How does a new course get into the curriculum?

People outside medical education might be surprised to learn how difficult it is to get a new topic accepted into the medical curriculum. They would be unaware of the passions aroused and the intense lobbying that goes on behind the scenes, often for many years, before a new discipline is finally accepted.

One of the reasons for this is that there is so much to be learned, with the result that the curriculum is very dense. Every minute of student time is taken up with the study of essential material. Another reason is that in professional courses like medicine, unlike the more general courses in arts and sciences, there is very little student choice. Government funds faculty to produce properly-qualified medical practitioners who will serve the country well. So arguing for a new discipline to be introduced into the curriculum means going right back to the beginning – which involves defining the attributes, knowledge and skills of the ideal doctor for the modern world.

And there is another problem. When a new discipline is introduced as a compulsory component of the curriculum, with marks attached, other, formerly highly regarded, hard-fought-for components must be either downsized or omitted altogether.

So once the battle is over, and the smoke cleared, it is interesting to look back and try to decipher exactly what made it all possible. What were the various threads, events, or changes in the zeitgeist, that all came together at a particular point in time to provide sufficient impetus for change? How did medical humanities become a compulsory part of the medical curriculum, with marks attached to it?

As any historian would quickly perceive, the reasons were wide-ranging. The academic reasons are the best documented, being mainly published in the international literature on medical education. So far as the University of Auckland was concerned, the case was argued in part on an idea described by W. W. Benjamin in an article in the New England Journal of Medicine. He maintained that for thousands of years the doctor’s basic kit had contained three tools – “the herb, the knife and the word”. Today, whereas treatments involving both “the herb” and “the knife” had progressed enormously, treatments involving “the word” had fallen badly behind. In the decades gone by, medical educators had concentrated on producing a safe doctor, and
more recently, of necessity, on producing a scientifically sophisticated doctor. Now, in the face of huge technological advance, much of which patients experience as both painful and frightening, was it not time to go further again and re-introduce the concept of the humane practitioner?

International trends are always influential, particularly when the world’s leading medical schools are the ones introducing the new disciplines. In this case however, the situation was slightly complicated. The Americans had had medical humanities for a decade or more, but this was as much an umbrella for communication skills training and medical ethics as it was for the humanities as a whole and Auckland University already had strong courses in both these disciplines, incorporated into their medical psychology programmes. In most other high profile medical schools, medical humanities was conspicuous by its absence.

It should be noted however, that although New Zealand was perhaps among the first to introduce a broad-based humanities programme, there was something in the zeitgeist. Across the globe, medical educators were thinking about the same problem, namely producing a doctor who could understand the need to work with sick and disabled people in a way that took an even fuller account of the patient’s perspective than had been common in the 1980s and 90s.

In addition to the academic arguments and the new international focus, were the sorts of local factors one might expect in any setting. If the new initiative is to be successful, it is likely there will be one particular person who is keen to see it implemented and prepared to put a lot of time and energy into seeing that it is. It is also likely that many aspects of the course will have been trialled earlier. In our case, we had been running successful small options papers in basic humanities since 1996. Things are also likely to be more successful if the head of the institution is at least sympathetic, and in our case, we were fortunate in that the Dean’s late father had been a determined supporter. There needs to be a growing, and ultimately majority opinion among faculty that the timing and content of the new course is appropriate, that its implementation will enhance not only medical training but also the reputation of the school and also, a preferably not too acrimonious arrangement about which disciplines or topics are going to be required to retract in order to provide the time and marks for the new one. Finally, if there is some support among “stakeholders” – the general public, the health care providers and the politicians that such an addition to the curriculum is likely to benefit all patients, as well as be value for money, then it is more likely to gain acceptance within the faculty. At the University of Auckland’s
medical school all these things came together just at the right time to enable a compulsory, assessed course to be implemented in 2000.

**Foundational Principles of the Medical Humanities Programme**

The medical humanities programme was instituted after seven years of discussions (see Report to the Faculty, September 1998) and a further two years of work by members of an Inter Faculty Committee (Medicine, Arts and Law). When agreement on the nature of the course was finally reached it was based on twin promises.

The Arts Faculty’s bottom line, which the (then) Medical Faculty accepted unconditionally, was that only a person trained in the discipline (that is in Arts or in Law, and accredited by the relevant Faculty) would be permitted to teach in the programme. There were to be no hobbyist teachers, no matter how well qualified in other areas. In general, the relevant HoD of the discipline would suggest, or at least confirm, the suitability of any teacher representing the discipline is this programme.

The Medical Faculty’s bottom line, which the representatives of the all the other faculties also accepted unconditionally, was that the subject matter of the teaching would be selected to consist of material that would be of particular interest to medical students – material which could, in some way, improve the sensitivity, competence or professionalism of the graduate doctor. To this end, for example, the medicine in literature programme would offer texts specifically selected for their ability to provide useful background, often of patients’ perspectives, or doctor’s dilemmas which any doctor might expect to meet during his or her career.

A key pedagogical feature of all courses in the medical humanities was to be the critical analysis of ideas. Students were to be taught in small groups, and there was to be plenty of opportunity for the presentation, exchange and defence of ideas. A decision was taken early in the negotiations not to include any ‘creative’ courses (e.g. writing poetry, composing music or performing dance). All courses were to be based on an established literature in scholarly disciplines.

From the beginning (2000), the medical humanities was allocated marks for a full, one-semester course. The method of assessment comprised seminars (on-course, or formative assessment) and a final essay. Essays were to be written using the conventions of the discipline in an accurate manner—e.g. referencing, structure, style etc. Most teachers found they had to give at least one seminar on how to write a well-argued essay.
Essays were to be not only accurate in their use of knowledge gained by studying the relevant discipline, but they were to be well-researched, and most important, argue a point of view. That is, several documented points of view would be described and the student would finish with a personal viewpoint supported by reasons.

Over the last decade these principles appear to have served the courses well. We were fortunate in being able to attract teachers of a high calibre – recently retired professors and others of similar standing who understood, and agreed with, the nature of the task and performed it well. On the whole students responded quickly and enthusiastically to this different style of teaching. Faculty were impressed with the high standard of work and decided to award an annual prize for the best essay. In addition we have been delighted that two students have had their essays published in literary journals.

**Further reading**

In the two papers listed below, there is further information on “Squeezing curriculum time”, “Reasons to include humanities in the core curriculum”, “The route to establishing a new course”, “Assessment and evaluation” and “Course details” for the foundation programme, as well as an example of an excellent student essay, published in full in the second paper, along with the lecturer’s appraisal of it.

Grant, V. J. 2002 Courses, content and a student essay in medical humanities. *Journal of Medical Ethics: Medical Humanities*, 28 49-52.

In 2007, another student essay was published, this time in *Poetry NZ* vol. 34, 97-105.
Vivian Fu, “The poet and doctor as one: the theme of responsibility in the work of William Carlos Williams and Glenn Colquhoun.

Dr Valerie Grant
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