 46 (7%)
   - 25 - 49%: 55 (8%)
   - 11 - 24%: 94 (14%)
   - 10%: 125 (19%)
   - 5 - 9%: 150 (23%)
   - less than 5%: 97 (15%)
   - Plus 413 Not Indicated

-12-
Only 68 faculty spent 100% of their time teaching human values, ethics or the humanities. They include mostly the bona fide humanists -- ethicists, historians, philosophers, theologians, teachers of literature -- who are the backbone of these programs. They comprise only 10% of the total number reported by medical schools to be involved in this kind of teaching. But even among the humanists only one out of five gave more than 25% of their time to medical school teaching in human values.

The number of full-time teachers in these programs is, therefore, small in proportion to the full-time faculty teaching in other departments and programs of medical schools. Most programs are built largely on a small cadre of humanists, assisted by a larger number of teachers who have heavy commitments to other activities in the medical school.

While the total number of faculty reported to be involved in teaching human values is large (1,064) the number who are full-time is still quite small. The following table shows the distribution of full-time faculty among schools:

<table>
<thead>
<tr>
<th>Range (# of faculty)</th>
<th>Schools</th>
<th>Full-time Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 20 faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>5-9</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>1-4</td>
<td>45</td>
<td>29</td>
</tr>
<tr>
<td>Not reported</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>122</td>
<td>68</td>
</tr>
</tbody>
</table>

If we examine the schools which report more than one full-time faculty we find that they are distributed in the following fashion.
TABLE IV

Schools with More Than One Full-Time Faculty
(rank by number at 100%)

<table>
<thead>
<tr>
<th>School</th>
<th>Total Faculty</th>
<th>Full-Time</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>7</td>
<td>6</td>
<td>6.83</td>
</tr>
<tr>
<td>b.</td>
<td>5</td>
<td>5</td>
<td>5.00</td>
</tr>
<tr>
<td>c.</td>
<td>6</td>
<td>4</td>
<td>4.65</td>
</tr>
<tr>
<td>d.</td>
<td>12</td>
<td>4</td>
<td>8.39</td>
</tr>
<tr>
<td>e.</td>
<td>5</td>
<td>4</td>
<td>4.05</td>
</tr>
<tr>
<td>f.</td>
<td>3</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td>g.</td>
<td>5</td>
<td>3</td>
<td>3.70</td>
</tr>
<tr>
<td>h.</td>
<td>4</td>
<td>2</td>
<td>2.75</td>
</tr>
<tr>
<td>i.</td>
<td>7</td>
<td>2</td>
<td>3.40</td>
</tr>
<tr>
<td>j.</td>
<td>7</td>
<td>2</td>
<td>2.65</td>
</tr>
<tr>
<td>k.</td>
<td>4</td>
<td>2</td>
<td>2.67</td>
</tr>
<tr>
<td>l.</td>
<td>5</td>
<td>2</td>
<td>2.30</td>
</tr>
<tr>
<td>m.</td>
<td>9</td>
<td>2</td>
<td>3.50</td>
</tr>
<tr>
<td>n., o.</td>
<td>3</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>82</strong></td>
<td><strong>44</strong></td>
<td></td>
</tr>
</tbody>
</table>

3. Courses and Activities

In the survey of 122 schools, 109 schools reported 554 courses and other activities, a total of 5.08 per school. One hundred fifty-six of these were "required," and 315 were elective. Eighty-three were not categorized either as required or elective. The largest number of courses in any school was 31; however, 20 of these took place outside the medical school environment. The most common pattern was for a school to offer 5 courses of which 1-2 would be required and the remainder elective.

The courses and "other activities" fell into the following categories:

(1) Courses in medical ethics and bioethics.
(2) Human values teaching as part of other courses. Most of these were classified as sub-sections of larger courses devoted to law, ethics, or other non-technical concerns. Classified as "human values."
(3) Humanities or human values courses per se; e.g., philosophy, literature, religion, history, or social sciences related to medicine.
(4) Clinical ethics -- courses devoted to ethics or bioethics, given in some close relationship to a clinical setting.
(5) Other courses, most of which are not directly concerned with humanities disciplines but which were counted as human values experiences, especially those that dealt with interpersonal relations, interviewing techniques and the like.

(6) Courses outside the medical school. Many of the programs involved teaching either in nursing or allied health schools in a medical center or in the parent university.

(7) Miscellaneous activities not classified as specific courses and for which there was usually no credit. These included special lectures, symposia, journal clubs, student and faculty retreats, etc.

The numbers of required and elective courses and the number of schools in each of these categories is as follows:

**TABLE V**

Summary of Courses and Other Human Values Efforts

<table>
<thead>
<tr>
<th>Category</th>
<th>Required</th>
<th>Elective</th>
<th>Information Not Available</th>
<th>Total</th>
<th>Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethics</td>
<td>16</td>
<td>77</td>
<td>0</td>
<td>93</td>
<td>59</td>
</tr>
<tr>
<td>Part of Course</td>
<td>43</td>
<td>1</td>
<td>2</td>
<td>46</td>
<td>38</td>
</tr>
<tr>
<td>Human Values or Humanities</td>
<td>34</td>
<td>104</td>
<td>0</td>
<td>138</td>
<td>52</td>
</tr>
<tr>
<td>Clinical Ethics</td>
<td>31</td>
<td>104</td>
<td>0</td>
<td>138</td>
<td>52</td>
</tr>
<tr>
<td>Other Courses</td>
<td>24</td>
<td>29</td>
<td>2</td>
<td>55</td>
<td>33</td>
</tr>
<tr>
<td>Outside Medical School</td>
<td>6</td>
<td>38</td>
<td>22</td>
<td>66</td>
<td>21</td>
</tr>
<tr>
<td>Miscellaneous Activities</td>
<td>2</td>
<td>35</td>
<td>31</td>
<td>68</td>
<td>45</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>156</strong></td>
<td><strong>315</strong></td>
<td><strong>83</strong></td>
<td><strong>554</strong></td>
<td></td>
</tr>
</tbody>
</table>

Of the 93 ethics courses reported 16 were required. They ranged from an extreme of 180 hours spread over a two-year period, to as low as 4 hours. About half the courses were in the range of 12-24 hours.

In a number of schools, courses in human values and ethics are taught as part of other required courses for freshmen and sophomores -- such as "introduction to clinical medicine," "introduction to patient care," etc. In our analysis of 46 of these courses in 38 schools, we found that on the average 14 of each 100 hours of course work was devoted specifically to human values teaching.

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One hundred thirty-eight courses were classed simply as "human values" by the reporting schools. Most of these were elective and ranged from minimum of 4 to a maximum of hundreds of hours.

Formal clinical teaching was reported by 47 schools which offered 88 courses of which 31 were required. A variety of teaching modes was included -- ethical ward rounds, ethical grand rounds, clinical conferences, seminars, and full-time clerkships of 4-6 weeks duration. The preponderance of programs in "clinical" ethics took place in departments of medicine with pediatrics and family medicine outranked by medicine in a ratio of three-to-one.

Ten percent of the courses reported in this survey were placed in the category, "other courses." They included courses that respondents designated as "human values" but which did not fit very well as ethics or one of the humanities per se. Such courses had such labels as "introduction to medical interviewing," "human sexuality," "behavioral sciences," and "development of interpersonal skills." They represent the kind of teaching many associate with the term "human values" -- emphasizing the affective dimensions of the physician-patient relationship.

The variety of subjects included in the 138 courses labelled as "human values" and "humanities" by medical schools and some of the characteristics of these courses are evident from the following table.

<table>
<thead>
<tr>
<th>Subject</th>
<th># Courses*</th>
<th># Required</th>
<th># Elective</th>
<th>Avg. Hours</th>
<th>Avg. Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>17</td>
<td>3</td>
<td>14</td>
<td>25.00</td>
<td>43**</td>
</tr>
<tr>
<td>Law</td>
<td>16</td>
<td>5</td>
<td>11</td>
<td>25.71</td>
<td>53**</td>
</tr>
<tr>
<td>Death/Dying</td>
<td>14</td>
<td>4</td>
<td>10</td>
<td>40.44</td>
<td>23</td>
</tr>
<tr>
<td>Literature</td>
<td>13</td>
<td>0</td>
<td>13</td>
<td>27.57</td>
<td>20</td>
</tr>
<tr>
<td>Philosophy</td>
<td>12</td>
<td>2</td>
<td>10</td>
<td>23.17</td>
<td>26</td>
</tr>
<tr>
<td>Human Values</td>
<td>9</td>
<td>2</td>
<td>7</td>
<td>35.71</td>
<td>60**</td>
</tr>
<tr>
<td>Humanities</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>23.00</td>
<td>77**</td>
</tr>
<tr>
<td>Religion</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>26.00</td>
<td>68**</td>
</tr>
<tr>
<td>Art</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>22.50</td>
<td>19</td>
</tr>
<tr>
<td>Languages</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>15</td>
<td>34</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

*Total of 143 courses includes 5 courses counted twice because each includes 2 disciplines.

**Very uneven with more than 1/2 of students in just one or two courses.
Courses in ethics were not included in this table; hence, those listed as "philosophy" deal with other branches of that subject such as logic, epistemology, or philosophy of medicine. The category of "other" in this table includes a diverse group of topics, for example "man and society," "social issues in medicine," "rural life styles," "plain doctoring." They are usually a compound of society, psychology, and perhaps some history and anthropology. In the cases of "law" and "literature," these subjects were related in some way to medicine, being a physician, being a patient or dealing with medico-legal issues such as malpractice, commitment, confidentiality and the like.

Some Observations

The data from the survey are rather incomplete, and difficult to correlate because of differences in reporting by medical schools. They do, however, give some idea of the topography of human values teaching in American medical schools.

For one thing, almost every school today has some program that can be classified as human values, ethics or the humanities. Of those that do not, all, with one or two exceptions, are planning such programs. This is in very sharp contrast with the situation two decades ago when very few, if any, programs existed. The introduction of this kind of study is one of the major innovations in medical education in this century.

The interpretation in medical schools of what constitutes "human values teaching" is very wide indeed -- going from philosophy and ethics on the one hand, to interviewing techniques on the other. It would appear that a significant number of the courses generated in the mid-sixties under the aegis of the behavioral sciences have now been incorporated into, or identified with, "human values" teaching.

It is significant that teaching occurs not only in the classroom but in the clinic and at the bedside. Eighty-eight of the courses were offered in clinical settings or in the clinical years. This number appears to be growing as it is increasingly appreciated that teaching ethics or human values at the bedside is the most effective way to influence the attitudes of medical students and faculty members. It is crucial too in legitimatizing the humanists' contribution to medical education.

The opportunities for integrating the knowledge and intellectual skills of the humanities are many and they are being exploited widely in medical education. The cadre of humanists engaged in this kind of teaching is still small
and will probably remain so. But they are finding that
good teaching assures them a place in the education of
students, house-staff and faculty members that is unpre-
cedented in the history of medical education. These
humanists are assisted by a large number of faculty
members from the standard medical disciplines -- predomin-
nantly medicine, pediatrics, community medicine, family
medicine and psychiatry.

The experiences offered in most schools are usually
part of a larger course required of all students although
in increasing numbers of schools, ethics, humanities or
human values are taught in separate courses -- usually as
electives. The commitment of resources, time and effort
to these courses is small compared to the traditional
subjects in the medical curricula.

In subsequent chapters we will comment on the quali-
tative aspects of these programs -- on the characteristics
of successful programs, on the strengths and weaknesses,
and future viability. These features were only indirectly
discernible in the survey responses. They were more reliably
determined from the site visits made by the Institute staff
during the course of a decade of resource visits.


(11) Information received in our survey was compared with AAMC Curriculum Directory: 1979-80, Washington, D.C.: Association of American Medical Colleges, 1979. Few differences were noted; however, the directory was followed in identifying the Departments of the History of Medicine.
CHAPTER II

Curricular Pediments and Impediments:
Ten Years of Site Visits*

Of the three major programs of the Institute, its "resource" visits received the largest commitment of time and effort. Eighty medical campuses were visited in a ten-year period by the Institute staff and its consultant teams. This chapter draws on the observations and reports made during those visits to outline a composite profile of the characteristics of successful programs together with the obstacles they had to overcome.

The purpose of the resource visits was twofold: to encourage and assist in the development of new teaching programs, and to evaluate the effectiveness of existing programs. Through the visits it was possible to make the consultants' expertise and experiences available to a faculty inquiring about teaching human values. The Institute acted primarily as a "broker" -- in the best sense of that term -- bringing interested parties together without imposing some predigested program as a panacea of success.

The visits were therefore designed to emphasize informal discussion and dialogue. The agenda was built around the issues and questions chosen by the campus as most pertinent to its stage of development. The visiting teams served a variety of purposes: they sometimes reinforced ideas already under discussion or in planning; at other times they introduced the subject of human values teaching for the first time; yet again, they served as a sounding board and as friendly critics. Most often, they gave concreteness and verisimilitude to what had previously been only vague sentiments or unclear aspirations for curricular reform. The aim was always to assist the campus faculty to clarify its own goals, assess its own resources and commitment, and test the feasibility of its own plans against the experiences of those who were actually teaching human values at other schools.

The visits were conducted usually as two to three day on-site consultations. The requests for visits originated from a variety of sources -- administration, faculty members, and sometimes student groups -- almost always with the formal request coming from the Dean or some other senior official. All shared an interest in the teaching of ethics, human values, or the humanities in their schools, though the definitions of these fields were varied. Schools were en-

*Presented by Pellegrino at the 8th Symposium on Veterinary Medical Education, Univ. of Tenn., June 28-30, 1982.

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couraged to choose the composition of the visiting faculty from among those who were already operating programs. Each visit included some combination of humanists, physicians, or other health professionals, and one or more members of the Institute staff or its Board of Directors.

Visits were devoted for the most part to interviews with individual faculty members, groups or committees of faculty interested in the possibility of new programs, and academic administrators as well as students. Individuals to be interviewed were chosen in prior consultation between the inviting institution, the Institute's Program Director, and the extra-mural visiting faculty.

With new programs, the emphasis was on course content, teaching methods and materials, administrative organization and governance, financing and faculty selection. The experienced visitors surveyed the field, explained the rationale for their own programs and by lectures, seminars and demonstrations showed how the humanities can be integrated into medical teaching. Emphasis was placed on practical as well as theoretical factors. Successful experiences were described as well as the lessons to be drawn from those programs that had not fared well.

With existing programs the focus was a practical and objective analysis of strengths and weaknesses, together with recommendations for improvement. Responses were given to any specific questions raised by the host school before or during the interview. An oral report to the Program Director and senior administrators was made at the end of the visit and followed by a written report a short time thereafter.

From the collated reports of individual visits and comparisons between programs we have extracted a composite portrait of those characteristics most frequently found in successful programs as well as the obstacles most frequently encountered.

A word about our criteria for judging a "successful" program is in order. We took the curriculum to be primarily an instrument with which to engage the interests of both students and faculty and not as an end in itself. Hence a curriculum was "successful" if it engaged its teachers and learners, was visible and respected outside its own confines, occupied a secure place organizationally, and if funding was assured. The degree of clinical involvement and "spill-over" into other parts of the curriculum were additional indicators of success.
We made no attempt to evaluate in any quantitative way whether students were more "ethical" or "sensitive" as a result of exposure to these programs. Evaluation of this kind is of dubious value while a student is still in medical school. There are, moreover, serious methodological difficulties which we cannot address in this report. Suffice it to say that it is equally difficult to assess whether other subjects in the medical curriculum, e.g., biochemistry, or psychiatry, make for better clinical decision-making. There is some indication that students who have had courses in ethics are more sensitive to these issues and may make better value judgments when they become residents. But such studies are very limited in number. For the most part, however, we must assume that teaching values, ethics and the humanities to students of medicine, nursing, and allied health is worthwhile.

Given these assumptions, let us turn now to the first half of our assignment -- a description of the pediments of successful curricular innovation. What will emerge is a composite profile of the features of a successful program.

The "Pediments" of Successful Curricular Innovation

1. Clarity of Conceptual Design

The most important characteristic of successful programs is clarity of conceptual design. Most programs achieved rapid and early success by responding to teaching opportunities, meeting the expressed needs of faculty colleagues, or moving into undisputed areas of the curriculum. While this is politically expedient, ultimately a discriminating selection of aims, objectives and methods is essential. Without this careful selection a curriculum can dissipate its early successes by doing too much, too superficially and failing to develop a distinctive character. Too many obliging departments of community medicine, for example, have become the "wastebaskets" of the curriculum by following this routine.

No program can possibly satisfy all the wide interpretations and expectations subsumed under such titles as "human values," "humanism," "medical humanities," or even "medical ethics." Some equate these terms with humanitarianism, sensitivity to, and concern for, the dignity of the patient, treating the "whole" person, or assuring a more humanistic relationship between students and faculty. Others take "humanism" in a more cognitive classical and literary sense to mean a liberal or "rounded" education, with emphasis on its literary, cultural, and artistic dimensions. Still others expect human values teaching programs to be instruments for bringing a better awareness of the behavioral and social
sciences into physician's education. Whatever is thought to be missing in the over-technical education of today's physician has at one time or another been assigned to "human values" in the curriculum.

Instead, in each school it is essential to decide what part of the variegated spectrum of medical "humanism" can best be addressed with the resources available. Careful, stepwise growth of a limited number of well taught courses is preferable to a melange of offerings. It is less important which portion of the spectrum is selected than to define it clearly, and address it with sound teaching and research.

Selective excellence is indispensable for academic probity. The medical school milieu is notoriously antipathetic to global teaching enterprises. They quickly become labelled as "fuzzy," "soft" or "romantic." Over the last two decades some worthy curricular innovations in psychiatry, community medicine or the behavioral sciences have suffered dissolution by failing to establish academic credibility. They were not necessarily victims of the "built-in biases" of technologically oriented faculty colleagues. More often they were victims of their own well-intentioned but vaguely described objectives or over-emphasis on "process." Nothing fails so quickly as a loudly proclaimed curricular reform which attempts too much or raises expectations unrealistically.

In this respect let it be said that modest end points are as important as modest selection of which portion of the spectrum of humanistic study to engage. Teaching ethics or the humanities in medicine cannot replace a liberal arts education. Nor can they make ethicists, historians or philosophers of medical students. Rather, the end point is a refurbishment of liberal education, drawing from ethics, philosophy, history or literature those things most pertinent to the experience of a medical education and being a physician.

The successful curricula, in our experience, always related to what physicians do, particularly to medical decision-making. Thus, if the aim is to teach the skills of ethical analysis, these must relate to the value-laden character of medical decisions; if it is an improvement of skills in language or literature, they must be linked to the narrative and biographical character of medical histories. Literature can be taught if it deals with being ill, suffering, being a physician, being a patient or the social role of the physician. It can be the most effective way to evoke empathy, for example, when hours of lecturing will be totally ineffective.
There must also be sensitivity to the time constraints under which medical students and faculties habitually function. Reading lists that would tax the time and patience of full-time graduate students will be ignored. Whatever sessions are planned must fit the established schedules peculiar to medical schools since these are not likely to change soon. Visions of lecturing to the whole third or fourth year class must be dispelled for almost never are classes in the clinical years together in one body. Brief courses, highly focused are preferable to those that need large segments of curricular time.

Needless to say all the usual criteria of good curricular design familiar to educators must be observed and in addition adapted to the special nature of the medical curriculum. It is too large a burden for these programs to attempt not only to gain a place in the curriculum but also to undo all the real or imagined deficiencies of those curricula.

The emphasis on relevance may at first prove disturbing to humanists unaccustomed to teaching their disciplines in such instrumental fashion. If they can overcome their initial dismay, they will discover that they can teach a good part of what they cherish. Medical students are bright. Despite their heavy schedules they can manage to embrace well taught courses that they are convinced will make them better doctors. While relevance to medicine is initially imperative, a significant number of students will come to appreciate the humanities for their intrinsic worth and will seek more advanced work. Some even make humanistic studies part of their lifelong learning. What humanists may not have achieved in college may paradoxically enough be achieved by teaching in the medical curriculum.

2. Effective Leadership and Faculty

Historically the early leaders in teaching human values were chaplains or clergymen serving as campus ministers in a few medical schools. Their interest was stimulated usually by the examples of disinterested, insensitive or inhumane medical care they observed in teaching hospitals. They might or might not have had extensive training in theology or one of the humanistic disciplines. Their aim was generally to influence the education of physicians so that they might be more sensitive human beings or more knowledgeable about the ethical dilemmas of medical practice. Their interests were therefore more in the affective and behavioral than in the cognitive realms of human values teaching.
They were joined by a few physicians who cherished similar ideas about medical education and wished to neutralize what they conceived to be its narrowly technical orientation. These physicians and ministers usually formed informal seminars or discussion clubs with fellow faculty members and interested students. Their influence was small. They attracted mainly those who already had an interest in medical dilemmas.

These committed pioneers worked at first without title, recognition, or fiscal support. They were regarded as a little "odd" but probably harmless by their more pragmatic colleagues. They met in their homes and after hours, to discuss the medical moral dilemmas beginning to receive public attention even in the early sixties.

As public interest and the complexity, urgency and ubiquity of these dilemmas became more manifest these efforts were given more formal status in the medical curricula. Concomitantly, ministers were joined by increasing numbers of philosophers and ethicists who represent at present the predominant group. Later, teachers in literature, religion, law and a variety of other disciplines were added. Though medical historians had been present for some years in a small number of medical schools they played lesser roles in the early development of human values teaching. Only recently have they broadened their interests sufficiently to participate in these programs.

Today the majority of established programs rely on full-time bona fide humanists, working in collaboration with physicians, nurses and other health professionals. They teach as formal part of the curriculum in elective and required courses. Clergymen play less prominent roles than they did at the beginning. A more intensive participation by theologians and clergymen can be expected as some of the limitations of philosophical bioethics become apparent. (1)

The requirements for successful participation by humanists in medical teaching are now quite definitive: a capacity to relate to the medical community, security in one’s own discipline, a desire to teach it to health practitioners, a feeling for the urgency and complexity of medical decisions, a non-condescending attitude about medical morality and a willingness to learn something of the language of clinicians. None of this implies an uncritical acceptance of the whole of medical mores but it does require some respect for the integrity of the profession as a whole. Self-righteous preaching and over-eagerness to correct all the ills of medicine are sure formulae for hostility and rejection.

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The humanist in the medical setting must above all be accomplished in, and comfortable with, his own discipline. The most significant successful humanists saw their interdisciplinary efforts as an enrichment of their own professional and scholarly endeavor. A humanist actively doing scholarly work in his own field has a stronger base from which to interact with, and contribute to, medicine than someone who becomes a "hyphenated" humanist, i.e., a "medical-philosopher," "medical-historian," or "medical-sociologist," for example. The hyphenated humanist is as little regarded by his "home" department as by his medical colleagues.

A good scholar in the humanities does not automatically become a good teacher in medical school. Nonetheless, we find that humanists with positive ties to their parent disciplines do a more satisfactory job. They also grow in sophistication in their own disciplines as a result of the stimulation they receive from the problems they encounter in hospitals, clinics and medical school classrooms.

The humanist must also be "authentic." The medical setting requires that the humanist incorporate the values he or she professes and the character traits that are embodiments of the liberal arts teachings, to be human if not humane. The humanist can never be a role model of the "good doctor," but the humanist will demonstrate in his or her behavior the effect of humanities teaching. Inauthentic behavior, show and pretense on the part of humanists are certain "turn-offs" for the medical student even where they may be admired or tolerated in the clinician; truly, the humanist must be "holier than thou."

A very small number of physicians by virtue of a formal degree or intensive self-study of one of the humanities can incorporate an interdisciplinary approach into their personal teaching. They provide rare but important models of the way that medicine and the humanities can be closely integrated in daily practice. On the whole, however, the rarity of such persons underscores the need for truly collaborative teaching efforts between humanists and clinicians. It is very difficult to maintain scholarly credibility in clinical medicine and a humanistic discipline simultaneously. It is a common mistake to think that physicians can, with some smattering of ethics or philosophy, substitute for bona fide humanists. It is just as difficult to be both a philosopher and a clinician as it is to be a biochemist and a clinician.

Leadership in the establishment of these programs may come from a wide variety of sources -- clinicians, campus ministers, the Dean's Office, students or interested humanists. In every school we found a cadre of faculty members -- usually
clinicians -- who harbored interests in human values teaching for many years. They influenced students and faculty colleagues by their personal example. They served to encourage others with like interests and to act as a nidus around which an embryonic program might grow. Their contributions are not to be demeaned, but inevitably their efforts were augmented and formalized in the curriculum when a professional humanist was added to the faculty.

In most schools a successful program counted on a dedicated and often charismatic founder whose influence was pervasive. Over-reliance upon dedicated leaders must not be allowed to obscure the need for a wide base of faculty support. This fact often became manifest only when the founder or leader of a program left for another post or fiscal exigencies brought the program under scrutiny. Personal dedication is an important factor which becomes a negative force if too much of the substance of the program depends on a single individual.

A common error was for humanists who entered the medical school to over-extend themselves in an effort to get started and attract support. The ready acceptance of the humanist -- especially the most competent humanists -- was a dangerous trap which few escaped; to be over-committed and therefore to sacrifice substance for show, depth for display. These humanists had subsequently to realign their priorities to close the inevitable gap between expectations and the capacity to satisfy them. A slow, steady, planned growth is much preferred to a brilliant, but short-lived success.

As fiscal exigencies force medical deans to re-examine the pertinence of all academic expenditures, dedicated leadership cannot remain the sole pillar of survival. Managerial, administrative, and fiscal capabilities must be added to personal charisma and scholarship if human values programs are to remain as permanent elements of the medical curricula of the 80s.

3. **Acceptance by Academic Peers**

In all our visits, successful programs coupled strong leadership with the moral and political support of academic colleagues. Unless some strong external lever, like federal or foundation funding, is available, support has to be generated through persuasion and respect for the academic quality of the undertaking. Whatever other beliefs they may hold, medical faculties are attentive to competence and intellectual probity. A program might be initiated on the strength of enthusiasm, but it cannot survive unless the quality of its teaching and scholarship are at least comparable to the rest of what is being taught in the medical curriculum.
In all programs, intellectual integrity was a central factor in eliciting support. It encouraged those who quietly harbor hopes for humanistic medical education but fear the ridicule of their peers until some evidence of academic acceptance is evident. These allies may have an amorphous notion about what constitutes human values teaching. Often, some of the most influential senior clinical faculty members belong to this group. Their interest and support was often crucial to getting a new program off the ground. But no single category of allies can by itself assure successful establishment of a program. Faculty colleagues, administrators, students, in some combination were all needed at some time or another in the uncertain process of academic acceptance.

In those medical schools associated with universities, the support of the university departments in the humanities was helpful but not essential. Indeed, at times unexpected resistance came from university departments in the humanities. They were unaccustomed to, and even fearful of, too-close an involvement with the medical faculty. Their stand-offishness was usually rooted in the historical antipathies between medical and university faculties or in the fear among humanists of dilution of the purity of their disciplines by "applied" teaching or research. We will say more about this later in the section on impediments. On the other hand, when the cooperation of humanistic colleagues in the university is forthcoming intellectually attractive programs can be developed.

Students in many schools played a significant ancillary role, and sometimes even a primary one, in fostering the teaching of human values and ethics. Many programs received their first impetus in the late sixties and early seventies when student "participation" on committees and councils in medical schools was popular and sometimes quite effective. Our visits and surveys have shown consistently that in each school there is a cadre of students interested in ethical and value questions and that most students respond well to good teaching in this area. Everywhere, however, student acceptance depends upon the quality of teaching and the degree to which subject matter and method are linked to practical problems in medicine. Human values teaching has verisimilitude for them. They can see its essentiality for the daily work of a good physician.

In a few programs students were the major driving force. They usually started by initiating student-run forums, seminars, journal clubs, discussion groups, or inviting speakers from their own or outside faculties. These informal programs served to attract the interest of student and faculty colleagues. Some of these early efforts even provided the eventual content and method of curricular reform. Student
initiative and success in these pilot programs were sometimes the crucial factor in a dean's decision to initiate a program.

One effective way students can contribute to the acceptance of a program is to carry its lessons into their other courses. They can raise ethical and moral questions in almost all their clinical and even their basic science work. If they do so in a non-threatening and sincere way, they can engage the attention of faculty members and other students who would otherwise not be sensitive to these issues. The same applies to their hospital work where they can ask questions about patient care which would arouse antagonism if asked of one faculty member by another.

Student support is not an unmixed blessing. Their time is limited; their involvement in governance is less than it used to be. Succeeding generations of students differ in their enthusiasm for ethics. Each may have a different version of what human values courses should teach -- some want doctrinal or religious commitment; some want a secular humanistic approach; others seek resolution of personal emotional dilemmas; still others hope for affective experiences to offset an excess of science and technology. These factions can destroy a program unless the clarity of conceptual design emphasized above is assured.

A very important group of allies is the clinical faculty. A senior and respected clinician can enhance or damage a program simply by expressing his opinion. A disparaging remark, even when based in spurious reasoning, or ignorance, is tolerated because few students can discriminate between expertise in one field and its inappropriate transference to another. We have only to cite the instant omniscience conferred on Nobel laureates to understand the seduction of expertise for students and the general public.

Influential clinicians are extremely valuable if they agree to act as "godparents" for the teaching of ethics and values. They can introduce the humanist to the hospital wards and clinics and thus provide a legitimacy that sanctions the relevance of his or her teaching for clinical medicine. In order to reach students at the crucial stage at which they begin bedside medicine, the influence of a clinician in support of a humanist far exceeds anything a dean, curriculum committee, or professor of the humanities alone can possibly achieve. In our visits we were repeatedly impressed at how often the approval of a respected clinician was the deciding factor in the decision to introduce this kind of teaching into the curriculum. If, in addition, he or she participated in the teaching, the humanist's status was multiplied.
Another useful way to gain academic acceptance is through the faculty retreat. Several schools have used this device successfully to examine the "why," "how," and "what for" questions about human values teaching. The opportunity to discuss these questions informally and outside the vexed arena of faculty committees is usually welcomed. The unhurried exploration of content, method and objectives helps to reduce the strangeness and suspected threat to the curriculum so many see in these programs. Best of all are the opportunities for personal acquaintance between humanists and medical teachers. This can reduce the misunderstandings that arise so easily between people who do not know each other as colleagues.

Administrative acceptance and support are necessary ingredients even if there is faculty acceptance. Few programs can succeed without the dean's support. Administrative neutrality is as damaging as outright rejection. The most important factors here are the conviction that ethics and human values are substantive for medical education, that the curricular time commitment is worth spending, that there is fiscal support and that the proponents of the program are academically respectable.

In the future, the support of deans may be more difficult to obtain. Competing fiscal demands are already creating a competitive climate that favors the more traditional programs. Outside funds are disappearing rapidly so that "pump-priming" is no longer available and scarce university resources will have to be committed.

One might expect the university's humanists to be staunch allies but this is not always the case. There are substantial reasons for their animus. The higher salary scale of medical school humanists is difficult to accept. There is fear of diluting or distorting the humanistic disciplines by teaching them in a utilitarian and instrumental fashion. The social and authority structures of medical schools and hospitals compound the difficulties. It is undeniable that the university humanist and the medical academician belong to different cultures.

Some of these tensions are alleviated by joint planning and recruiting, and teaching on each other's "turf." It can be important for a medical school humanist to teach in his or her university department. If there are to be graduate programs the degrees should be part of the graduate programs of the university and not the medical school.

Assurance of these cooperative activities has proven most significant in enlisting the support of the provost or president in those medical centers organized as part of a comprehensive university.
Every successful program we visited relied on some combination of allies -- clinicians, students, administrators, or university colleagues -- even when generous external support was available. Needless to say, academic and administrative acceptance will become critically important in the years immediately ahead.

4. Institutional Organization

A fourth factor in the successful programs is a favorable location in the academic structure of the medical school. A variety of patterns was evident. (See the descriptions in Chapter I.) In most places the program was located within an existing department, most frequently community medicine, family medicine, behavioral sciences, or psychiatry. In a very few cases, a separate department of medical humanities was established. Also, in a few cases the program existed in an institute of its own. In still others, human values teaching was assigned to a committee, or task force, reporting directly to the dean or the vice president for medical affairs, in the case of a health science center serving other health professional schools in addition to medicine.

No single mode of organization seems applicable to all schools. The "best" location is usually determined by pragmatic considerations like the interest and willingness of existing departments to foster or fund human values teaching, the amount of funding available, and the willingness of the dean to brave faculty resistance to the establishment of new departments or school-wide programs.

The major advantage of an autonomous department is the establishment of a peer relationship with other departments and thus a place in school councils, curriculum committees and budget negotiations. As a result, there is greater freedom to experiment with content and teaching methods. Recruiting, appointments, and promotions become easier. On the other hand, if a "department" is too small, poorly led, or precariously funded, the advantages of autonomy are outweighed by loss of the political protection, access to funds, and curricular time that come with being part of a large parent department. Under those circumstances, it is better to be a division of a larger department than to be free-standing.

Being a division or section, however, imposes other limitations. Success or acceptance may be too closely tied to the fate of the parent department. Although successful and certainly appropriate in some schools, the location of these programs in departments of community medicine, behavioral sciences, or psychiatry can sometimes detract from their...
chances of success. These departments are not always held in high esteem in the academic "pecking order." Indeed, some of these departments are themselves being reduced in size or even phased out. Family medicine is a somewhat more secure location than most these days. But here, too, the fate of human values teaching will be linked to the academic strength and position of the parent department and this varies markedly from school to school.

Divisional status can interfere with interdepartmental or inter-school teaching. In a multi-school health sciences center, a medical school department may resent "its" humanist teaching in nursing or dentistry.

Divisional status complicates the matter of faculty appointment and tenure. Because of differences in criteria and priorities, considerable difficulties can be encountered with departmental appointments and promotions committees. For humanists in clinical departments, the usual impediments may be magnified. Matters of promotion and tenure were among the major causes of dissatisfaction in some of the schools we visited.

Organization as a separate institute has all the advantages of autonomy in program development, research, and interdisciplinary engagements as well as clear sources of funding. However, institutes are generally regarded with suspicion in medical centers because they are outside the familiar departmental structures. Students do not see them as part of the "regular" teaching faculty. Most institutes do not have authority to make separate faculty and tenure appointments. For these they are dependent on the "parent" departments with all the difficulties just outlined.

Some other organizational devices -- like medical school or medical center teaching committees, task forces, and the like -- though less formally structured, are analogous to institutes in their advantages and disadvantages. They are convenient administrative devices that enable an interested dean to establish a new program quickly. They do so by circumventing the usual routes of academic approval. They serve as useful ground in which to test feasibility, acceptance, and academic viability. They can be organized quickly in response to student interest, to attract available grant monies, or provide a vehicle for faculty members who want to try an innovative program. They suffer eventually because their informality places them outside the academic power structures where they are particularly susceptible to budget-cutting, a change in deans, or the retirement or transfer of some influential faculty advocate. At best, committees and task forces are half-way houses and beachheads useful for the initiation of programs but rarely successful as long-term arrangements.
In our visits the question of optimum location was a recurrent one. Few schools were satisfied with their choice and most sought some alternative. The most stable arrangement was the independent department provided it was of sufficient size, had a base of hard-money support and was competently led. This combination of conditions is at the moment not common; therefore continuing re-examination of the problem of location can be expected.

5. Program Funding

We were not able in our survey to collect data on budgets, costs, distribution of expenditures, salaries or other fiscal data. This information is vital but unfortunately not yet available on a national scale.

On the whole, human values teaching programs are less costly than most other medical school ventures. Teachers in the humanities command lower salaries than basic scientists and clinicians. They do not need laboratories, complex clinical facilities, or equipment. They do not require large teams of assistants or technicians for their research. The preponderance of costs is for salaries. Our survey shows the number of full-time faculty in most programs rarely exceeds two or three. Only two or three programs have as have as high as six full-time faculty members. All programs rely heavily on "volunteer" faculty to assist in small group sessions and seminar discussions.

These facts notwithstanding one of the major problems for the immediate future will be to find stable sources of funding. A large majority of programs were founded on grant monies, usually from the National Endowment for the Humanities, or a small number of private foundations. Only a small number of programs are now funded on "hard" money, i.e., from regular medical school budgets. Even in the programs that are well-conceived, well-received and competently led, funding promises to be the most important limiting factor in the immediate future. Decisive factors in budgetary decisions will surely depend upon the degree to which a program exhibits some combination of these "pediments" outlined above.

The period of evangelism and enthusiasm that has prevailed for a decade in the teaching of ethics and human values is ending in the face of fiscal exigencies. As the unimpassioned eye of the budgeteer scrutinizes each program, the profile of successful attributes will have to be as nearly complete as it can be. This summary, although based on a period in which funds were more available than they are at present, contains what we believe to be the five-fold foundation of successful future work: conceptual clarity, effective staffing, committed allies, proper organizational location, and sound funding.
Impediments to Curricular Innovation

To match the profile of successful attributes there is an accompanying profile of obstacles and impediments to be overcome. They were observed in every school although they varied in intensity and emphasis in different schools.

Perhaps the commonest obstacle is curricular inertia. An established curriculum quickly takes on the qualities of a scriptural or constitutional document -- a sort of pedagogic credo. The curriculum becomes an ideology, and like all ideologies, insusceptible to rational discourse. Some inertia is simply the result of the large expenditures of emotion and energy required to hammer out any curriculum. Few would want to repeat the experience without good cause. Others have invested so much of themselves in the effort that any change, or addition, becomes a personal assault.

Curricular inertia can be overcome only by an instrumental approach that recognizes that a curriculum is a tool for engaging the interest and the intellects of students and faculty in order to advance specific academic goals. It should be changed when it fails to move students toward these goals. The good pedagogue has always recognized that different times, places and students require different curricula. That is why it is essential to be clear about where the curricular tools are intended to lead the student. The greatest deficiency in most curricula is the failure constantly to reassess their effectiveness and to alter them in the light of their instrumental value -- and not their fidelity to some cherished structure, content or ideology.

A corollary of curricular inertia is the objection that there is not enough time. The curriculum is already too packed, it is said, and this becomes the justification for rejecting any new proposal. It is as hard to remove something from the curriculum as it is to introduce it. Yet, if there is a crying need in medical curricula, it is to unpack them, to reduce their redundancy and to open the way for critical reflection, synthesis and digestion of what is being taught.

Specifically, it is objected that putting time into the teaching of ethics will take time from teaching scientific data. This objection ignores the fact that there is already too much factual material in the curriculum and too little time for critical reflection on that material. It ignores, too, the fact that skills in ethical analysis are as important in many clinical decisions as factual knowledge. Moreover, the actual time allotted to the teaching of human values has not posed any real problem especially if it is distributed over four years. Medical students can find
time even in their tightly packed schedules if they deem the course important enough. It is significant that students will attend courses in ethics and human values even when they are electives and are given at odd times — in the evenings or on Saturdays.

The objection that the curriculum is already "overcrowded" has merit. However, there is no doubt that new courses and new material are continually introduced. Where the significance of curricular material is established, it can always be made part of even the most seemingly impacted curriculum. Proponents of teaching ethics, humanities and human values would do well therefore to be clear about the importance of what they teach, to teach it well and convincingly, and to meet the standards of academic rigor.

A second set of obstacles arises from a misperception of the nature of ethics and human values. Here we encounter the commonplace "soft" versus "hard" science controversy. It is often asserted that ethics is "caught" not "taught." These are matters, it is said, of individual preference, or they should be instilled by home and church, or students should come to medical school with their values already set or they are not apt to be changed by teaching. There is no way to test values empirically; there are no answers to ethical questions; ethical debates are doomed to end in frustration.

So go some of the commonest misunderstandings of what ethics is, and what its teaching achieves. It is true that students come with values and moral principles. But in a pluralistic society, each student comes with a different set of values. Ethics is not just a set of visceral sensations. It is a formal discipline, a branch of philosophy that seeks to examine the right and wrong of human acts, rationally, to discover generalizable principles, to clarify the meaning of ethical terms, to examine the logic of ethical discourse and to identify the prelogical assumptions upon which decisions are made. If one has a set of values -- and what human does not? -- it is the task of ethics to encourage critical reflection on one's own values, to examine their relationships to those of others, and the ways in which conflicts in values and moral principles can be morally managed. This is essential for a physician in a pluralistic society. The physician is tempted to impose his or her own belief systems on patients. Their vulnerability and dependence on physicians make this a particularly urgent danger.

Ethics as a formal study can serve to identify common values as well as differences. There are common obligations -- those that bind all who profess to heal. They are urgently in need of being examined. By understanding our own moral principles, knowing where they differ and where they agree with others, the obligations we owe to our patients can more
clearly be perceived. Moreover, people mature ethically and they do change long-held allegiances to moral principles. After all, no belief is really our own until we have consciously assimilated it -- and that is what ethics helps each of us do. Indeed, ethical maturity consists less in a state of complacent certitude than it does in a constant refinement of the principles we hold.

A closely allied objection is that while ethics is important to medicine it is not an intrinsic part of medicine and therefore should not be taught in medical school. Those who propound the model of medicine as applied biology take this view. It is the dominant one among academic clinicians. Ethics, they hold, should be taught in college and should not dilute the medical experience.

The error of this point of view is two-fold. First, even if ethics is taught in college, and it should be, it must be reinforced by direct application to clinical problems in medical schools. This is true with other premedical subjects including the sciences as well. They lack verisimilitude unless they are part of the physician's daily activity and especially clinical decision-making. Premedical education in ethics is not depreciated by teaching ethics and values in medical schools. Rather, its effectiveness is enhanced by reinforcement in the clinical and medical setting.

The second error is even more serious. To say that ethics is not intrinsic to medicine is to misunderstand the nature of the healing relationship. At the heart of that relationship, as one of us has tried to argue in detail elsewhere (3), is a right and good healing decision. The "right" decision technically speaking requires a knowledge of scientific fact, of course, but a "good" decision must also be morally sound, and that requires a knowledge of ethics. At the moment of decision, the moral beliefs of the patient and the physician may well be in conflict. To analyze the ethical dilemma in a medical decision is often as important as making the correct diagnosis or selecting the correct treatment.

Parenthetically, we must admit that some of the more romantic versions of "wholistic" medicine have given ethics and human values a bad name. Their intuitive approaches to values, their uncritical acceptance of dubious and even dangerous modes of therapy, and their anti-technological bias are as inimical to ethics as a rational discipline as to scientific medicine. These esoteric forms of wholism must not be confused with the more legitimate models, nor used as evidence against the rigorous teaching of ethics as an intellectual discipline.
Perhaps the most serious obstacle to combatting these attitudes is the deficiency of faculty models -- of a cadre of clinical faculty members who can exhibit the fusion of fact and value, of scientific and ethical analysis intrinsic to the healing relationship. There is no doubting that the example of a respected clinician is an effective way to teach human values. That example often can do more than weeks of lecturing about "humanism." It can also negate weeks of lectures if the clinician's behavior contradicts his or her teaching.

Another impediment is the unfortunate illusion of some clinicians that they do not need education in ethics and human values. They practice "ethics" every day, they say. All the students need do is observe them.

These views deny that ethics is a formal discipline. Unfortunately, they are often held by people whose ethical positions may be very questionable and in need of critical analysis. They ignore the fact that students must form their own moral judgments, not parrot someone else's. This is an important impediment to overcome since it feeds the natural tendency of students to think they must be all things to all men. To deny that the ethicist can contribute to medical ethics is to close off an essential source of criticism without which medical ethics becomes an exercise in self-justification.

There is, for this reason, a genuine need to educate a cadre of clinical teachers who are conversant with ethics, human values and the humanities as they apply to medical decision-making. This cadre will provide the faculty models of the future and perform a needed intellectual liaison function with humanists in the medical schools and the universities. There are today a surprising number of students and physicians who would like to prepare for such careers. What we lack currently are programs and fellowship funds specifically for this purpose. For most, a one-two year fellowship in ethics or one of the humanities would suffice. For a few, a combined M.D./Ph.D. program akin to what is now done in the sciences basic to medicine is in order.

A big obstacle is the current lack of methods of evaluation of the effectiveness of the teaching of human values in medical schools. It must be admitted that studies are few, suitable methods are difficult to find, and not wholly adequate to the task. Much depends on what it is we wish to evaluate. A limited evaluation would measure whether the student has imbibed the content and skills the courses aim to inculcate. This sort of evaluation differs little from the usual course evaluations which are routine in many medical schools today.
The more crucial evaluation -- what is really behind the skeptic's question -- is whether or not those who have taken these courses are "more ethical," or whether their behavior has been changed, and in what ways. This is an extremely difficult question to answer, and we know of no study that adequately addresses it.

What we do know is that over the past decade, concomitantly with the growth of teaching programs in ethics, the moral and ethical issues in clinical decisions and the applications of technology to medicine have received unprecedented discussion. The amount and quality of research has expanded exponentially as has the literature in ethics and the philosophy of medicine.

It is now a routine matter in American medical schools to hear ethical issues discussed in every facet of clinical activity. It is hard to argue that such open discussion does not make for more careful decision-making and for greater sensitivity to the obligations of physicians and the rights of patients.

These developments would be inconceivable without the establishment of teaching programs in ethics and human values which provided the forums, seminars, rounds, as well as the student and faculty preparation requisite for productive discussion of these complex issues. Ethical discussions are now commonplace in medical societies and clinical journals and continuing education courses. This is a great contrast with only a few years ago when each physician's ethical decisions were his alone and few dared to discuss medical ethics beyond the level of professional etiquette.

Despite the lack of evidence, therefore, that individual physicians' behavior is more "ethical," it is clear that a new climate of heightened sensitivity, open discussion, research, and writing about ethical issues has resulted. This is an impressive outcome. It would be hard to argue that there is no value to such discussions or that they are without effect on those who participate in them.

Thus far, we have emphasized the major impediments in the attitudes and beliefs of medical faculties and clinicians. We would like to close with emphasis on another powerful impediment -- the negative views of some ethicists, philosophers, and humanists in the university. We have alluded to this already but it is worth repeating. There are humanists who feel that professional students are not susceptible to the teaching of human values or the humanities. They see them as primarily technicians who have compromised their college educations to engage in excessive study of science. They are caricatured as money-grubbing, anti-
intellectual and unwilling to give the time necessary for a true understanding of the humanities. To teach the humanities in a medical school is to water them down, to provide "service" courses, superficial in content and fit only for the inferior teacher or "burnt-out" scholar. In any case, "medical" ethics or "medical" humanities are applied fields and lower on the scale of values than the "pure" disciplines presumably taught in the university.

To this, one can only reply that ethical and humanistic concerns are at the heart of the healing relationship and will persist. Bona fide humanists have turned their attention to these issues and feel they are important enough to devote their time to teaching medical students how to confront them. In this effort, these humanists are finding stimulation for their own research.

We can only remind the "purists" in the humanities that in medicine, the humanities and the physical sciences, practical and mundane issues have often been the springboard for the most daring theoretical advances. No subject is intellectually demeaning for the creative scholar.

Finally, the humanist who eschews contact with the practical affairs of humankind fails in his or her obligation to make the connection between humanistic study and everyday life -- a connection the whole of society badly needs right at this moment.

Summary

From our Institute's visits to 80 campuses to do "resource" consultations, the physiognomy of a successful program emerges quite clearly with these features: conceptual clarity, academic credibility, moral support and participation by administrators, students and faculty colleagues, sound location in the organization of the school and secure funding. Similarly, the impediments to success can be deduced from the negative image of the successful features and from the attitudinal responses usually generated by programs outside the usual realm of medical school teaching.

The future of human values teaching programs is dependent upon how well they respond in each school to the particular local interplay of these pediments and impediments. They are entering a period of maturation, when the enthusiasms of recent years must meet the tests of institutional politics and budgetary reality. The observations and lessons drawn from our visits and our survey should provide a useful guide for those who believe in the importance of the teaching of human values, ethics and the humanities to all health professionals.

(2) D. Seldin, "The Boundaries of Medicine," Presidential Address, Transactions of the Association of American Physicians, XCIV 1981, LXXV-LXXXVI.

CHAPTER III

Present Rationale and Future Viability:
The Liberal Arts in the Health Professions (1)

Introduction

Since classical times, the liberal arts have been the indispensable accoutrements of educated people. As the medieval trivium they provided the intellectual tools necessary for all serious scholarship and professional work. For centuries they were the essential prophaedetic to a medical education. Even today, some aliquot of liberal education is deemed necessary in preparation for medical studies.

In the last two decades an unprecedented departure from this tradition of separation of professional and liberal studies has occurred in American medical schools. Of 125 schools surveyed, most either had or were initiating teaching programs in human values, ethics, or the humanities. To anyone familiar with the inertia of medical curricula, as well as the positivistic bias of medical faculties, this is a remarkable development indeed.

There are two major reasons for this change: first, a deepening public and professional concern for the moral dilemmas posed by new medical capabilities, and second, an awareness of the need to guarantee the humanistic elements of medical care against erosion by its increasingly technological character. In the late sixties and early seventies, these same concerns attracted the support of private foundations and the National Endowment for the Humanities. With commendable prescience they enabled most of the programs now in existence to become established. An era of almost evangelical expansion was ushered in.

Today the "pump-priming" funds are beginning to run out. Medical schools and universities must decide whether or not to support programs on university funds at a time when fiscal constraints are becoming a major problem for most institutions. Financial support must now be more vigorously justified. As a result, the teaching of medical ethics, human values, and the humanities must squarely confront some fundamental questions. The post-evangelical period has begun.
Why should the humanities be taught in medical schools in the first place? Are they not the province of college education? How can the time, effort and expense be justified? Do they make for better patient care? In the evangelical period these questions could be answered more with exhortation and missionary fervor than conceptual clarity. Now, as future survival becomes a real problem, the answers must be more definitive.

These questions are vexing not only to medical educators. They occur at a time when the place of the humanities themselves in American life is under scrutiny. Very recently the Commission on the Humanities asserted the need for a reaffirmation of their importance to education and public life. Especially, the Commission said, "the humanities, science and technology need to be substantially connected." (2) What are those connections and how do they operate?

Recent trends seem to militate against making these connections -- weakening of the teaching of the humanities in the universities, demands of the job market, bias against intellectual elitism, lowering of the standards of civilized discourse, expansion of technical information, the dominance of TV, films and other non-verbal forms of learning. Yet in the face of a decline in their influence generally, the humanities have established a promising beachhead in an unpromising place, the medical school curriculum.

Some of the answer lies in the nature of medicine itself. It has always been situated halfway between science and technology on the one hand, and the needs of suffering human beings on the other. Medicine connects technical and moral questions in its clinical decisions; it is required to be both objective and compassionate. It sits between the sciences and the humanities, being exclusively neither one or the other but having some of the qualities of both. Medicine is, in fact, an excellent paradigm of those "connections" the Commission on the Humanities is seeking. By examining the teaching of the humanities in medicine we can gain some insight on the larger issues of the way the humanities relate to public and private life in a technological society.

Why Teach the Humanities At All?

There are at least three reasons for teaching the humanities to all educated people and especially to physicians: 1) they are vehicles for teaching the liberal arts; 2) they convey a special kind of knowledge that liberates the imagination; and 3) they are sources of delectation for the human spirit.
1. Vehicles for Teaching the Liberal Arts

It is a common misconception that the humanities and
the liberal arts are synonymous. This is an error as common
to humanists as it is to the general public. The liberal
arts are habits of mind, not disciplines or bodies of know-
ledge. They have, since classical times, consisted of the
intellectual skills needed to be a free man -- not only in
the political sense, but more critically in the sense of
being free of the tyranny of other men's thinking and
opinions, free to make up one's own mind and take one's
own position, free to become a person of one's own. The
liberal arts comprise the skills most commonly associated
with being human -- the capability to think correctly and
critically, to read and understand language, to write and
speak clearly, to make moral judgments, to recognize the
beautiful, and to possess a sense of the continuity between
the present, and the past we all inherit.

Philosophy, literature, language and history are the
classical Studia Humanitatum. They can most effectively
inculcate those skills that enable us to live truly human
and humane lives. They are pre-eminently the arts of the
word. Only humans use and manipulate words and symbols to
express ideas. To serve that end the humanities must be
taught liberally -- as vehicles for the liberal arts and
not as specialties, not primarily as research endeavors, not
as professionalized bodies of knowledge and not as imitations
of science. That they often are not taught as vehicles for
the liberal arts accounts for much of the loss of connection
between the humanities and contemporary life.

The liberal arts are the cognitive instruments needed
in every truly human activity. They enable the trained mind
to address any body of data in an intelligent and orderly
way, to distinguish truth from untruth, opinion from demon-
strated conclusion, and to define what is known and not
known, to distinguish fact from value. While they are best
taught through the humanities, the liberal arts are also
essential for a full appreciation of the humanities them-
selves as bodies of knowledge. They are as essential to
science as to the humanities. Science and the humanities
are two different ways of knowing the world but both depend
on the intellectual skills of the liberal arts if they are
to be cultivated beyond their factual contents.

Since they are the working tools of the educated person,
the liberal arts are essential to the daily work of all the
professions. In medicine, the arts of the word are in-
trinsc in the arts of the clinician. (3) The physician's
thinking is not solely scientific. To be sure, scientific
and actuarial logic are crucial in diagnosis, prognosis,
and therapeutics. But in deciding what ought to be done,
the physician is required often to analyze an ethical dilemma
and make a moral judgment. Differential diagnosis is an exercise in dialectics; history-taking is the development of a narrative — really a biography -- using a unique primary source, the patient himself; the physician-patient transaction is an exercise in communication demanding a deep perception of the meanings of words, language, and culture. The cognitive skills of the liberal arts make the physician's decision more than the simple application of diagnostic algorithms or decision-trees. They are what distinguish the technical from the professional elements of medical practice. They are as important to being a good physician as the knowledge of the basic and clinical sciences.

2. Liberating the Imagination: The Content of the Humanities

The humanistic disciplines are not only vehicles for the liberal arts but they convey a special kind of knowledge, not susceptible to the methods of the sciences. They liberate the imagination. Their specific content antedates modern science and in some ways opposes as well as complements it.

The humanities deal with the dramatic, the artistic, the meanings of language, symbol and myth, and the history of men's ideas about reality and how men respond to the experience of living. Humanistic studies seek out the idiosyncratic, the particularities, the uniqueness in human experience. They have the power, too, to evoke vicarious experience through the artful use of language, sound, paint, stone, or design. They struggle with all the things science must eschew -- the mysteries of living, dying, suffering, enjoying, with their meanings for persons and the way they are communicated between human beings. The prodigious advances of science have not eradicated mystery; wisdom is still a rare commodity; creativity is as inexplicable as ever; aesthetic experiences delight some of us and not others. The humanities wrestle in every age with the same questions and problems -- who we are, why we are here -- with the inextinguishable search for meanings. Science too searches for the meanings of natural phenomena, but the humanities focus on those experiences that are not quantifiable, testable, or instrumentally explicable. Science has values of its own. While it uses values, it does not prepare us with the methods needed to analyze, judge, and sort out competing values.

Science deals with new answers to old problems. Its content is progressive and cumulative. Scientific paradigms change. Things previously credible are no longer so. The humanities instead ponder the same questions, often posed in the same way, century after century. They exasperate anyone who seeks the solace of certitude because they always throw us back upon ourselves -- to ascertain our own
meanings. They ask us to make our own assessments, and force us to realize that we cannot be fully human by merely parrot-
ing other men's opinions. They create anxieties precisely because they challenge us to be persons, to locate ourselves not just in time and place but in relationship to ideas -- other men's ideas and our own.

Medicine is turning today to the humanities because it needs this special kind of knowledge. Being ill and being healed are complex, not wholly comprehensible phenomena, involving the person as much as his organs and tissues. The ill person is an historical entity whose experience is not wholly penetrable by even the most dedicated healer. To heal another person we must understand how illness wounds his or her humanity, what values are at stake, what this illness means and how this illness expresses the whole life of this patient. The physician who does not understand his own humanity can hardly heal another's. This is a powerful reason why the humanities are taught in many medical schools even though they were studied in college.

Literature, for example, has proven an effective way to teach empathy for the sick, suffering, and dying. Through the creative words of George Eliot, Tolstoi, Chekhov, Camus, or Thomas Mann, the experience of being ill, being a doctor, or dying can be powerfully evoked and vicariously felt. Literature also teaches the nuances of language, the way its structure and form communicate the inner experience of another person.

Philosophy teaches the arts of logic and dialectic but also tells us what men have thought about human nature, truth, goodness, right and wrong. It challenges the physician to know his own values and to give a reasonable account of them before daring to undertake the delicate task of deciding with another person what is "good" for that person. The skills of ethics are as essential to being a competent physician as those of the basic and clinical sciences because at the heart of the clinical decision there is a value choice -- an interaction between what the doctor decides is good for this person, and what this person thinks is good.

History traces where we have been as a species and what constraints the human past puts on each of us. It creates that sense of continuity without which individuals and societies lose their bearings. It teaches how to validate a temporal account of human events which is what the patient's own history turns out to be. In a sense, the physician has an opportunity rarely afforded the historian -- he is almost always in direct contact with his primary source, a unique one at that -- the patient. Yet how many times do physicians, like historians, ignore the source in favor of a plethora of secondary and tertiary sources -- or their own imaginations?
All the things the humanities teach, write and think about, have some relevance for the work of medicine and parenthetically of all the professions. That is why they are essential to good education in the first place. The need for further reinforcement in medical school is strong evidence of the pertinence of the content as well as the method of the humanities.

3. Sources of Delectation for the Human Spirit

The practical uses of the method and content of the humanities must not overshadow their intrinsic worth which is to enrich and enhance the whole experience of human living. This value of humanistic learning and study transcends even their most practical applications because it enables us to live with satisfaction.

To cultivate literature, philosophy, history, painting, or music is to add special dimensions of delight to living. These pursuits delight us because they correspond so closely with those capacities that most clearly distinguish us as human -- the capabilities to recognize and experience truth, beauty, and virtue. They stretch our capacity to enjoy what other men have created, or what we may create ourselves and thus to communicate something of our inner world to our fellows.

Medical men have always turned to the humanities and the arts to counter the aridity of too zealous a dedication to the technical demands of their daily work. Hours spent in the pursuit of humanistic studies refresh and restore. They reawaken sensitivities obtunded by the demands of time, routine, and detail that beset the conscientious practitioner. The number of physicians who write, paint, play an instrument or read literature attests to the restorative powers of the humanities. Some become so entranced that they abandon medicine altogether and become "medical truants." (4) A few can even continue as active practitioners and lead a double life as creative artists, like William Carlos Williams or Richard Selzer, in our own time.

It must be apparent by now that we believe that one cannot be a genuinely competent physician without imbibing the three things that, uniquely, the humanities have to give -- the skills of the liberal arts, their freeing of the imagination, and their power to enrich and restore the spirit. Indeed, we would say further that failure in the professions is as much a result of defects in humanistic education as it is in technical skills or information.

The liberal arts are, moreover, the indispensable requirements for a democratic and civilized society. Democracy itself is impossible without citizens whose minds are
free enough to resist the tyranny of political demagoguery and who can discern the values that underlie public policies. Civil and international order depend upon a humane education. As Camus puts it, "And naturally, a man with whom one cannot reason is a man to be feared." (5) Without those pursuits that elevate the human spirit -- the arts, music, literature, and conversation -- civilization itself is impossible. The utility of the liberal arts to medicine is only a subset of their indispensability for humane living within which medicine now plays so important a part.

Why Teach Them in Medical School?

Let us grant that the humanities are important to the work of medicine and that they are tools needed by all educated persons. Why should they be taught in medical schools? Why not require that they be taught better, or more fully, in college than at present? Why take time in the packed medical curriculum for what should be done before students enter medical school? Does this not amount to remedial education? Is it not an unnecessary expansion of our already swollen and pretentious medical curriculum?

To begin with, there is no suggestion here that teaching humanities in medical schools should substitute for a liberal college education. As the intellectual tools of all educated people, the liberal arts are the proper domain of college and secondary schools. However, even a good liberal arts education will need reinforcement, repetition and refurbishment during a professional education for several good reasons.

First, we know from our experience with pre-medical science that exposure to college subjects does not mean that contagion or even sub-clinical infection will occur. College subjects, even those directly related to medicine, need repetition and connection with the daily work of physicians. It is a puzzling but persistent fact that medical students often fail to see the connections between the things they study in college and their utility in medicine. Thus, the points of "connection" need to be made clear in clinical teaching even if the student has had an authentic liberal arts education. If he has not, it is all the more important that these connections be established for the first time. They must be demonstrated to be intrinsic to being a good physician or they will not have any lasting influence on the medical student.

Moreover, college teaching in the humanities often neglects one or more of the three contributions of the humanities, to free the mind, to free the imagination, and to enrich the experience of being human. Often they are taught solely for their content as fields of special study.
This is a legitimate aim for aspirants to professional scholarship but it is insufficient to encompass the fuller contribution that the liberal arts make to the clinical arts. In this sense, teaching humanities in medicine does have something of a remedial tinge to it. We wish it were not so. For the most part, however, repetition and reinforcement, and not remediation, will be the pedagogic aim.

Medical students need actual practice and demonstration in how the liberal arts apply in clinical medicine and the healing encounter. They are understandably wary of arm-chair ethicists. The lasting lessons in a medical education are the practical ones -- the hands-on experiences under supervision in small groups. This is the special distinction of American medical education. It is particularly well-suited to an exploration of the student's personal values, logic, and presuppositions. These need to be as carefully examined as his scientific logic and judgment. In this way, the close integration of value and fact in clinical decisions can be examined in individual cases, in the context which will be the clinician's habitat for all the years of his practice.

Finally, students who have enjoyed a creditable experience in the humanities in college will want to enrich it while in medical school. Some of the best students we have encountered have complained bitterly of the lack of intellectual stimulation in the usual medical curriculum. They accept the need for a plethora of facts. But they are surfeited with information unaccompanied by critical reflection on the deeper issues involved in the humane use of an increasing reservoir of facts.

Having experienced the capabilities of humanistic studies to enrich all of life's experiences, these students want to deepen their contact with them. Since medical curricula are so drastically out of phase with university calendars, they cannot take university courses in the humanities. The only alternative is to offer such courses in the medical school. The skepticism and negativity of medical faculties notwithstanding, these students can easily handle some study of the humanities along with their medical education, to the enhancement of both.

If we grant the importance of the humanities and the need to teach them in medical school, we must still avoid pretentiousness in the aims and objectives of such teaching. Certainly the medical school must not misappropriate the function of the liberal arts college, nor aim to make each student an ethicist, philosopher, literary critic or historian. The aim must be to refurbish, renew, and implant the liberal arts in the student's experience so they can be used in medicine, clinical decision-making and judgment. All students who intend to be clinicians ought to have enough familiarity with the skills of ethics and enough sensitivity
to moral questions to know how to define a conflict of values between themselves and their patients and to resolve it. This means they should be able to analyze a critical dilemma as rigorously as they analyze a dilemma in diagnosis or prognosis. The physician should be familiar with his own values and presuppositions and know how to handle conflicts of values in a morally responsible way. He or she cannot distinguish or compromise a principle at a lesser level if he does not understand the ethical foundations of the decision. For this reason, all physicians should be able to use ethical reasoning, to understand the meaning of the terms used in ethical discourse and how they apply in clinical decision-making.

Medical students and physicians need to appreciate that the medical decision rests on several modes of reasoning -- not just one. Classical and probabilistic logic are intermingled in medical decisions and both are modulated by the end of medicine -- a right and good healing action for a particular patient. That end is moral as well as scientific; it requires a combination of objectivity and compassion, the capacity to stand back, and at the same time to empathize and become involved with the patient.

It is this combination of objective compassion or "compassionate objectivity" as Temkin has termed it, that fuses the sciences and the humanities in the doctor's education. (6) In addition to the basic skills in ethics, then, at least one other humanistic study pertinent to medicine should be experienced by each student. For some it will be literature with emphasis on evocation of empathy and vicarious experience of illness or suffering, for others it might be medical history, for others philosophy or religious studies. The aim in these studies, as with teaching ethics and human values, is to expand the physician's awareness of as many of the dimensions of healing as possible.

How Should the Liberal Arts Be Taught? When? By Whom?

The experiences described in Chapters I and II provide a reliable foundation for the development of teaching programs in the humanities, human values and ethics in the foreseeable future. At the risk of some repetition, we can summarize the profile of characteristics that should guide both new and existing programs.

We believe that successful programs consist of an introductory course in the first year, followed by some integration of teaching in the clinical years, and the opportunity for
elective experiences in specific humanistic disciplines throughout the medical curriculum. The emphasis in the introductory courses is on ethics and human values, as well as clinical decision-making. Teaching is most effective when conducted in seminars, small groups, or a combination of lecture and small group discussion. The optimal approach is exposure to specific clinical cases or problems, selected to illustrate the major dilemmas encountered in clinical practice.

Following the introductory experience, many schools offer more detailed elective instruction in ethics, or one of the humanities related to medicine. But the most important teaching occurs in the clinical years -- not by lecture, but by some form of integration with instruction at the bedside or in the clinic.

The most successful integration occurs when teaching of human values least disrupts the normal patterns of clinical instruction. One very useful method is to devote one grand rounds per month in a major clinical department to a case in which ethical or moral dilemmas figure prominently. Another is, in each clerkship, to spend one session per week discussing a current case or problem pertinent to the appropriate specialty. Most successful experiences are built on current cases in which decisions are being made as part of the day-by-day care of patients on a clinical unit. In this way the students see that the liberal arts are united to the arts of the clinician and are therefore part of being a "good" doctor.

As with all clinical teaching, cases must be selected carefully, the questions they pose clearly defined, and back-up readings offered for deeper understanding. The all-too-frequent reliance on a fortuitous clinical situation or off-the-cuff discussion is even more damaging in this kind of teaching than it is in clinical medicine per se. This caveat is particularly applicable since clinical teachers are, too frequently, the amateur ethicist. They succumb easily to the temptation to substitute random thought and "experience" for critical and informed reflection. Few clinicians are well enough grounded in ethics to teach it as a formal discipline.

For this reason, the optimal teaching mode is a cooperative one. An experienced clinician interested in, and open to, serious discussion about ethical and value questions must work with a bona fide humanist or ethicist interested in communicating what he knows to medical students and their faculties. The technical expertise of the clinician complements the ethical expertise of the humanist. In this
way the positivism of clinical medicine and the intellectual
hubris of the humanist are both leavened to the advantage
of student and patient.

To be successful, the humanist must respect the diffi-
culties and urgencies of clinical decision-making, concen-
trate on concrete details and restrain his natural impulse
to criticize what he may perceive as moral lapse or sopho-
moric ethics. He must be secure in his own discipline,
willing to learn and to teach in the milieu of actual deci-
sion-making. There is evidence that given the satisfaction
of these conditions, humanists are well accepted and can
teach effectively in clinical settings. The initial
skepticism of clinicians usually yields if the humanist
combines competence with authentic interest in improving
the quality of clinical decisions.

Will Physicians and Patient Care Be Better?

One of the most difficult questions is whether or not
teaching human values makes for better physicians or patient
care. The current emphasis on evaluation and cost/benefit
analyses guarantees that this will be the skeptics' trump
card. Unfortunately, it cannot be answered with definitive
data at present. But neither can the question be answered
for individual basic or clinical sciences. Within limits,
more technical knowledge should make for better decisions.
By the same token, more familiarity with making ethical
decisions should improve their quality.

So far as ethics and the humanities go, they undoubtedly
raise the sensitivity of students and faculty to ethical and
value questions. Such issues as patient autonomy, truth-
telling, promise-keeping, consent and justice in the patient-
physician relationship are now openly discussed. Even a
decade ago they were the private domain of each physician,
not open to criticism or examination even among one's own
peers. The growing number of articles on such topics in
scientific and professional medical journals is sufficient
evidence of a heightened sensitivity and common concern in
the profession for the moral foundations of their daily work.

Almost everywhere, as a result, patients are better
apprised of their part in clinical decisions, and of the
value and moral issues woven into their relationships with
the physician. This is a result to be desired in a society
that is democratic, educated and pluralistic in its value
systems. Whatever personalizes and particularizes healing
will make it more humane. The heightened sensitivity of
physicians to value questions cannot fail to make some of
them better persons, more competent physicians and more
efficient healers. What better justification can there be

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for teaching the method, content and rewards of the humanities to physicians, while they are also learning how to be good physicians?

Some Problems for the Post-Evangelical Years

Even if the teaching of the humanities and liberal arts in medical schools can be justified, and financial support assured, there remain some significant impediments to its future viability.

Perhaps the most subtle but most critical danger is a failure to secure the intellectual foundations of this kind of teaching. It is true that a large volume of literature has appeared and this seems to be expanding at present. Close scrutiny of this literature raises some serious questions, however. Most of it is in medical and bioethics. This is to be expected given the preoccupation of public and profession with the urgency of many ethical dilemmas. But there are some signs that the productivity of this kind of research may be reaching a plateau. The growing evidence of repetition points to some exhaustion of the vein of bioethics per se.

There is promise in the still small literature on the philosophical foundations of medical ethics. The logical epistemological or metaphysical problems underlying the more urgent ethical issues are receiving more attention. (7) Formal interest in fundamental questions about the nature of medicine, the concepts of health and illness, the meaning of autonomy, and the broader issues of social medical ethics are receiving more attention. So, too, is the search for some theory of medical ethics. (8)

These studies are still too sparse to tell whether a vigorous intellectual effort can be sustained. No formal theory of medicine or healing is yet available. The humanities in medicine and medical ethics can survive in the hypercritical environment of the medical school only if the research they foster compares favorably in quality and depth to that which is occurring in the medical sciences.

Equally worrisome is the lack of models whom students can emulate -- clinicians who themselves can demonstrate that the liberal arts are useful, and actually used in daily clinical medicine. Without such models, medical students quickly conclude that the few physicians who can function at the junction of medicine and the humanities are rarae aves -- more to be observed than emulated.
The problem of faculty development will remain serious for some years to come. It cannot be approached through formal training programs. Faculties resent any suggestion that they are not "ethical" or lack something in their pedagogical armamentaria. Many will protest that they "teach medical ethics every day" in their care of patients. The most successful approach is by some form of participation, not some massive institutional program of "faculty renewal."

The mere presence, for example, of a program of teaching in bioethics or human values alerts a faculty to the issues and generates discussions with students and faculty colleagues. If ethical grand rounds or sessions within the clerkships are part of the program, many faculty and house staff members will be exposed. This is a non-threatening way to introduce the subject, to permit involvement of faculty members, and enable them to do so on their own terms and in their own environment.

Another effective way to involve clinical faculty members is by their participation as discussion leaders in small groups, following the more formal seminar/lecture presentations. Many schools use this method which has the advantage not only of involving the clinical faculty, but convincing the student that the subjects have clinical relevance. To be successful this method requires careful selection, orientation, and supervision of the participating faculty whose teaching capabilities, sophistication and knowledge will vary widely.

Perhaps the most hopeful sign for the future is the number of medical students manifesting an interest in a career that combines clinical medicine with bioethics, or one of the humanities. Some are interested in obtaining both the M.D. and the Ph.D. degrees and hope to follow teaching careers in these fields in medical schools. While formal programs are still in their early stages, a small number of students on their own are doing masters-degree level work in the humanities and human values and some in divinity schools. Others are taking a year out to study and do research in the humanities or ethics.

Another source of future faculty members is the seminars and conferences organized by the Kennedy Institute for Bioethics at Georgetown, the Hastings Center, the Institute on Human Values in Medicine and the several summer institutes under the aegis of the National Endowment for the Humanities. They have often influenced the career decisions of both humanists and medical people, often out of proportion to their brevity.
Faculty development seems to parallel the developments in the late forties and fifties when so many clinicians were educated in medicine and also developed familiarity with the sciences basic to medicine. This was the origin of many of today's senior clinical investigators. They are now being succeeded by clinical faculty members more formally trained in the biological sciences, even with combined M.D. and Ph.D. degrees.

Tomorrow's clinical scholars in the humanities may well come from a similar group who are now schooling themselves in philosophy, ethics, and the humanities as they relate to medicine and healing. They will not eliminate the need for humanists in medicine any more than the clinical investigators have replaced the basic scientists. They will be, however, essential "grey-zone" intermediaries in teaching and research.

There is no question that medical-moral dilemmas will continue to confront individuals and society. The wise use of medical knowledge will demand the same intensity of engagement between medicine and the humanistic disciplines that medicine has enjoyed so fruitfully over the last century with the physical and biological sciences. Public concern for the humane use of medicine and other technologies is likely to intensify in the years ahead. Medicine has been too influential in contemporary life to be left to professional and technical judgment alone.

There is every indication, therefore, that powerful external stimuli will impel medical schools to continue their new-found teaching and research efforts in human values, ethics, and the humanities. In the middle ages Greek philosophy and Christian theology confronted and influenced each other. In the last century science and medicine have had a similar mutual influence. Today, medicine and the humanities seem about to engage each other in the same way, medicine becoming the science of man par excellence, the humanities giving to that science its humane purposes and values.

In his latest book, Norman Cousins quotes one of the fathers of clinical science, Claude Bernard, as follows: "I feel convinced there will come a day when physiologists, poets, and philosophers will all speak the same language." (9) The national experience of the last decade or so in teaching the humanities, liberal arts, and human values in medical schools is a beginning fulfillment of Claude Bernard's prophecy. It confirms the fact that science and the humanities, values and technology are not incompatible, that they converge in the clinical decisions, and that they are both essential, though different, ways of knowing about the realities of illness, healing, and health.
Medicine is therefore the paradigm example of the "connections" between the liberal arts and the humanities and everyday life. Even in the coming "post-evangelical" period, the humanities and the liberal arts can be confidently and unequivocally justified as permanent and integral parts of the education of all health professionals.


PART TWO

"Capstone" Conference Workshops:

Reflections on the State of the Art

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GROUP I

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Session # 1

Almost the entire discussion concerned the aims/purposes of medical humanities in schools of medicine. The general agreement was: a) everything in the medical curriculum must be aimed at producing better physicians, thereby better patient care; b) the medical humanities contribute importantly to that goal; c) but precisely how the medical humanities do so contribute is difficult to articulate.

Thus, after the initial discussion listing the virtues of studying the humanities (everything from sensitivity to sophrosyne) it became clear that many other disciplines can reasonably claim to make contributions. General agreements about aims of the humanities disciplines emerged in the course of this discussion. In the first place, whatever else the medical humanities might be said to aim for, it is not "behavior change" in the way, say, humanistic psychology aims. As a member of the medical "team" the medical humanist seeks clarity and understanding for himself and for others. A second issue related to the above is the autonomy of the humanist. It is clear that the medical humanities seek to "teach about" autonomy; but does a humanist also advocate that physicians must respect patient autonomy, since at this time in our culture this seems to be the thing to do? That is, the question raised is just how directive (in a normative sense) the medical humanist can be in his various medical school activities. Although opinions on this differed somewhat, no one was prepared to advocate that merely one moral view be inculcated as the only normatively legitimate one. The difficulty is complicated by the issue of being "value-free": if the medical humanist claims that stance, his "politics of conceptual reform" (or the "politics of infiltration") may well be defeated before it begins, for then the basic sciences, already legitimated in medicine, seem to be and to do everything the medical humanist claims to be and to do.

Hence, the critical question concerns the differences between the medical sciences and the medical humanities. To this, it was generally agreed that two basic characteristics are crucial; a) The medical humanities embody certain distinctive attitudes of mind (intelligence) which, for instance, enable physicians to distinguish between the "right" (medical) decision and the "good" (moral) decision -- i.e., the intellectual talent to decide among alternatives by means of dialectical and presuppositional thinking, learning to assess alternatives by attending carefully to hidden value assumptions. b) Beyond that, medical humanities are characterized by their specific issues, themes, problems or phenomena (e.g., the nature, scope and justification of medical knowledge) -- which issues are themselves already present in
medical situations. They are not (or rarely) noticed explicitly as such by others even though these issues deeply texture the meaning of the medical situations (e.g., the way in which what are often called "psychiatric phenomena" turn out to be deeply moral in character). The medical humanist, therefore, serves to recover and discover dimensions and facets of medical situations which otherwise remain hidden but forceful.

It was emphasized that the presence of the medical humanities in medical situations (classes, conferences, or clinical settings) ultimately serves the aim of producing better, more informed and critically alert physicians -- hence, better patient care. The difficulty which persons in the medical humanities face is also clear: learning to respect clinical discipline, the necessity for an empirical fund of knowledge, and especially learning to detect and deal with those hidden but significant issues in the contexts of their actual occurrence (whether the issues be ethical, epistemological, metaphysical, or social/political in character). It was also pointed out, then, that the medical humanities work not only with medical students, but medical faculty, hospital staff, and even patients.

Several questions were left hanging: What about Art? Is it to be thought of as part of the humanities (in medicine)? Or as something to be placed in the service of this study? Also left unresolved were how best to deal with issues like informed consent, autonomy, etc.

Session #2

A number of issues were brought up. Leadership received much attention. After creating a wonderful list of desiderata for being a good leader (from political savvy to prudence), the group pretty well agreed upon three essential ingredients: a) It is absolutely necessary for the medical humanist to know his field competently and thoroughly (and confidently), it also being very helpful, especially at the early stages of any program's development, to be recognized by one's peers. b) Each such person must have the desire and the ability to communicate this knowledge within medical settings (hence, with a minimum of technical jargon); not only are humanistic issues important in themselves, but more especially for medicine (even, as possibly leading to the transformation of medicine). c) Finally, it was stressed that each medical humanist should strive for congruence between his practical conduct and his teaching (the Dorian Mode). To "talk about" confidentiality and not embody this in one's conduct can be devastating for the person and for the program.
Several important issues were tackled. Discussion began with a focus on the qualities specific to medical humanities as a group, as a unit, in the medical school -- especially on what marks the successful ones as successful. So to speak, what must a newcomer into such a program understand? What expectations are there of his conduct, teaching, research? When an additional position becomes available, what sort of humanist should be sought?

To this, a number of interesting points were made.

1) For the internal integrity of any medical humanistic unit, any newcomer into it must understand that program's history, be committed to its specific aims, and show a willingness to work within it in ways promoting, extending and/or enhancing its mission -- otherwise, internal fragmentation could ensue. Hence, each unit needs to be especially clear in communicating its aims, nature, history, etc.; it needs to be clear about its expectations of new faculty/staff, especially as regards rewards (salary, promotion, tenure, etc.). It was noted that few such units have achieved this measure of consistency.

2) The program should become appropriately (i.e., according to local conditions) integrated into the structures of the medical school, avoiding being placed in situations (weak departments, e.g.) which might inhibit growth and/or fulfillment of its mission.

3) When a medical humanities faculty includes more than one person, there must be a functional partitioning of responsibilities -- as regards not only areas of individual interest, but kinds of involvement each member is expected to do (working with clinical faculties, on research teams, teaching medical students, etc.).

4) Task assignments must be made explicit -- i.e., a parsimony of roles is most desirable.

5) An order of priorities as regards teaching, research, and service, needs to be established, especially for the purposes of promotion/tenure evaluation. These must be clarified within the medical school criteria and committees -- who seem often to have somewhat higher expectations of medical humanities faculty.

6) A sound, stable fiscal base needs to be established.

7) The unit needs to become part of the recognized mission of the specific medical school itself -- where one may see itself as primarily devoted to family practice, especially of part-time persons.

8) One must be especially attentive to the methods, processes, and timing in the evaluation of faculty in medical humanities programs, and to the variety of rewards for efforts.

9) The development of a medical humanities program is itself a moral enterprise, and thus involves the moral commitment of each person within it. Hence, the embodiment of the Dorian Mode already noted is particularly im-
portant for these programs: medical faculty and medical students seem to have very sensitive noses for hypocrisy, not only as regards individuals, but the unit itself. Both must be responsive to their own values and exhibit them in both teaching and conduct. 11) Other components of medical schools already have relatively clear images and expectations for the medical community; medical humanities do not as yet. The latter have neither the metaphors, the language, nor the symbols for conveying what medical humanities is all about to medical colleagues. These need to be developed and communicated.

Another general issue was then discussed, namely, the unique way in which humanities are, or at least can be, seriously and importantly reshaped, reconceived, thanks to the experiences of medical humanities programs. Seven advantages were noted. 1) Medical humanities programs and experiences involve one in the concrete, urgent value questions of our times -- thus showing the actual relevance of humanistic study for these issues. 2) One learns how to communicate value issues (and other issues) within the settings of their actual occurrence, and thus to become an actual member of a health-care team. 3) The medical school environment offers positive aids for conceiving and conducting humanistic research into significant issues. 4) One in general learns to teach in and from life itself -- from actual cases whose outcomes are directly dependent upon the actions, values, thoughts of the health-care team. 5) One learns new ways in which to serve other persons: students, colleagues, families, patients. 6) There are also positive advantages for one's undergraduate faculty colleagues in dealing with the entire problem, and myths, of pre-med programs. 7) Often, medical humanities courses taken by medical students can be utilized as "humanistic laboratories" for the pursuit of straightforward humanistic issues.

The many issues and questions inherent to the national scene were then discussed. Of principal importance was the clear need for a more refined, stricter, more consistent conception of medical humanities as a discipline. It was noted that the first plenary session presented statistics which were quite misleading in one way: when one school can report that it has two full-time faculty in medical humanities, and another can report that it has 77 faculty, something is deeply amiss as regards what medical humanities is understood to be, since the latter figure is clearly misleading. There is a need to know the actual "state of the art" and this requires a far more consistent, accurate, justified conception of the nature of the medical humanities, especially on the criteria defining the field. Finally, there is a need for a "national forum" for the faculties involved in medical humanities (as distinct from what was called
"human value" teaching). In sum: There is a positive need to secure the intellectual underpinnings of the discipline. This concluded the second session.

Session # 3

The remaining issues for the workshops were handled here: methodologies, relationships, structures, incentives.

Methodologies: Here the discussion was quite worthless, by common agreement. There was a failure to distinguish among techniques of teaching, methods of teaching, and methodologies (i.e., theories of methods and techniques). It was noted that while each of the traditional humanities disciplines has its own methods, the medical settings require the development, at times, of different methods -- but for the medical humanities both are needed, and both are supposed to lead to that fabled "better physician."

Structures: The main question here was concerned with the best placement for the medical humanities in the medical school. Several possibilities were discussed: being "free-floating" (e.g., under the dean or the vice president), which is, generally, undesirable; being located within another department (medicine, family practice, psychiatry, etc.); being established as a separate department; or conceiving the medical humanities program as distinct from the departmental location of individual faculty participants. Of all these, the establishment of an independent department of medical humanities seemed best, even though there were some reservations: the isolation this can bring about; the difficulties of academic legitimation within medicine; the exposure of such departments to demise in times of fiscal retrenchment.

The discussion then turned to the structuring of courses. The group was unanimously in favor of some mode of requirement: some block of contact hours needed to be successfully, seriously, passed by every medical student as a condition for reception of the M.D. Strategies for introducing such requirements will, of course, vary.

Relationships: Alliances with other units and faculties need to be secured and maintained. 1) Some courses should be team-taught; e.g., bioethics should include a clinician, not only for legitimating the content and course, but for faculty development purposes (inviting a clinician often results in the medical humanities being invited in turn to the clinician's course). 2) It is desirable to make use of and keep strong relationships with the faculty
in the general university. 3) Set up good relations with the chairperson of the curriculum committee; 4) Establish far better relationships than have yet been done with the faculty in the biomedical sciences (who have often felt ignored, wrongly). Their students have not normally been included, nor have these faculty been invited to lecture in biomedical courses. 5) Relationships with both students and administration must be cultivated.

It was generally agreed that medical humanities should stay away from psychiatry departments: i.e., try not to be included in that department. The reasons are: a) Psychiatry is itself still striving for legitimacy, and is frequently not thought well of by medical faculties; b) psychiatry, being presumably primarily therapeutic in character, should never be confused with medical humanities which is not therapeutic in character -- yet this confusion can be, and too often is, made.

6) While family practice departments seemed to some to be not entirely suitable for medical humanities faculties, others contended that this connection can be fruitful: both medical humanities and family practice are innovations in medical education (the only two which have thus far lasted), and thus share the value of challenging the orthodoxy of medicine generally; faculties in both often share outlooks on medicine and patient care; faculties in both often share concern for ethical and social/political issues; thus, there can be a real mutual reinforcement from such connections.

7) Relationships with schools of allied health and nursing should also be cultivated.

Incentives: Here things seemed to be lucid and clear. Still, several points were made: First, one needs to work for the commitment by the university to permanent faculty lines for the medical humanities; second, one needs to work for clarification of promotion and tenure criteria, and to attention (as already mentioned earlier in our workshop) to the processes, methods, and timing of the evaluation of faculty, the need to represent the specific problems of the medical humanities evaluation to one's medical colleagues, and perhaps even to have representatives from the medical humanities on appointment, promotion, tenure committees. Third, one strong incentive is that of released time, possibly funded by a grant. Fourth, it was also mentioned that one way to attract humanists to this field is to make clear the intrinsic fascination of the issues as regards medicine -- whether for an historian, philosopher, literary critic, lawyer, theologian, or art historian.

Our discussion concluded with mention of Georgetown's and Vanderbilt's plans to develop M.D./Ph.D., M.D./M.A. programs in philosophy; their and others' -- such as those at
the University of Tennessee -- efforts to develop Ph.D.'s with a specialty in medical humanities or medical ethics; and finally, the need to continue to cultivate medical settings for the medical humanities -- not only on behalf of extant programs, many of which may well be threatened by the current fiscal malaise of the country, but also to cultivate those medical settings both here and in Canada which do not yet have medical humanistic representation.
GROUP II

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The initial fervor which established humanities programs in medical schools around the country is almost over. In its place are concern and confusion; concern that the movement not ossify or fizzle and confusion about modes of evaluation, validation and even certification. These feelings are natural. In part, they are due to the extraordinary growth of human values teaching in the past decade. Then years ago, the medical humanities were a vision with a handful of examples. Now such programs are a reality throughout medical education.

Perhaps it would be better to say that the period of growth nurtured by the Institute on Human Values in Medicine was Phase One -- development. As we reach the crossroads for Phase Two, the very successes of the development present the current challenges.

It is my task to comment on the challenges which were identified by my colleagues at the "Capstone" Conference. If my remarks appear optimistic, it is because of the deep conviction that applying the humanities to the special urgencies of medicine -- patient needs -- is not only a necessary, but also a noble task. Although the task is far from complete, it has attracted extremely creative teachers and scholars in medicine and humanities. These creative individuals, acting together, cannot fail to meet the challenge.

Accordingly, my remarks are organized around ten themes of concern raised by these colleagues. I have been asked to offer my own perspective on these issues. Needless to say, my perspective has been influenced by our dialogue.

Introduction

There is a field called medical humanities. It is often seen as a specific branch of the applied humanities. Because the humanities are composed of so many disparate disciplines, we experience an academic failure of nerve in trying to define them. The failure of nerve is compounded by some degree of boredom as well. Have not all of us struggled to clarify our objectives and our roles by explaining the medical humanities to others? Why not move on to more exciting topics? The reason we must continue this struggle is that the field is our primary academic identification. If we are ever able to be successful, we must provide some standards for objectives, evaluation, and program design.
But definitions of this field seem to face a brick wall. To scale that wall will take time. Some specific steps to be taken will include the following.

The Validity of the Field

First, those in the field will have to acquire enough confidence about it so they do not constantly look back to their original discipline for approval. This is a common experience. In fact, it is helpful during the early stages of any new discipline because we are forced to prove the validity of the branches to the roots. As was the case with history and philosophy of science, however, the branch must soon break off and become its own sapling. The mainstream discipline will never wholly absorb the new movement. The reason is that, like all pure humanities and science disciplines, it must possess, as in Marvin Harris' apt phrase, "the supreme virtue of being useless." (1) This freedom to explore ideas without potential applicability runs directly counter to that urgency of patient and professional need in medicine which characterizes our enterprise.

Departmental Status

Second, the overwhelming number of programs as compared to departments will have to convert to departmental status as the field establishes itself. It is too early to judge whether this will happen. Nonetheless, a field does not become legitimate until we acquire academic structural recognition and begin to reproduce ourselves. As of now only a few departments in the country do so, and that only in medical ethics. We will soon have to concern ourselves with training new teachers in medical humanities as the funds for fellowships run dry. To date, we have accomplished this training largely through post-doctoral fellowship awards.

Effective Teaching

Third, we must establish the most effective models of teaching and research which will be, because of our different task, startlingly new forms of teaching the humanities. Most of us were trained in traditional humanities or medical specialties. It is already the case that new forms of teaching humanities, such as ethical grand rounds, clinical conferences, teaching on rounds, appear
to our root departments as forms of heresy. Specific to the task of establishing these new forms is re-thinking the role texts have played in the humanities. There is little time for serious exploration of texts in a medical school. As one member of our group said, the very nature of a humanities text will have to be redefined to include moments of suffering and pain. These prompt a personal focus in the midst of the technical discipline of medicine.

Technological Context

Fourth, we must re-examine the validity of the traditional task of a humanities education in light of technological society. The character of society has changed dramatically since the Second World War, largely due to rapidly deployed technologies. As Leo Marx observes about new technology in communication and energy alone: "...new technologies, portend a nation state dominated by a web of interdependent, hierarchical bureaucracies -- a totality so intricately organized, so vulnerable in the sense that a failure in any part could jeopardize the whole, that it will require a highly disciplined, controlled, and pacified populace." (2) The needs of a technological society, then, run exactly counter to the purpose of the humanities, which have traditionally stressed the primacy of self-determination through a blend of harmony of reason and emotion.

As a matter of fact, the task of medical humanities programs can be much more precisely defined than as a footnote to the struggle between the needs of technological society for passive acquiescence and the goals of human self-determination. This is because technology has become an almost autonomous force within the field of medicine, requiring its own labor force, economics and moral code. (3) In other words, it has become the stage upon which the lives of patients and health professionals are played, providing the particular dramas which occupy our educational strategies. The struggle to be human is an education in this environment precisely because it illuminates the good and evil within our nature, our medical, social and cultural context.

Re-thinking the traditional task of humanities with an eye on medical technology is required because that traditional task was to serve ends beyond itself, to create a good citizen. As Max Black argues, "for all its pretensions to universal validity, [humanistic] education should always have been both elitist and vocational, serving in fact, whether in Greece, Rome, Renaissance Italy or Victorian
England, the special interests of a governing class or their clerks... It is hard to advocate in good faith a vocational curriculum, designed for gentlemen and their literate aides, when the very concept of a gentleman has become an anachronism." (4)

As a consequence of our changed cultural situation, Black argues that only an emphasis on the non-objective perspective of the individual and his world is valid in a technological age. All of the other aims of a traditional humanistic education remain suspect: the superiority of man, the search for a human essence, the essential goodness of that essence, and the like. Thus, he suggests that the distinctive task of humanistic criticism is to "delineate and articulate" the human perspective as against the ideal objectivity of science and technology.

I believe Black's approach has great merit for helping us identify the field of medical humanities. Much work needs to be done, however, before anyone can judge the final value of this approach. In the main, what was lacking in medical education, lost, as it were, during the post-war era, was exactly this "human perspective." And it is this which medical educators want reconstituted in the midst of a highly technical curriculum. However, we should abandon the idea, if we ever tendered it, of educating physicians to be humanists. Instead, we should substitute the more specific and concrete aim of providing tools for the discovery and nurture of a human perspective in medical theory, practice, and delivery.

Relationships

Fifth, the relationships of medical humanities to other disciplines needs close attention. As was remarked in our group, we should be thankful to the behavioral sciences for failing to accomplish the goals for which they had originally been invited into the medical curriculum! Their failure is the reason medical educators turned to the humanities. It is well to remember this fact. It requires our most earnest efforts to discern the point at which the behavioral sciences did fail. I suggest that it lay in that discipline's failure to keep objectives clinically oriented, a danger which also faces us. It is not sufficient to claim that relations with clinicians are required to gain educational turf. Our relation to clinical teachers should be more profound than that. The source of the need for a partnership with clinicians, as I have described it elsewhere, (5) is the professional practice of medicine in which the re-defined "texts" of the medical humanities arise. It
is from this practice that problems are posed and the need for the human perspective arises. That is why I remain skeptical of the ultimate effectiveness of traditional courses in humanities in a medical school. Wendy Carlton demonstrated to my satisfaction that the professionalization process occurring in the training ground of the hospital virtually eliminates the effect of all pre-clinical classes in ethics. Consequently we must direct our educational strategies to the clinical years, including residency programs.

In addition to failing to develop clinical relationships, two other dangers face the medical humanities. First I would call the psychosocial slide. In this slide, we begin to adopt roles and stances inappropriate to the discipline, and more to the point of ministerial or behavioral sciences professionals. The slide is this: to somehow make medical students "more humane." This expectation is often forced on us by well-intentioned allies. But the humanities education of many Nazi war criminals should be sufficient evidence that an exposure to the humanities does not in itself guarantee humane responsiveness. The problem is tricky. We do want to claim that the humanities, as modified to explore the human perspective of medicine, will have some impact on professional behavior. But we do not want to claim that our task is to directly modify student behavior. Of course, we hope it will. But we cannot assure it. To accomplish such modification the entire curriculum, including clinical training, would have to be revised. I fully expect that a growing awareness of the need for such reform will occur among medical humanities educators. It will drive us to reconsider some joint strategies with colleagues in the behavioral sciences. If I am correct in this perception, we will need even greater precision of the nature of medical humanities in order not to be absorbed into behavioral science objectives.

The second danger was noted by Sam Banks in his closing remarks at the conference. He quoted with approval Larry Churchill's resistance to reducing the field of medical humanities to decision-making alone. Much more is going on in medical practice. Because of the extraordinarily rapid growth of medical ethics, and its undoubted relevance to medical decision-making, it is often convenient for some to reduce the tasks of medical humanities to those of medical ethics. In fact, I noted with some dismay a developing rancor at the conference; a rancor of philosophers toward the other disciplines represented in the collage constituting medical humanities and an equally evident rancor of professionals representing these other disciplines toward philosophers. I am dismayed on two counts. First, this rancor represents old, departmental disputes which are inappropriate to carving out a new discipline called medical
humanities. Second, such rancor can only subdivide the essential unity of the "human perspective" into ineffective subspecialties huckstering their own limited visions. We would then fall victim to the very overspecialized view of medicine we are attempting to counter.

A final note is necessary about relationships. Many of us are concerned about revitalizing our root disciplines. As a matter of fact, most of these disciplines could be accused of solving crossword puzzles during a challenging period of human history when profound assaults are made on human dignity and social institutions. One of the obvious and tempting goals of medical humanities is to assist this revitalization. But I am concerned that it remain a secondary enterprise, one which we can perform in our root discipline's journals or in an occasional seminar. It must remain secondary because it can too easily divert us from our primary educational goals in a medical center. We cannot revolutionize everything at once. Some priorities must be established. As the confidence in the field of medical humanities grows, a confidence mentioned in the first section, the revitalization function should continue to remain a secondary concern. I submit that the effectiveness of those for whom this task is prominent is somewhat diminished in a medical context.

Medicine as Humanities

A sixth step in scaling the wall towards defining our field is to explore more deeply the inherent qualities of medicine which make it one of the humanities. With his customary foresight, Ed Pellegrino has placed before us his now classic account of how "medicine is the most humane of the sciences and the most scientific of the humanities." (8) I do not think we have paid sufficient attention to this insight, especially with respect to clarifying our objectives. If the problems we address arise from medicine, and the questions are framed by the medical context, the insights we offer are relevant to its employment, the strategies we use are molded by its educational framework, and clinical relations are necessitated by its practice, then we ought to critically question whether medical humanities are a branch of applied humanities at all. Instead, might they not be a branch of medicine itself?

In the introduction, I noted that medical humanities are often viewed as a branch of applied humanities. But this may be an incorrect characterization. True, they do use the tools of analysis found in root disciplines normally called the humanities. But if their origin, goal and matter are in medicine, they are best seen as second order reflections on medical theory and practice which are
themselves a branch of the humanities. As such, the medical humanities are a form of meta-medicine, as is the title of one of the journals in the field. This consideration, which is only suggestive here, can lead to greater specificity of objectives, a point to which I now turn.

Objectives

The seventh step toward detailing the field of medical humanities most severely tests our resourcefulness in defining our field. It is to create objectives which closely parallel professional training without diminishing a specific humanities focus. I have suggested that the goal of medical humanities is to delineate and articulate the human perspective of medical theory and practice in the midst of the ideal objectivity of science and technology. The means to accomplish this goal ought to be the same as the objectives of medical education, aside, of course, from the specific technical training skills also required. Al Vastyan presented us with an excellent set of objectives in this regard. (9) I offer my own below, if only to explain how these should be more closely tied to professional qualities, virtues if you will, that are available to all health professionals.

1. Increased Care for Persons

The familiar distinction between cure and care can be fused by educating young professionals about the human core of need for both. A new definition of what it means to be human and to be a person in need can be contributed by explaining the personal nature of the medical relationship and theories of disease and well being.

2. Increased Self-Critical Attitude

The practice of medicine requires constant self-criticism traditionally associated with Socrates' phrase: "The unexamined life is not worth living." Defense of this appeal for reason in conduct, however, can be focused on the obligation to care for persons, to act in concert with them on their behalf, and the requirement of having reasons for a course of action defensible to peers, patients, and the law.

3. Increased Capacity for Personal Growth

One cannot treat persons unless one is a person. The profound sense that both healer and healed are locked in the same human condition can be conveyed through skills in understanding and by articulating the mystery of life as it unfolds in the person behind the professional mask.
4. **Enhancement of Patient Autonomy**

Attention can be paid to the goal of medicine; what is really meant by curing, the quality of life, or restoring some functions to those in the care of practitioners. Not only the skills of reason, but also the insights of poetry and literature are essential for a more complete "human perspective" on patient self-determination.

5. **Understanding Norms of Professional Conduct**

In this objective, both the legal and moral expectations of professionals can be explored, with special attention to the minimalist standards represented by codes, their inadequacy as well as necessity, and their historical origins.

6. **Contribution to Public Policy Debates**

Young professionals need help in developing their perceptions regarding the major public policy debates in medical care because they will be expected to contribute to these debates.

While these six objectives are only a few of the many medical humanities might offer, they illustrate the way professional qualities in medicine call for the second-order reflection on medicine itself. They also possess the virtue of being able to be measured in some way. (10)

**Evaluation**

The eighth step toward a definition of medical humanities as a field of study is as problematic as the seventh. We often do worse in evaluation than in setting proper objectives. Because of the emphasis on evaluation in a medical setting, most of our courses have a set of concrete and measurable objectives. The concern about evaluation I heard expressed at the conference was much broader in scope. It dealt with evaluating the enterprise of medical humanities itself. Until such enterprise is properly defined with a demarcated goal and standard objectives, no real evaluation can take place. Instead we can only receive "reactive" evaluations of the sort we have become accustomed to hearing. They range from "You are doing a great job for us," to "These courses have really changed my thinking." That is, if we are lucky.

The only serious efforts of evaluating the medical humanities as programs of education have customarily been confined to annual management by objective reviews or consultation by peers. While the former is to be highly recommended, it requires much greater national precision of the field to set standards for local programs. The latter form
of evaluation can only focus on institutional and programmatic goals without the same national consensus on what constitutes a good program.

The use of Kohlberg-based tools, such as the Rest Defining Issues Test, has some validity with respect to the specific objectives of medical ethics courses. For example, Sheehan, et al., have shown that training in medical ethics correlates well with a series of clinical skills residents require, and that those that did well in medical ethics did well also in their clinical evaluation. (11) It remains to be seen whether these methods of evaluation can be adapted to entire programs, however, particularly since they are subject to the philosophical objection that they merely measure an increased capacity to reason complexly. (12)

I mentioned that objectives of the sort outlined in the previous section are capable of measurement. It is possible to gauge the beginning and ending ability of students to identify public policy issues in medicine, or to self-critically examine the reasons they offer for a recommended course of action. By becoming more precise about our objectives, we can face the challenge of evaluation of programs. In particular, we will be able to avoid trying to evaluate whether our students have become "more humane" through our endeavors.

Validation

The ninth step is the need for national validation of the medical humanities effort. To date, validation of programs was offered through the activities of the Institute. Concern about its future, and the confusion mentioned at the outset of my remarks, underline the importance of such validation. Renowned scholars and educators in the field helped establish the vision which has been transcribed into programs. If these are not to languish or die during the present and future budget crunch, they must be constantly nourished by peers around the country. Among the challenges I have cited, at least two need our constant attention: setting standards for program objectives and formulating authentic evaluation procedures. The consultations provided by the Institute inaugurated these tasks. They are far from over. The Society and the Institute will have to develop methods to meet these challenges.

Validation is also accomplished through the network of scholarship encouraged and begun in some cases by the Institute. In effect this network established norms for what Al Vastyan called "a trans-disciplinary discipline that has
intellectual rigor." Although there are now separate journals for medical ethics, law and medicine, history of medicine, philosophy of medicine, and literature and medicine, there is no journal devoted to the "trans-disciplinary" venture of medical humanities. Until there is, the movement will continue to walk on an ice-floe about to crack apart.

Finally, validation should be seen as a form of certification of programs. Perhaps the best means to accomplish that end would be for the Society for Health and Human Values to create a committee in whole or in part composed of the Institute Board to develop criteria for certification of programs. Such a committee will be drawn into the task of establishing standards for objectives and evaluation.

Medical Humanities

In order to summarize the ideas contained in a list of challenges we face, I offer yet another definition of the medical humanities as the tenth step. This one incorporates points made in each section. The definition is briefly explained.

Medical humanities is a disciplined study of the forms of thinking and acting required by health professionals to maintain a human perspective on medical theory, practice and delivery in a technological age.

1. The concept of humanities is essentially a contested one, as Max Black observed in the article cited. (13) This means that competing traditions vie for the honor of its appellation. The definition offered skirts fruitless debate on the authentic meaning of the humanities by restricting medical humanities to second-order reflection on medicine itself, and by linking them to the task of a professional education.

2. The "forms of thinking and acting" can be taken in their broadest sense, as the arts of criticism, articulation, reflection, and the like, which are common to the liberal arts. These free one from dependency on the opinions of others and provide a self-critical attitude about one's own values and culture. (14)

3. The "human perspective" in a technological discipline is provided by concreteness rather than scientific abstraction, by attention to the dramas of disruption, pain and suffering experienced by those who are ill in synchronism with the usual attention to laboratory data and disease entities.
4. "Medical theory, practice and delivery" is meant to encompass the history and scientific thinking of the discipline of medicine, its practice in concert with patients, and the structures of its local and national delivery. Thus a focus on patients' concerns or on national health allocation or on professional duties are all equally valid.

5. Finally, by thus defining medical humanities as a unified discipline arising out of medicine itself, we avoid the seemingly inevitable specialization and professionalization of the individual, root disciplines from which we received our training, whether in medicine or in liberal arts. This does not mean that we must abandon these disciplines in our work, or neglect the importance of the standards and ideals they set for us. It only means that we describe our field and its evaluation in much wider terms than these disciplines normally allow. In this way, we explicitly recognize the validity of a cardiologist to use poetry or a philosopher to employ anthropology in the common task of educating new health professionals.

Conclusion

Is it, then, the best of times? While the challenges I have outlined are formidable, they are not insurmountable. Meeting them is to bridge the two cultures C. P. Snow described and to pose this bridge as a model for all education in the forthcoming 21st century. Who would want to trade this front-line adventure for rear-action academic teaching? None of our colleagues expressed such a wish.


(7) Bergsma, Jurrit and Thomasma, David, "The Contributions of Ethics and Psychology to Medicine," draft submitted to the *Journal of Medical Education*.


(9) A reference to the introduction to the Conference workshop by E. A. Vastyan.

(10) I have presented similar objectives in somewhat more detail in a paper entitled, "A Cognitive Approach to the Humanities in Primary Care," submitted to *Family Medicine*.


(13) Black, Max, *op. cit.*, p. 79.

GROUP III

Reporter Glen W. Davidson
Professor and Chairman
Department of Medical Humanities
Southern Illinois University School of Medicine
Medical humanities (medicine in society, values in medicine, etc.) programs are an effort on the part of medical teachers to provide an education for physicians schooled with post-Flexnerian emphasis on the basic sciences and post-war (WWII) emphasis on clinical technology. Since the establishment of the first department of humanities in 1967 at The State University of Pennsylvania Hershey Medical Center, there have been some outstanding experiments which are now thoroughly part of medical curricula. There have also been some notable failures, such as the program at the University of Arizona where not even a major endowment guaranteed longevity.

Before the Hershey program, a comparable effort was made in the 1920s with medical history as the dominant discipline. In some medical schools, medical history units still exist, such as at the University of Washington, University of California-San Francisco, University of Minnesota, Harvard University, and The Johns Hopkins University. Dr. Chester Burns has given us insight into why a few of the medical history programs survived the economic depression of the 1930s, and of those surviving, why those units often failed to meet the interest of medical educators in the 1960s and 1970s.

Participants in the "Capstone" Conference Group III seemed unanimous in the opinion that the opportunity to reflect on the successes and failures of the last fifteen years proved invaluable in identifying programmatic characteristics. This report tries to capture the flow of the review by following an outline provided by E. A. Vastyan. Responsibility for the opinions of the report, however, rests solely with the author.

**Purpose, Objectives, and Goals**

Little time in the workshop was spent on examining the unique presuppositions that humanists bring to medical education. Some participants referred to the need for rigorous examination of scientific and clinical assumptions, for balance in a technologically obsessed profession and society, for systematic logic in decision-making, and for humane balance in the physician-patient relationship. Yet, despite the differences of disciplines, language, methods, and skills, participants seemed to agree that we have in common the responsibility to teach distinct skills of inquiry, decision-making, and human relationships.

It was noted that medical humanists have tended to come from three disciplines: medical history, religion, and philosophy. There seems to be consensus that certain ques-
tions in medical education are more adequately addressed by one discipline as opposed to others. Medical history dominated the 1920s at a time when both orthodox (post-Flexner) medicine and medical students were attempting to define the distinct characteristics of the profession. Religion tended to dominate the 1960s when new programs in new medical schools were being established — a time when questions of society's obligations for health care and the purpose of the physician's role were dominant. Philosophy has tended to dominate since the Quinlan case and the multiple questions which have been raised about values and the physician-patient relationship. Other disciplines such as law and literature are also represented in a number of programs.

The nature of a discipline seems to carry with it assumptions which affect other aspects of the humanist's role in medical education. The following typology may be exaggerated, but the points of difference were well represented at the Conference, particularly between the humanists coming from religion in contrast to those coming from philosophy.

In response to clinicians' questions about being a member of a profession, those humanists from religion tended to identify with the historical assumptions that a profession is a "calling." There seems to be a mutual recognition with the physician that a profession requires taking on obligations of skills, behavior, styles, and values unique to the professional. To the philosopher, however, this seemed at best to be uncritical and at worst to be acquiescent. The philosophers generally do not think of themselves as a profession nor are they seen by physicians as members of a profession. A profession, for many philosophers, is an organization for vested interests often compromising patients' rights.

In response to the question about how one is most likely to respond, as a top priority either application of principle to a human being's needs or maintenance of an idea and its analysis -- those in religion tended to respond to the former, the philosophers to the latter.

To questions of validation, those from religion rely primarily on institutional colleagues (trans-disciplinary) while the philosophers tended to argue that primary validation had to come from colleagues of discipline, regionally and nationally.

The questions of teaching strategies for humanists from religion tended to be integrative while those from philosophy tended to be analytical.
To questions of institutional strategy those from religion tended to call for a variety of disciplines, arguing that the questions of the moment may not be the questions of the future. The philosophers tended to argue that rather than an "eclectic group of humanists" there should be a "critical presence" of one discipline in a given school. In a faculty of three or more humanists, the former would have each faculty member representing a different discipline, while the latter would have three philosophers.

To questions of teaching areas, those from religion tended to focus on clinical activities -- clerkships, rounds, case conferences -- with emphasis on both the didactic and experiential. A frequent question addressed is "What kind of a person ought I to be in the clinic and how ought I to function as a clinician?" Those from philosophy tended to focus on classroom structures with emphasis upon didactic presentations and reflections. A frequent question addressed is "How are clinical decisions made?"

Whether or not these typologies are accurate, they seemed to structure much of the debate at the Conference and, many agreed, represented the kinds of debates encountered locally. What some criticized as intellectual laxity, others regarded as creativity; what some looked upon as ideological indulgence, others took pride in as acts of moral commitment. It led some of us, mindful of the course of other revolutions in Academe, to be less sanguine.

Incentive

A repetitious concern for administrators of medical humanities programs has been salary scales. No public data are available. However, a confidential study has been done among select programs every other year for the past six years. The latest study, 1981-82, based on 27 programs (including four of the American and one of the Canadian departments) shows that medical humanities faculty receive salaries comparable to the pre-clinical faculties of their respective schools. The lowest humanities faculty salaries are paid at those medical schools with the lowest salary scales. Little or no discrepancy occurs within a medical school for any academic rank between the humanities and their Ph.D. basic science colleagues. M.D. faculty appointed in the humanities tend to receive remuneration comparable to M.D.'s appointed to basic science (in contrast to clinical) departments.
the deanery. If the tenure of the dean is short, so too is the staying power of the humanist. Review of the large humanities programs reveals that all have been shepherded by vice presidents for health affairs, provosts, or deans with long tenures. Similarly, several very promising programs have become inconsequential or nonexistent where there has been rapid turnover of a school's executive leadership.

Many problems at this stage of development depend upon cross appointments from parent departments in the liberal arts college. Most participants reported facing frequent problems of reconciling different objectives and incentives between their colleagues in schools of medicine and of liberal arts, particularly for tenure and promotion decisions.

The second step in the assumed evolution of humanities program is location in a clinical department where stability of a chairman and senior medical faculty can compensate for any change in the deanery. The major risk identified for this type of organization is being on the low end of a department's priorities when competition for resources is high. The example was given of the present risk for one of the oldest and most developed programs. When the School of Medicine was required to reduce the number of faculty allocated by departments, the chairman of the department indicated that he will probably reduce the number of humanists from three to one in order to preserve the size of his clinical staff.

The third step of organizational evolution is the established department for which there is distinct budgeting within a school's fiscal structures, committed time in the curriculum, and space identified as "humanities." Not all participants felt that departmental status would work at their institutions particularly where there are responsibilities to other schools in the health science complex (i.e., nursing, allied health, pharmacy). The organization of the Medical Humanities Institute, The University of Texas Medical Branch at Galveston, is an example of trying to meet that challenge while keeping the strength of departmental organization.

"It's unnatural to transcend departmental lines," suggested a participant, and the workshop members were reminded that the organization of an earlier attempt to include the humanities in medical education became insular and aloof from undergraduate medical education and clinical activity.

Despite the possible impediments of departmental status, however, many participants felt it was the most ideal organization since it allows establishment of internal standards of performance for both students and faculty, the humani-
ties faculty have a greater sense of autonomy both in relationship to their liberal arts and their clinician colleagues. Most of the departments have successful, on-going cooperation with clinicians. The department at Hershey, for example, has established an interdisciplinary structure for participation in clinical teaching. The departments at Southern Illinois and Wright State have distinct clinical programs team-taught with physicians but under departmental control. Finally, departmental chairmen participate in the regular channels of a school’s administration, and departmental faculty participate in the school’s regular process of evaluation and validation. It was noted, for example, that the LCME review teams interview all chairmen, important literally and symbolically for humanities.

Concluding Summary

It has been difficult for humanists in medical education to adapt to the three economies of ideas, time, and resources. Every idea germane to humanistic inquiry is not appropriate to curricular offering. All participants seemed to agree that it is inappropriate to construct courses for medical students as though they were in pre-med curricula. Content and style of humanities courses need to account for the questions and experiences prevalent in the medical curricula. Addressing ideas in the laboratory and the clinic are a full-time endeavor. Challenging the misrepresentations of science in medical education and resisting the reductionism of both basic scientists and clinicians ought to take priority over time to teach the ideas and methods peculiar to our own disciplines. As one participant summed, "We are not in medical schools to create miniature historians, but to assist in training the best of all possible clinicians." In at least three of the major humanities programs, a core curriculum has been identified as faculty have addressed the question, "What should every graduating M.D. know and experience?"

All participants seemed to agree that the economy of time, while important any place in Academe, is pervasive in a medical school. This leads to great pressures to summarize thoughts, reduce complexities, and use reading and writing exercises minimally. Most participants saw themselves still fighting for more time in the curriculum. The chairmen present cautioned against over-extending commitments which would compromise quality. The chairmen seemed unanimous that having once succeeded in becoming part of the medical curriculum, they now face the necessity of turning down frequent requests for more curricular and research involvement. If one has to choose between amount
of involvement and quality, they agreed, one ought to choose quality performance.

Economy of resources has become severe for the humanities in the 1980s. Yet, despite cutbacks in grants and contracts, little effort seems to have been made in many programs to develop and tap local resources. Far more effort, it was agreed, needs to be expended on joint resource endeavors with clinical departments, on seeking assistance for teaching strategies from within the university and school of medicine, and on developing relationships ("ligatures" was suggested as a better metaphor) with county and state medical societies.

With all the variations and possibilities at our different universities before us there did seem agreement that it is a waste of resources to be creating new graduate programs where we attempt to replicate ourselves. Few, if any of us, see sufficient job opportunities in the future to warrant the time and money spent on graduate programs. Far better, it was agreed, to focus and concentrate resources in areas of medical education where the humanist becomes known, expected, and held accountable to regular quality performance. A challenge far greater to the humanities in medical education than acceptance by physicians may be application of the humanist's greatest resource -- imagination -- to our own tasks.
# APPENDICES

## Additional Programs of the Institute

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APPENDICES

Other Programs of the Institute

This report focuses almost exclusively on only one of the programs of the Institute on Human Values in Medicine -- its resource visits and consultation services. While this program did indeed consume the greatest proportion of time, effort and fiscal resources it did not exhaust the full range of the Institute's services to the medical teaching community.

The other major programs of the Institute were: 1) publications and public information; 2) dialogues between the disciplines; 3) the fellowship program; and 4) conferences for Directors of Medical Education. A brief sketch of these additional programs is provided in these appendices to afford a more complete view of the work of the Institute.
APPENDIX A

Publications of the
Institute on Human Values in Medicine

Over the years the Institute has become a major source of information about every aspect of the teaching of ethics, human values and humanities in medical schools. Through its publications faculty members and administrators have had access to detailed information about the majority of teaching programs in the country: location, content, teaching methods, faculty, curricula, contact time, administration and teaching materials. The Institute's publications now number seventeen.

Institute on Human Values in Medicine -- Proceedings of the First Session, 1971
Institute on Human Values in Medicine -- Proceedings of the Second Session, 1972
Institute on Human Values in Medicine -- Proceedings of the Third Session -- Southwest Regional Institute, 1973
Reports of the Institute Fellows, 1973-1974
Human Values Teaching Programs for Health Professionals, 1974
Fostering Ethical Values During the Education of Health Professionals, 1974
Conference on Human Values in Medicine for the Six Medical Schools in Philadelphia, 1975
Human Values Teaching Programs for Health Professionals, 1976
Reports of the Institute Fellows, 1975-1976
Reports of the Institute Fellows, 1976-1977
Conference on Medical Education and Malpractice Litigation, William J. Winslade and Bernard Towers, editors; Philadelphia: Institute on Human Values in Medicine of the Society for Health and Human Values, 1977
Reports of the Institute Fellows, 1977-1978
Nourishing the Humanistic in Medicine: Interactions with the Social Sciences, William R. Rogers and David Barnard, editors; Pittsburgh: University of Pittsburgh Press, 1979
Medicine and Religion: Strategies of Care, Donald W. Shriver, Jr., editor; Pittsburgh: University of Pittsburgh Press, 1980


The Healing Arts: Literature and Medicine, Joanne Trautmann, editor; Carbondale, Illinois: Southern Illinois University Press, 1982

Among Other Things, Art: The Visual Arts and Medical Education, Geri Berg, editor; Carbondale, Illinois: Southern Illinois University Press, in press

Further information about these publications can be obtained through the Society for Health and Human Values now located at the following address:

Institute on Human Values in Medicine
c/o Society for Health and Human Values
George K. Degnon Associates, Inc.
1311 A Dolley Madison Boulevard
McLean, Virginia 22101
(703) 556-9222
APPENDIX B

Dialogues Between the Disciplines

The Institute Board was convinced from the outset that the conceptual foundations of the teaching of the humanities and human values in medical schools should be examined concurrently with developments in their teaching. One effort in this direction was the program entitled "Dialogues Between the Disciplines," which brought humanists and medical educators together in small groups to discuss the intersections between their respective disciplines.

Five areas of intersection were chosen -- the social sciences, history, literature, religion and the visual arts. Each dialogue group was composed of representatives of the disciplines in question and physicians or other health professionals with a special interest in that discipline. The groups consisted usually of no more than ten persons. They met for periods of two or three days, for a total of 5-6 times in a two-year period.

Each group was charged with examining the points of intersection, the common interest and conflicts between medicine and one of the humanistic disciplines. They were asked to examine how medicine and the humanities could contribute to each other to outline the most fruitful areas for future research and teaching and ways in which continuing dialogue could best be sustained.

The dialogues centered on critiques of papers prepared by members of each group. Syntheses of their deliberations have been published by the Institute (see Appendix A). The dialogue group in history and medicine does not at present plan to publish its findings.
In four of its periods of grant support from the National Endowment for the Humanities the Institute conducted an unusually effective Fellowship program. Its aim was to enable students and faculty members from both the humanities and the health professions to spend time in each others' environment doing research, learning about teaching methods, and examining the possibilities of a personal career expansion, or change.

In all, a total of 77 fellows were chosen on a competitive basis from 253 applicants representing 118 medical schools. Included among the fellows were medical and nursing students, graduate students, junior and senior faculty members and a few practitioners in medicine and/or nursing. Their activities were varied: Some of the humanists usually wanted to gain direct experience related to specific research projects in which they were engaged; other humanists wished to become familiar with the kinds of ethical problems encountered in clinical settings to which they might direct their future teaching efforts; still others hoped to develop programs in their own schools and wanted some direct experience with faculties already experienced in teaching human values, ethics and the humanities.

Medical and nursing students usually wanted to spend their time with a humanist, deepening their knowledge of the techniques, content and method of a particular humanistic discipline. Ethics or philosophy were most often chosen but literature, religion and some of the social sciences were included as well. Some already had in mind a specific research project in a related humanistic discipline and spent their time completing a research project.

Medical and nursing faculty members usually had aims like those of their students: to expand their own research or teaching. Some were particularly interested in establishing teaching programs in human values, ethics or the humanities in their own medical schools.

The "crossover" between humanists and health professionals which enabled each to sample the environment and thinking of the other was uniformly fruitful for both groups. Humanists had first-hand experiences in the clinical setting and even participated in some decision-making. Medical and nursing students and faculty learned how the humanities might relate to their own disciplines.
A significant number of the fellows supported by the Institute used their experience subsequently to establish or teach in a program of human values in a medical school. Twenty-eight of the 77 fellows are known definitely to be teaching in such programs and 15 of them are either directors or co-directors of their programs.

The Fellowship Program came at a most fortuitous time -- just when interest was developing in medical schools in the teaching of ethics and human values. New courses were being developed, programs designed and formal teaching introduced for the first time in many schools. The opportunity of an Institute Fellowship was often the most significant impetus to the fellow's eventual involvement in what was then a very new type of teaching.

The amount of money spent annually -- $50,000-$70,000 -- was very small when one considers the far-reaching impact of these fellows on the teaching of human values in American medical schools. When coupled with the resource visit program to a campus, the effect was synergistic.
APPENDIX D

Conferences for Directors of Medical Education

The overwhelming emphasis in the Institute's program has been on medical and graduate education. However, as programs were developed in many medical schools, it became apparent that interest was also growing in the practicing professions -- particularly in the teaching of medical ethics. To begin to meet this need, the Institute developed pilot programs for Directors of Medical Education.

This group was chosen because of their importance in continuing education of practitioners. They are the persons in community hospitals responsible for the content and organization of all continuing education programs for the hospital and house-staff. If they could be educated about the possibilities of teaching ethics and human values they could make such teaching a regular part of the in-hospital teaching of practitioners. Thus, a large number of practitioners around the country could be reached with a relatively small expenditure of Endowment funds.

Two national conferences and a series of regional conferences were organized with these objectives in mind. Directors of Medical Education were invited from community and teaching hospitals and from the Veterans' Administration -- the largest hospital system in the country. The conferences were themselves designed primarily as workshops, with a minimum of didactic sessions and a maximum of small group discussions. Ample opportunity was provided for contact with the conference faculty. Emphasis was placed on why human values, ethics and humanities should be taught, how, by whom and under what circumstances. All the presentations were practically oriented, illustrating those teaching techniques that have proven most successful. The conference faculty was chosen from among the most experienced educators in the field of human values and from the most successful programs in the country.

The aim was not to make overnight experts or teachers of the Directors of Medical Education, but to acquaint them with how they might organize regular teaching sessions such as ethical grand rounds, journal clubs and seminars. The Directors were acquainted with the nature and availability of teaching material, bibliographies, films and speakers. Considerable emphasis was placed on engaging the interest and participation of the local liberal arts college faculty in planning and carrying out the teaching programs.
The program was initiated in the last two years. Hence, it was in its initial stages when the NEH grant expired. Its impact was just beginning to manifest itself particularly in the Veterans' Administration hospitals. Some of the participants reported as many as six teaching experiences conducted by them in the year following their attendance at the conference.

The program was in existence for too short a time to measure its effectiveness. It is clear that the subject is of interest and importance to those engaged in continuing education, that they are interested in how to introduce such teaching into their own hospitals and that further efforts in this direction are emphatically needed and feasible.
APPENDIX E

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