

MEDICAL HUMANITIES IN MEDICAL SCHOOLS

Willy F. Maramis *)

ABSTRACT

The reflections on education by John W. Alexander and UNESCO (*United Nations Educational, Scientific and Cultural Organization*), show that a “good doctor” and a medical specialist (including a psychiatrist), must not only be competent in empathic communication, clinical knowledge and clinical skills, but more so in humanities (especially in morals, ethics and bioethics) and soft skills. Humanities and soft skills education is therefore very important in medical schools. The main objectives in humanities education are mainly in the affective domain. Relevant and effective learning experiences must therefore be provided. For this, small group discussions is at present the most effective one, is not so difficult to do and also financially affordable. There is an added beneficial effect, this is that the facilitators will also experience an enrichment in moral development. A model of a humanities curriculum and of a moral dilemma discussion group is presented. There are no principal differences between morals, ethics or bioethics education for undergraduates and that for residents (including psychiatric residents), only the moral dilemma cases may be adjusted to the level of education and more specific to the specialty.

Key word : Objectives of education, 5-star doctor (WHO), medical humanities, moral education

ABSTRAK

Reflexi mengenai pendidikan oleh John Alexander dan juga oleh UNESCO, (*United Nations Educational, Scientific and Cultural Organization*) menunjukkan bahwa “dokter yang baik” dan juga seorang dokter spesialis (termasuk psikiater), harus kompeten bukan saja dalam komunikasi empatik, pengetahuan klinik dan keterampilan klinik, tetapi terlebih dalam humaniora (termasuk moral, etika dan bioetika) serta *soft skills*. Karena itu pendidikan humaniora dan soft skills sangat penting dalam pendidikan dokter dan dokter spesialis. Tujuan belajar humaniora sebagian besar terletak dalam ranah afektif. Untuk itu perlu diberi pengalaman belajar yang relevan. Sampai sekarang pengalaman belajar yang paling efektif untuk tujuan dalam ranah afektif (seperti untuk humaniora) adalah diskusi kelompok kecil. Di samping pemberian pengalaman belajar seperti ini tidak sukar dan tidak mahal, ada efek tambahan yang bagus, yaitu para fasilitator juga diperkaya dalam bidang perkembangan moral dan menjadi lebih mantap. Dikemukakan suatu model kurikulum humaniora dan model kelompok diskusi dilema moral. Tidak ada perbedaan prinsipil antara pendidikan moral, etika dan bioetika bagi mahasiswa kedokteran dan bagi calon spesialis (termasuk psikiatri), kecuali kasus-kasus dilema moral mungkin perlu disesuaikan dengan tingkat pendidikan dan lebih spesifik, sesuai dengan spesialisasinya
Kata kunci : Tujuan pendidikan, dokter bintang lima (WHO), humaniora kedokteran, pendidikan moral.

*) Prof. W.F. Maramis, dr, SpKJ(K); Dean, Faculty of Medicine, Widya Mandala Catholic University, Surabaya

INTRODUCTION

Let us reflect on some aspects of education before we go to the main topic of this article. What is the objective of education? John W. Alexander's thoughts on this may be a good beginning. Further, UNESCO's reflections on education are also thought provoking. Please read the following.

Objectives of Education (John W. Alexander, 1978):

1. To help a person learn think.
2. To help a person understand himself as an individual.
3. To help a person understand the society of which he or she is a part.
4. To help a person understand the environment in which she or he as an individual and society as groups live.
5. To help a person enjoy that understanding.
6. To help a person make wise decisions.
7. To help a person implement those wise decisions.
8. To help one earn a living.

UNESCO on Education, 1996 (UN Educational, Scientific and Cultural Organization)

- ⊙ **Learning to know:** to help learners to become competent in critical and systematic thinking as to understand the reality of self, others and the world.
- ⊙ **Learning to do:** to help learners in problem solving.
- ⊙ **Learning to be:** to help learners to become authentic human beings, holding on principles, and not easily becoming frustrated by self interest and environmental pressures.
- ⊙ **Learning to live together:** to help learners to become aware and understand that to develop unity not by denying differences, but by respecting each other's differences and uniqueness (loving, caring and forming each other).

Later added:

- ⊙ **Learning to learn:** incite learners to practice life long learning and be able to learn from each life experience.
- ⊙ **Learning to love:** to help learners to be able to love oneself, other human beings and the Creator.

Output of Medical Schools are human doctors, not robotic ones

What kind of graduates do we want from our medical school? Of course, we want: "A good doctor". But what is a "good doctor"? I think a "good doctor" is not only the one who has the competencies described in our SKDI (Standard Competencies of Indonesian Doctors): clinical knowledge, clinical skills and communication skills. If these only, than our graduates will be "robotic doctors" only, not "human doctors" (in our SKDI there are also other things than these).

In the beginning, the students and graduates may be studying and working with their "heart, brain and hand", with care, commitment and anthousiasm. But, if day by day

the only thing they are confronted with, and nothing else, are medical-technical matters, they will lose their “heart” and start studying and working with their “brain and hand” only, and the patient will be seen as a conglomerate of cells and organs which follow the laws of physiology, biochemistry, and pharmacology. And when this goes on, may be they will end up becoming a robot, working only with their “hand”, without “brain” and “heart”.

I hope this will not happen to our graduates. How to prevent it? Yes, by seriously educate and train them in medical humanities, in the cognitive domain, and especially in the affective domain.

We may also reflect on what is a “human doctor”? (Schillebeeckx, 1969). Please read the following:

- Able to find meaning and self.
- Be aware and able to develop existing potencies.
- Able to control existing drives.
- To form conscience.
- To develop appreciation and able to express feelings and thoughts honestly and rightly.

Beside this, there is the “5-star doctor” of WHO (World Health Organization).



Star-1: Care-provider

Besides giving individual treatment the “five-star doctors” must take into account the total (physical, mental and social) needs of the patient. They must ensure that a full range of treatment - curative, preventive or rehabilitative - will be dispensed in ways that are complementary, integrated and continuous. And they must ensure that the treatment is of the highest quality.

Star-2: Decision-maker

In a climate of transparency “five-star doctors” will have to take decisions that can be justified in terms of efficacy and cost. From all the possible ways of treating a given health condition, the one that seems most appropriate in the given situation must be chosen. As regards expenditure, the limited resources available for health must be shared out fairly to the benefit of every individual in the community.

Star-3: Communicator

Lifestyle aspects such as a balanced diet, safety measures at work, type of leisure pursuits, respect for the environment and so on all have a determining influence on health. The involvement of the individual in protecting and restoring his or her own health is therefore vital, since exposure to a health risk is largely determined by one’s behaviour. The doctors of tomorrow must be excellent communicators in order to persuade individuals, families and the communities in their charge to adopt healthy lifestyles and become partners in the health effort.

Star-4: Community leader

The needs and problems of the whole community - in a suburb or a district - must not be forgotten. By understanding the determinants of health inherent in the physical and social environment and by appreciating the breadth of each problem or health risk “five-star doctors” will not simply be treating individuals who seek help but will also take a positive interest in community health activities which will benefit large numbers of people.

Star-5: Manager

To carry out all these functions, it will be essential for “five-star doctors” to acquire managerial skills. This will enable them to initiate exchanges of information in order to make better decisions, and to work within a multidisciplinary team in close association with other partners for health and social development. Both old and new methods of dispensing care will have to be integrated with the totality of health and social services, whether destined for the individual or for the community.

Input - Output – Performance

When we consider the input-output model, then we have: Input (students, residents) → Process (learning, teaching, training, experiences) → Output (general practitioner, specialist) → (Outcome) → **Performance** at work place (this is the most important thing; but many factors are influencing it). Maybe, the physician graduated with honors, but at the work place he or she is not liked by patients and colleagues, difficult to collaborate with, not disciplined; when he or she is really very good medically-technically, then he or she is “hated, but needed”, etc. In such cases, competencies in humanities are lacking.

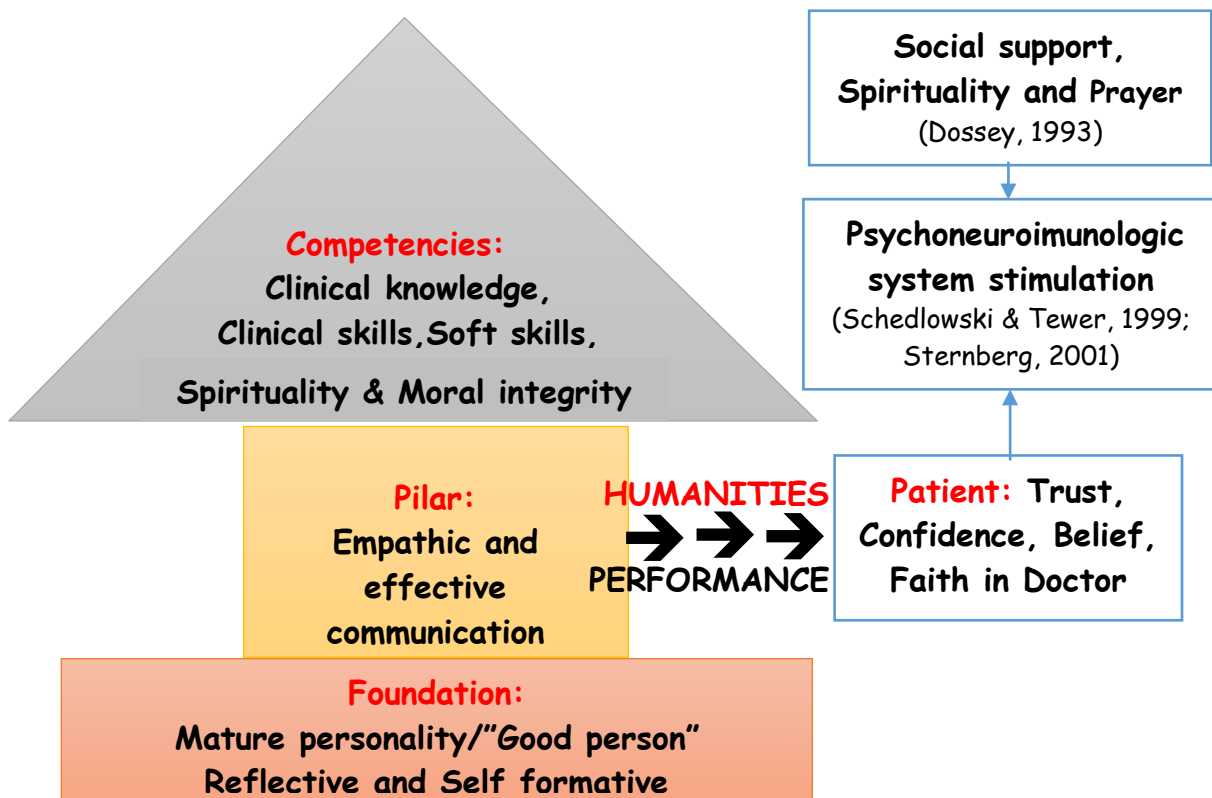
Surveys show that, for example when there are two graduates with the same grade point averages (GPA) or maybe both with cum laude, in practice the one with better competencies in soft skills or humanities will perform better or be more successful.

So, an excellent grade point average does not guarantee good performance. It must be supported by competencies in humanities. A good reason why humanities are so important to be seriously included in a medical faculty’s curriculum and the students provided with appropriate learning experiences.

Remember that the medical faculty is responsible for the quality of her output, but no more so for the quality of their performance, many factors outside the medical faculty are influencing it. Never the less, the medical faculty in that case must not feel good, because her name is still attached to her graduates when they don’t show a good performance. It means that she has failed in preparing her students and in giving them appropriate learning experiences in humanities, so that they are mentally strong to face and cope with the non-scientific and non-technical pressures in the outside world.

Please look at the foundation of competencies of a physician.

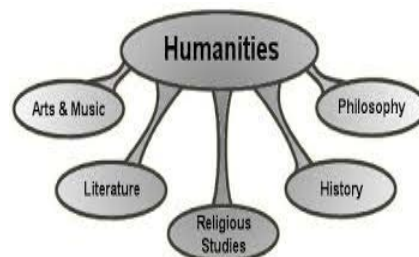
Foundation of Competencies of Physicians (modified from SKDI)



So, beside clinical knowledge, clinical skills, communication skills, as stated in SKDI, medical faculty students have to grow in their spirituality [each religion has its spirituality, but spirituality is not a religion; its the tendency to see all things on earth having a connection with a Creator (Collins, 2007)], moral integrity and soft skills, serving with love.

Medical Humanities

What are humanities and what are medical humanities? **Humanities** (also known as **Liberal Arts**), beside science and technology, is a conglomerate of aspects of sciences and arts which play a role in the development of a holistic human being as a bio-psycho-sociocultural-spiritual being (See figure below).



Questions Addressed by the Humanities

A field of study in humanities often includes questions that many have contemplated and attempted to answer. Here are some questions which the humanities might address:

- ◆ How do human beings behave?
- ◆ Why do they behave this way?
- ◆ How do human beings interact with each other?
- ◆ How do human beings interpret the world around them?
- ◆ What kind of political, social and cultural institutions do they form?
(Wikipedia, the free encyclopedia):

The humanities exist to ask and answer the question:

> *What are we living for? or*

> *What is the meaning of human life?*

If the answer is going to be to make money, or, to have more technological gadgets, then education and the nation have no real future. Only the humanities can address these questions in a nontrivial way. If we want to have a future, our universities are going to have to make the humanities central to the education of our students.

(Morris Berman)

Medical Humanities are aspects of science and arts in humanities applicable to medicine (like Behavioral Sciences in Medicine, which is a conglomerate of aspects of psychology, psychiatry, anthropology, sociology, etc. applicable to medicine), which help in the development of the holistic human being. Ethics, morals and bioethics are branches of philosophy, which is one of the sciences in humanities.

Studying Humanities:

Why do we study humanities?

- ◎ **Studying humanities** means covering all aspects of education which reflects the holistic human being and helps people to become more human.
- ◎ **Studying humanities** stresses more on the development of the whole personality of the learner rather than training of certain skills only which are ready for use in the medical profession

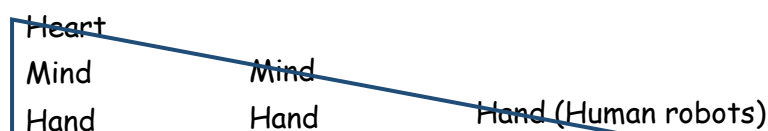
(Encyclopedia Britanica, 1978, Vol. 8)

Three important things contributed by Humanities

- ◎ Development of heart and mind going together (development of character)
- ◎ Opportunity to be acquainted with universal and unchanging values/principles
- ◎ Close collaboration and relationship between educator and student, and between theory and practice

We don't want our youth to slide down like this:

- ⊗ From Wise → Wealth
- ⊗ Decline of values, priorities and focus (Generation Y, Gen Z ?)



Remember this:

"We may adjust to a changing world, and still hold to unchanging principles"

(Jimmy Earl Carter)

PROPOSAL

MEDICAL HUMANITIES SYLABUS IN MEDICAL SCHOOLS

After this introduction, may I present the following proposal on medical humanities syllabus for Indonesian medical schools, plus some subjects which I deem very important for doctors in their future practice.

1. **Arts, music, sports:** included in UKM (Students Activity Unit); *extracurricular*.
2. **Literature:** included in UKM; *extracurricular*.
3. **Religious studies:** a physician must also know the rituals of the various accepted religions in Indonesia and the meaning of them, during times of important events in life, e.g. delivery and birth, serious illness, death, wedding, etc.; *Intracurricular*. Not teachings of a religion to become a member of that particular religion (this is better done *extracurricular*).
4. **History:** history of medicine; *intracurricular*.
5. **Philosophy:** morals , ethics, philosophy of man, philosophy of medicine, philosophy of suffering, philosophy of science; *intracurricular*.
6. **Medical law**, not in humanities, but has a close link with medical ethics and forensic medicine; *intracurricular*.
7. **behavioral sciences in medicine**, not in humanities, closely related to ethical behavior (we have a Code of Ethics and a Code of Conduct for the faculty and university); *intracurricular*.
8. **Moral Dilemma Discussions:** *co-curricular*
9. **Home visits:** *intracurricular*.
10. **Students activities:** BPM (Student Representative Body), BEM (Student Executive Body), LPM (Student Press), UKM (Students Activity Unit) e.g.: arts, music, sports, reading/study/discussion groups , community services, various competitions; committees for other activities, all for the development of soft skills and humanities; *extracurricular*.

Intracurricular activities will have grades and are calculated in the semester grade point (IPS, Index Prestasi Semester) and grade point average (IPK, Index Prestasi Kumulatif). Co-curricular and extra-curricular activities will get points of student activities, and there must be a minimum of points to be eligible for graduation.

When and how the learning experiences for these subjects will be and how many credit points per semester (SKS) or ponits of student activity and how is the evaluation, depends on the policy of the faculty involved. And this will be influenced by the vision-mission-objectives and the local situation and condition. This can be adjusted in the future if deemed necessary.

What is better: to begin with teaching of humanities until there are complete human resoures and fasilities, or begin with the best there is and developing while running it (perfectionistic >< dynamic)? It depends on the attitude of the faculty towards the importance and urgency of teaching of humanities at her medical faculty and her courage to change, to get out of the "comfort zone".

Moral Education

The objectives of moral education are mainly in the affective domain. Large group teaching on morals is done only when the objectives are mainly in the cognitive

domain, for specific topics only, e.g. basic terms, meanings, branches, ethical problem solving methods, etc. and other specific topics of choice, e.g. confidentiality, abortion, IVF, euthanasia, cloning, stem cell, regenerative medicine, personalized medicine, and other topics in biotechnology.

Especially for objectives in the affective domain (attitude) as in moral education, the learning experience of choice which is most effective is small group discussion.

Good, if there is a fasilitator. The fasilitator does not have to be an expert in morals or one with a certificate in ethics, bioethics or humanities. Every good willing teacher will be capable (like a fasilitator for PBL, you don't have to be an expert), as long as he or she is serious with education, and has commitment in helping students experience a development in morals, beside that the fasilitator him or herself also will experience an enrichment and development. As for each teacher encountering a group of students, he or she might do good to observe the group dynamics in the group, and especially for a fasilitator in a moral dilemma discussion group, it will be very helpfull to study **Lawrence Kohlberg's** theory of moral development (Duska dan Whelan,1982; Maramis, 2009), how to prepare and fasilitate a moral dilemma discussion (Maramis, 2015), and observe the group dynamics (Maramis, 2006) .

Sometimes I heard: "I'm not perfect yet to fasilitate a moral dilemma discussion, I'm not faultless". Hopefully nobody of us will say that. We are all imperfect human beings. If we must wait untill we have a perfect one, then we will never begin. Most important is that we want to share with others and help the students to progress to higher stages in their moral development and become better human beings morally.

In a moral dilemma discussion group usually the members have various moral development stages. In general, those with a certain stage are more atracted to the reasoning of one with one stage higher, not to the one with a lower stage. He or she can not understand the reasoning of the one with more than one stage higher. The fasilitator encourage the reasoning of one stage higher than the lowest stage in the group. **The fasilitator does not say whether it is right or wrong.**

THE MAIN OBJECTIVE of moral dilemma discussions is NOT to reach a concensus of the group on the solution of the dilemma, or that it must be in line with the view of the fasilitator or the faculty, but to train the students in MORAL REASONING so they can develop to higher stages of moral development and have a greater personal moral responsibility.

If the opinion of a member is not in line with the view of the fasilitator or the faculty, let it be so for the moment. There will be other learning experiences beside the moral dilemma discussions where it can be explained.

To reach higher stages of moral development, cooperative activities are needed through dialogue and discussions, not through an authoritarian approach. The students will take a more subjective responsibility for their decisions. A certain cognitive maturity is also needed.

The members of the discussion group must present their own thouhgts, of their own brains, not refering to other sources, e.g. to laws, holy scriptures, famous persons or scientific resources. When they do so, then ask why they think so, why they agree or disagree with it. Then they will acquire a greater personal moral responsibility in their

decision. They will not throw part of the responsibility to the source referred to outside them.

Kohlberg proposed a practical moral dilemma discussion group as follows:

Guide to Moral Dilemma Discussion:

1. A small group, 8 -12 members (PBL groups can be used); usually the members are in different stages of moral development.
2. Decide the moral dilemma to be discussed. The moral dilemma may be imaginary, publicly known, or experience of the fasilitator or one of the members.
3. ***The fasilitator must not tell wether a decision is “right” or “wrong”, let the discussion flow and the ones with the higher stages will stimulate the lower ones to develop upward.***
4. ***The fasilitator supports the moral reasoning of one stage above the lowest stage in the group.***
5. **The moral dilemma must be a real moral dilemma, involving justice, human welfare, property rights, law, conscience, right or wrong, and authority, not manners, disipline, orderlyness, cleanness or facts.**

CONCLUSION

If we are really serious in saying (not only lipservice) that morals and humanities education is very important in medical schools, then let us also seriously develop it. There will be always difficulties, but they can be solved with wisdom.

We are all working together
towards one goal; and this is that
our medical graduates become:
Professional doctors
with Spirituality and
Moral integrity
and prima Soft skills,
serving with Love.

Let us as teachers have
more Love,
because
Love
↓
Care
↓
Commitment
↓
Anthusiasm
↓
Joy & Happiness

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