Due to the broad, complex and ambiguous definitions of humanism in the medical field, research to find faculty perspectives in humanism was limited to only a few opinions and surveys. The majority of research found can be categorized into four major areas:

1. Existence of a dichotomy between technological/clinical competence and humanistic care;

2. Measurement of caring or humanism in students and practitioners in various settings;

3. A call for improving teaching of humanistic care using didactic and experiential models; and

4. Areas that should be focused on for humanism education.

Technological advancements have pushed clinical science farther than it has been, however the need for human compassion in medicine has not changed. Patients still expect and crave an emotional and psychological connection with their healthcare providers. Realizing the need to form a bridge between science and the human touch, healthcare institutions are now implementing studies and exercises to help students develop that humanistic quality that is often lacking in the core curriculum. Research has also shown that physicians that were perceived to be more humanistic had a higher patient satisfaction and health care outcome (Weissmann, Branch, Gracey, Haidet, & Frankel, 2006). However, unlike medical science, humanistic qualities can not simply be learned from a book, instead it is a lifelong skill that is only learned through experience and sharpened through dedication and care (Boudreau, Cassell, & Fuks, 2007).

While medical knowledge is easy to instill into the curriculum, it is often difficult to teach students the complexities of humanistic care. For many students, the rigors of the curriculum and the realities of the healthcare settings often leave them disillusioned and can cause a breakdown in ethics, morals, attitudes, and beliefs (Maheux, Delorme, Béland, & Beaudry, 1990). Experience teaches these health care professionals to develop an emotional barrier to prevent themselves from the pain and disappointment that can result from patient care. Sometimes it is not the fear of emotional attachment that has providers shying away from patient attachment, but the inability to
psychologically and emotionally deal with the ramifications and frustrations of disease, illness, and death (Dennis, 2000; Rizzolo, 2002). However, the health care system can also be blamed for the decrease of humanistic care due to its reimbursement system, managed care structure, and new technologies (Weis & Schank, 2002). For example, doctors under certain health care structures, such as HMOs, are often paid more for ordering less tests and performing less technical procedures, whereas the opposite can be said for other systems (Ribeiro, Krupat, & Amaral, 2007). This can often cause a lack in meaningful verbal or emotional communication and an increased suspicion and strain in the patient-doctor relationship, which can lead to a decrease in patient care and therapeutic outcome, and an increase in medical errors (Bayona & Goodrich, 2008).

Various measurements on the current trends of humanistic care in students and health care professionals show that there is a need for drastic changes in the health care curriculum. However, we could not identify or evaluate validated measures of humanism that had used a theoretical framework (constructs of humanism operationalized as measurable variables). Hence we report the results of studies published in the literature. One study showed that when nurses evaluated medical residents, they viewed the residents to be medically competent but inadequate in their humanistic behavior (Butterfield & Pearsol, 1990). Studies with Brazilian medical students also showed that a lack of patient care and communication has hurt doctor-patient relationship and there is a need for a more positive patient-centeredness (Ribeiro, Krupat, & Amaral, 2007). Even surveys of deans, curriculum leaders, and preceptors showed that although humanism is strongly emphasized in the teaching environment and needed, it is often less stressed than medical knowledge (Lown et al., 2007). Reasons for the lack of humanistic emphasis in the curriculum include time, faculty knowledge, and cost (Merkel, Margolis, & Smith, 1990). Evaluations of medical and nursing students throughout their education has shown that even though their definition of humanism has grown more complex through the year, the realization for the need of empathy has not (Bjorkstorm, Johansson, & Athlin, 2006; Mangione et al., 2002).

The recognition of these concerns in the health care systems prompted the establishment of various programs in schools and institutions to address the need to improve humanistic care and empathy in the next generation of health care professionals. These programs not only addressed the need for better patient care, but also the needs of the health care professionals in dealing with emotional and psychological issues (Dennis, 2000). Programs such as the Personal, Professional and Leadership (PPL) are implemented in medical schools to provide a social and emotional support group where both the students and faculty can come together in an open, safe, supportive network (Dennis, 2000). Other programs such as the Consortium of Academic Health Centers for Integrative Medicine (CAHCIM), Advance Pharmacy
Practice Experience (APPE), Geriatric Health Maintenance Program, Humanistic Teaching Model, and Integrative Care Conference (IC) focus on the multifaceted infrastructure of health care by integrating patient care, new guidelines and procedures and new innovations (Bayona & Goodrich, 2008; Kleiman, 2007; Kligler et al., 2004; Rose & Osterud, 1980; Sauer, 2006). Many times, these programs and others like it have the faculty and teachers role-model humanistic values, behaviors and actions to the students (Coulehan, 2005; Weissmann et al, 2006). Student then in turn emulate the instructors and share their experience and receive feedback from their fellow peers and instructors (Mangione et al., 2002). Other teaching methods use cinemeducation by using movies to catch residents’ attention and educate them emotionally on certain psychosocial issues (Alexander, Hall, & Pettice, 1994). Humanism is not only limited to the clinical setting, which is why many students are now encouraged to engage in service learning, such as working in free clinics, third-world countries, health education, public speaking, and other community service events (Rose & Osterud, 1980). These programs not only allow the students to gain a better understanding of their own self-awareness, emotions, and behaviors, but also make the student more culturally, spiritually, economically, socially, and psychologically sensitive.

The art of humanistic care and professionalism is often conflicted with medical competency. However, human compassion can not be memorized or taught from a book. It is only through interactions with patients, their family and other health care providers, that students can develop and hone their professionalism and humanism. Future improvements should lead to a more definitive description of humanism in a way that it can be operationalized and measured, so that it can be used to improve teaching and application. This will not only result in better patient satisfaction and therapeutic outcomes, but also make for more fulfilled health care professionals.


