TEACHING ETHICS AND THE HUMANITIES IN HEALTHCARE IN FRENCH MEDICAL SCHOOLS: OVERVIEW AND OUTLOOK

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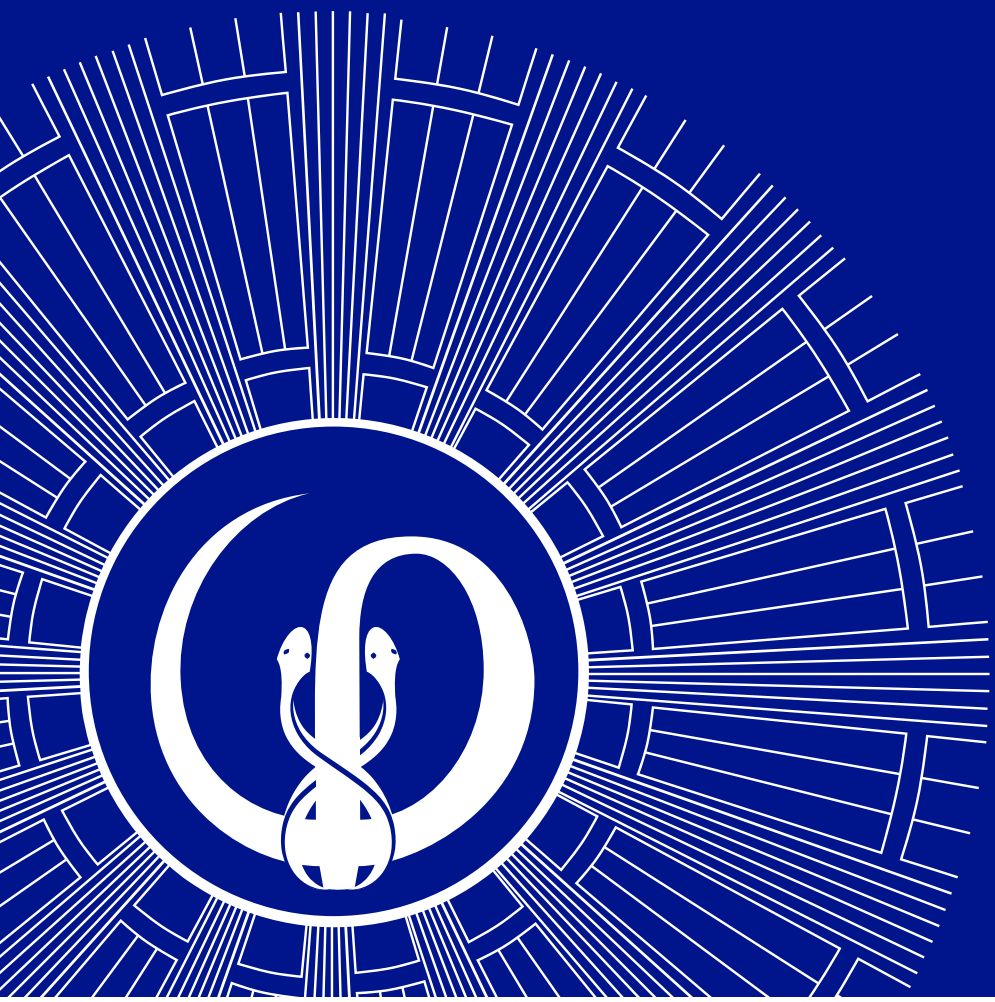

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PURPOSE

This white paper is intended to be an overview rather than an analysis. Its purpose is to leverage the mass of scientific articles published in English and in French—and to a lesser extent, in German—on teaching ethics and the humanities in healthcare since the 90s. By reviewing this literature as systematically as possible and performing a series of related meta-analyses we wanted to identify and map, if not quantify and measure, issues currently existing in France and abroad in the teaching of ethics and the humanities in healthcare, primarily in medical schools.

This doesn't mean that we only focused on medical schools; on the contrary, we wanted to highlight all the initiatives that are gravitating in their periphery, that currently play an increasing role in the teaching of ethics and the humanities in healthcare. This education evolves at various levels within a territorial grid that largely exceeds the restrictive institutional framework of universities. Therefore, we have chosen to examine, as much as possible, experimental projects and local innovations while paying special attention to specific structures and dynamics of teaching ethics and humanities in healthcare, as well as to the territorial differences and inequalities that could emerge.

The goal is not to create a survey report, which would obviously be imperfect, but to circumvent and explore a problematic environment with various dimensions while remaining open to its changeable boundaries instead of defining them in advance. This is one of the reasons why we will talk about "humanities and healthcare" or "humanities in healthcare" rather than "medical humanities". The role of the humanities in healthcare should not be defined only by their relationship with the medical profession, and even less by how much space they receive in medical schools. Therefore, our starting point will be this "inclusiveness postulate" since we do not really know how far the area of humanities in healthcare can extend; we know, at least, that they cannot be solely "medical." From that point, this paper is also intended to reflect on the articulation of human and social sciences in medicine, of clinical ethics and the humanities in healthcare, which should be neither confused nor treated as a homogeneous block. There is something vaguely 'literary' about all these fields, which is why they are all too often seen as equivalent, but that is not enough. This is why we will also examine the common ground and specific interaction that these fields must implement.

METHOD

In addition to an initial sweep using Google and, in particular, GoogleScholar, we browsed several databases, focusing, in each case, on articles published after 2010, including PubMed and Cairn, where we collected several articles with the following keywords in English and in French: *"medical education" and "medical humanities" or "health humanities"; "sciences humaines"* or "SHS" and "médecine"; 'humanités médicales", "humanités" and "santé"; "enseignement" and "éthique médicale" or "humanités médicales". Using the bibliographies linked to the articles reviewed, we were able to identify and add any missing data. We also

studied information posted on several institutional websites, including those of the Ministry of Solidarity and Health, the Ministry of Higher Education, Research and Innovation, as well as Legifrance (www.legifrance.gouv.fr) and La Documentation française (www.ladocumentationfrancaise.fr) for official texts and reports. Last, we collected information directly from the institutional websites of French and foreign universities.

This preliminary review of literature was supplemented with a partial quantitative survey on the teaching of ethics and humanities in French medical schools, completed based on the regulatory documents made available online by the schools (testing methods and syllabus). The methodology used for this survey is detailed in the beginning of the third part.

INTRODUCTION

MEDICINE AND HUMANITIES: DISSOCIATION AND REASSOCIATION

Historically, "the Humanities" have crossed paths and even mingled in many aspects of their metamorphosis with the history of medicine. Even though its strive for universality and its scope that is irrevocably open to all renditions of human "exceptions" have undoubtedly "blurred" the term, "the humanities" still carry a heritage that is very close to the idea of education as a whole. The fact is, throughout the 19th century in France, the act of learning and studying was still deeply associated with the expression "faire ses humanités", which meant "educating your mind by learning languages and literature". This is particularly true for medical students: since the earliest Hippocratic teachings, the foundation of their curriculum consisted of knowledge that, in hindsight, would be considered today as remarkably "nonscientific." It should be noted that in the 13th century, no one was admitted to medical school without holding a Master of Arts ("Maître ès Arts"), meaning without first internalizing the essential propaedeutics of the *trivium* and *quadrivium*. Likewise, in the 15th century, the Renaissance was a time of "rebirth", not only for *belles-lettres* but also for medicine: Man is "reborn" and should be seen as both mind and body.

Therefore, from a perspective of the European history of knowledge, it may seem natural to link together the respective destinies of the humanities and medicine. However, in the era of scientific positivism (*evidence-based medicine*) and cutting-edge technologies, and against a background of struggling healthcare systems, the link between the humanities and medicine appears more stretched than ever. It is as if the "humanist" heritage of medical science has been forgotten, so much so that the reintroduction of "human and social sciences" into medicine is now seen as a revolution. Since the 1950s, a new page of the history of the humanities in medicine has been written in small batches: the medical humanities, arrived later in France under the name "*humanités médicales*". This floating term refers to a movement of progressive "reassociation" through various paths, of philosophy, social sciences, literature, and the arts on the one hand and medicine on the other, after the split between "science" and "letters", or "hard science" and "soft science", was exacerbated in the 9th and 10th centuries. In the early 1960s, some theorists even talked of "two opposing cultures": the English-speaking world had been particularly disturbed by the issue of a seemingly insurmountable dichotomy that appeared insurmountable and damaging dichotomy between "sciences" on one side and the humanities on the other[4]. In fact, we should question this hiatus between the centuries-old heritage of European Humanities in the teaching of medicine and the very recent birth of "the medical humanities". This sudden need to "humanize" physicians' education is the problem. However, our purpose is not to write the history of an ambiguous "divorce" between the humanities and medicine; we want to question the aims and modalities of their alliance once again. For even though the history of the university undoubtedly shows that medicine can be nourished by the humanities, it doesn't necessarily solve the problem of their contemporary "reassociation". What should the humanities' role be in today's medical school curriculum? And what humanities are we talking about? This is not about teaching grammar and rhetoric to young physicians all over again. How can we devise this new link between the humanities and medicine in

4 SNOW, C. P., *The Two Cultures and the scientific revolution*, Cambridge: Cambridge University Press, 1962 [1959].

the emerging and problematic category of "medical humanities"? Should the humanities be added to the medical curriculum, applied to medicine, and integrated into the logic of healthcare and clinical practice? Even questions as these have a history. In France, the return of human and social sciences to medical schools began in the early 1990s; since then, numerous initiatives and innovative mechanisms have emerged to support this "second Renaissance" of the humanities in medicine. This is exactly what the Chair of Philosophy at the Hospital intends to highlight.

"General culture", "human and social sciences", "health, society, humanity" and, more recently, "medical humanities": different names, different teaching methods. The term "medical humanities" has only recently been used to describe human and social sciences teachings in medicine. As an example, the "Medical Humanities" program at Université Sorbonne Paris Cité was created in 2015. The Teachers' College of human and social sciences in medicine and healthcare (Collège des enseignants de SHS en médecine et santé, COSHSEM), founded 2008 was only renamed College of Medical Humanities (Collège des humanités médicales, COLHUM) in 2016. The "Humanities and Healthcare" Chair, part of the CNAM, was created in 2018. As for what is taught in medical schools, although there are certain common disciplinary characteristics in the teaching of human and social sciences, the content is so varied that it remains difficult to describe unequivocally. Consequently, before addressing the potential pitfalls and breakthroughs of a curriculum characterized by a fluctuating structure and uncertain future, we must "map" its main features and specificities, including by recontextualizing them from an international perspective. It is only by attempting to restore the parameters and paradoxes of teaching human sciences in medicine that we can succeed in addressing the issue at hand: why and how should we introduce "the medical humanities" into the French medical school curriculum?

MEDICAL HUMANITIES OR HUMANISTIC MEDICINE? DEFINITIONAL, TERMINOLOGICAL AND DISCIPLINARY CHALLENGES

Despite repeated and, in some cases, highly controversial pleas, it is not easy to precisely define these "medical humanities" that everyone is praising. Even though they are often the focus of attention today, they take on very different meanings and the issue of their scope, meaning and unity remains largely open. Therefore, the challenge of defining the medical humanities is literally crucial: it will determine the capacity for "medical humanities" to become a truly coherent field for research and teaching. We can identify four types of approaches and activities which all claim to represent a certain idea of "medical humanities" while not necessarily converging[5]:

1. Research and education on human and social sciences centered on medicine, both as a science and as a practice: for instance, philosophy, sociology and the history of medicine, the study and critique of the depictions of medicine and healthcare in literature ("medicine studies"), or the epistemology of biomedical sciences.
2. Introducing courses—formal or not—related to human and social sciences, literature, graphic arts, theater, cinema and music into the healthcare curriculum, and more specifically, that of medical students.
3. Complementing healthcare and care practices with resources such as the humanities and especially art, e.g. "art therapy" in psychiatry, or the simple use of artwork or artistic activities with therapeutic potential, particularly in hospital environments.
4. Creating alliances of humanities and art with medicine through projects promoting research or facilitating outreach through exhibits, shows, conferences open to everyone, or other activities aimed at leveraging the strengths of human sciences to address complex medical or scientific topics for the purposes of information, education and prevention.

The definitional challenge becomes a *terminological* and *disciplinary* challenge. In France, some prefer using the English term "***health humanities***" because it has a wider scope than "humanités médicales" (medical humanities). The term is difficult to translate into French, although there are iterations here and there such as "humanités en santé" (humanities in healthcare) or "humanités et santé" (humanities and healthcare)[6]. Using the term "humanities in healthcare" avoids restricting the field of study to the medical profession alone, and extends it to all healthcare professionals; additionally, it highlights an intentionally interdisciplinary approach; last, it gives a new connotation to the topic, with a scope is no longer limited to the clinic and pathology but extended to the global dimensions of human life and health. As we are particularly sensitive to the inclusivity effort, we will use the term "humanities in healthcare."

From here, the disciplinary challenge is easily identifiable: who should teach the humanities in healthcare, and where should they be taught? Should we create new departments or new schools, specifically dedicated to such interdisciplinary teachings? Should the humanities in healthcare be part of the departments of philosophy, history, or literature in order to preserve their argumentative potential against the biomedical sciences? In contrast, should we train teachers specializing in the humanities "applied" to medicine, who would be directly affiliated with medical schools or university hospitals, immersing them into the environment and clinical practice where they would be expected to teach? These simple questions of teaching and research location and "territories" suffice to stress the fact that the practical modalities of teaching "the humanities in healthcare" are far from obvious. In some cases, it is difficult to distinguish them from other closely related fields of study, such as medical ethics, bioethics, medical rights and public health; although these fields do not exactly share boundaries with the humanities in healthcare, they are the closest link with medicine as an applied science, since ethics, for instance, is considered the main entry channel of cognitive processes in the medical decision. Consequently, the humanities in healthcare do not enter *ex nihilo* into the medical curriculum; being polymorphous, they are fragmented into various preexisting "subjects" instead. For example, in France, the history of medicine is traditionally linked to legal medicine, which is still a fact today in some universities: many legal medicine professors also teach human and social sciences in medicine[7]. Likewise, economics, health law and public health courses were taught prior to the introduction of human sciences in medical schools in the early 1990s. This explains why teachings related to "the humanities" in the first common year of health studies (PACES) are still strongly infused with these disciplines, the teaching of which, by the way, remains absolutely essential.

The history of the humanities in health intersects with that of medical ethics[8] on the one hand, which was developed in the 1960s following the founding enactment of the Nuremberg Code in 1946 and, on the

5 We refer to BLEAKLEY, A., *Medical Humanities and Medical Education: How the Medical Humanities Can Shape Better Doctors*, London: Routledge, 2015, p. 45.

6 JONES, Th., et al., "The Almost Right Word: The Move from *Medical* to *Health* Humanities", *Academic Medicine*, 92(7), 2017, pp.

7 GALANOPOULOS, Ph., *L'Enseignement de l'histoire de la médecine à Paris au XIX^e siècle, 1794-1914: la défaite de l'érudition*, Thèse de l'École Nationale des Chartes, under the direction of E. Parinet, Paris, ENC: 2009. Available online: http://theses.enc.sorbonne.fr/2009/galanopoulos, last access June 6, 2019.

8 By "medical ethics" we mean clinical and applied ethics. By "biomedical ethics" we mean the common field of medical ethics and bioethics.

other hand, that of bioethics, a science more focused on the ethical issues of scientific research that prevailed in France in the seventies and were addressed for the first time by the legislators in 1994[9]. Whether in the English-speaking world or in France, the destiny of the humanities in healthcare has been inextricably linked to that of "biomedical ethics" in a broad sense. This flexible definition is totally suitable for research. However, it may not be satisfactory from a teaching perspective which should be guided by specific and consistent purpose, content, and methods. One of the major flaws in teaching human sciences in medicine that students point out today is precisely the "catch-all" aspect of a topic that they sometimes describe as an outrageous accumulation of knowledge that is "motley" and "useless" in their future practice[10]. Whereas human and social sciences could be considered, particularly during the first cycle of medical studies, an essential phase in terms of learning the foundations of philosophy, sociology, anthropology and psychology, in preparation of the study of medical ethics integrated into clinical practice in the second cycle. The first cycle covers the first three years of medical studies, not only the first year.

This raises the question of how we can teach the humanities in health to future physicians while avoiding the massive—and very seldom circumvented—pitfall of their pure and simple rejection[11]. The purpose is not only transmitting *content* and establishing a "common culture" among physicians in terms of the humanities, but also *training* future healthcare professionals and cultivate their talent not only in the humanities but also in "humanity" itself, in line with a project of transformative humanism targeting not only the ingestion of knowledge and principles, but also promoting behaviors and the meaning of life[12] Therefore, the scope of the humanities in heath is twofold: first, they should exist as a field of teaching and research able to nourish medicine; second, they should aim at strengthening physicians' "humanism" by acting as a defensive wall against the numerous dehumanizing rationales that currently plague our healthcare systems[13]. The humanities in healthcare also pertain to medical *professionalism*.

However, the apparently unreasonable ambition to create teaching designed to make young doctors "more human", assuming we could agree on the meaning of this expression, is not devoid of ambiguities. To believe that simply teaching of the humanities would make a person "more human" is rather idealistic. So, what can we expect from the humanities in healthcare? First, let us not confound *humanism* with *humanitarianism*: the former is a strong demand for criticism, education and culture, while the latter is defined as a sort of moral disposition to benevolence and compassion towards the entire humankind. We must know exactly what we mean when we talk about "humanizing" medicine. Is this about assuming the responsibility of a "humanistic" duty at the core of medical care, aiming to relentlessly seek the potential for human exception or, on the contrary, about calling medical practice back to its moral and altruistic dimension by rekindling its "humanitarian" spirit? These theoretical questions are followed by highly practical questions. Where will we find the means for a new "medical humanism" since, as we all know, hours and resources allocated to human science in medical education are not indefinitely extensible? How can we teach humanism in medicine without generating a new academic and moral dictatorship normalizing healthcare through fake rites and standard discourse rather than humanizing it? How do we negotiate the teaching of "human" care without *ex cathedra* promotion of rigid, academic humanism?

These questions on the philosophy of the humanities in healthcare must be defined in more detail before being answered. In particular, this implies that we should understand how the humanities in healthcare or rather "medical humanities" came to exist, which is our purpose herein.

9 LE COZ, P., *L'Éthique médicale: approches philosophiques*, Aix-en-Provence: Presses Universitaires de Provence, 2018, pp. 20-22.

10 GAILLARD, M., LECHOPIER, N., "Relever le défi d'introduire aux sciences humaines et sociales en première année commune des études de santé. Mise en perspective de quelques pratiques pédagogiques", *Pédagogie médicale*, 16(1), 2015, pp. 23-34.

11 SHAPIRO, J., et al., "Humanities and Their Discontents: Definitions, Critiques, and Implications", Academic Medicine, 84(2), 2009, pp. 192-198.

12 MONTAIGNE, M. de, *Les Essais*, Paris: Gallimard, "Bibliothèque de la pléiade", I, 26, "De l'institution des enfants."

13 CHIAPPERINO, L., BONIOLO, G., "Rethinking Medical Humanities", *Journal of Medical Humanities*, 35(4), 2014, pp. 377-87.

FROM "HUMANISTIC" PHYSICIANS TO THE HUMANITIES IN HEALTHCARE: THE LONG JOURNEY OF HUMAN AND SOCIAL SCIENCE IN FRENCH MEDICAL SCHOOLS

MEDICINE IN "CRISIS", THE HUMANITIES, AND ETHICAL REFECTION. A HISTORICAL OUTLOOK

From the medieval university to the university of the 21st century, it seems the dream of having physicians highly trained in "the humanities" or even "humanistic" physicians was always left on the back burner of medical studies. In 2004, Michel Patris said of the 1992-1994 reforms in favor of introducing human sciences into the medical curriculum: "We were hoping [...] to shift the selection criteria for future physicians at the end of their first year of medical school towards literature, philosophy and, more or less admittedly, humanism"[14]. For many, it was about making space, not only for the humanities, but also for "humanistic" care and ethics in a medical profession that was then in a full-blown crisis[15]. This idea is not new: it is a surprising echo to the observations of Max Simon, author of a pioneering book on "medical deontology" published in 1845.

The law requires that medical science candidates follow high-level and extensive literary studies: it could never be too strict. The need for such preparation is warranted by the complexity of a science that requires a highly seasoned mind; however, when a soul is enriched by seeds of noble and elevated ideas and generous feelings of the heart are enhanced by a selfless culture, literature will protect young doctors from the potentially dangerous influence exerted by the new studies they about to undertake. [...] [L]iterature and philosophy alone prepare in a suitable manner the intelligence and heart of man for the study of a science as difficult and perilous as medicine.

Most importantly, the mind of young doctors must have been nourished by solid philosophical studies. This is the only way for them to escape the gross materialism that they will absorb in the auditoriums where they breathe this doctrine like a disastrous miasma [...].[16]

This mention of the humanities should not surprise us. It must be noted that, paradoxically, the Humanities have often been named as an essential element of the *identity* and *prestige* of the medical

14 PATRIS, M., "Enseigner les sciences humaines et sociales: bilan de dix années", in BONAH, C., RASSMUSSEN, A. (éd.), Sciences humaines et sociales en médecine. Assessment and insight on 10 years of teaching. Strasbourg Symposium September 15-16, 2004, Strasbourg: Faculté de médecine, 2005, p. 11. (Online: https://colhum.hypotheses.org/files/2013/10/ Actes-du-colloque-2005.pdf, last access on June 6, 2019.]

15 See CORDIER, A., "Éthique et professions de santé", Rapport au Ministre de la santé, de la famille et des personnes handicapées, Mai 2003, p. 9.

16 SIMON, M., *Déontologie médicale ou Des devoirs et des droits des médecins dans l'état actuel de la civilisation*, Paris: J. B. Baillière, 1845, pp. 72-73.

profession. In the Middle-Ages and even, to a lesser extent, in the Renaissance, the knowledge of Ancient teachings was a long-standing prerequisite to medical excellence. Even though this is no longer true, we know that the Hippocratic oath, today devoid of any scientific and legal value, has nevertheless kept its powerful symbolic and initiatory role in the medical profession and thus remains a structuring reference for the identity of the physician. In addition, from the 19th century until today, the history of medicine has played a role that today could be qualified as "patrimonial": still taught in the first year of medical school, it provides a foundation to the profession's prestige by integrating successive generation of doctors into a continuous "great family" of physicians with illustrious names. In the reform plan for medical studies written by Félix Vicq d'Azyr for the Constituent Assembly in 1790, the history of medicine is thought to be the "crowning glory" of doctors' education[17]. The first chair of medicine history in France was created in 1794, at the same time as the Paris Health School (École de santé de Paris).

However, in the 19th century, teaching the history of medicine was not only motivated by patrimonial logic: it was also prompted by the need, in this crucial period of historical positivism, to contribute to the progress of medical science through the study of documentary resources and clinical data offered by history while simultaneously identifying the historical laws of medical advances. In view of the significant advances in medical science and technique, the history of medicine and the humanities in general became quickly marginalized within the hospital and university worlds in France in the 19th century. Dissolved in 1822 by royal decree, the chair of history at the École de Paris was reinstated in 1870: the dissolution had triggered a fierce debate in the medical community between those who felt the reinstatement was necessary to adequate medical education and those who saw it as unnecessary luxury[18]. It is as if the scientific positivism prevailing in the 19th century had led to the emergence of recurring questioning, still relevant today, on the meaning and role of the humanities in the identity, practice, and education of physicians.

This is what Christian Bonah rightfully points out: this questioning, as well as the "crisis" in the medical profession, are not radically new phenomena; on the contrary, they are a legacy from the end of the 19th century[19]. It was precisely at that time that the words "deontology" and "Diceology" appeared. Simultaneously, studies on medical ethics and professionalism abounded; the first medical syndicates were created; liability lawsuits against doctors were staggering. All this explains how the first International Professional Medicine and Medical Deontology Conference came about in Paris in 1900[20]. This shows that the healthcare "crisis" and brainstorming on the "humanity" of medicine were already on the agenda in 1900.

Already intense at the turn of the 19th century, the debate on the status of the humanities in medicine education took a new direction in the inter-war period. Consequently, the real question is: what theoretical knowledge should students have before enrolling in medical school? In 1893, a reform by the University of Paris had indeed required that any student wishing to study medicine hold a certificate in physics, chemistry and natural science (PCN) issued by the Faculty of Sciences. This requirement was fiercely debated in the inter-war period: some deans and professors of medicine firmly opposed a clause that limited student exposure to hospital practice, while others claimed that, on the contrary, a preliminary university education was necessary, although it should be in literature instead of science. Such debates are indicative of the issues faced by the French medical education system inherited from the 19th century and traditionally characterized, in

17 GALANOPOULOS, Ph., *op. cit.*

18 *Ibid.*

19 BONAH, Ch., "La médecine en crise: nouveautés et récurrences", in BONAH, Ch., RASSMUSSEN, A. (ed.), *Sciences humaines et sociales en médecine...*, p. 21 sq.

20 *Ibid.*, p. 25.

France, by the prevalence of clinical practice and hospital internship over university teaching; the internship examination, introduced in 1802 in Lyon, then in 1804 at the *Assistance publique* of Paris was in fact used to differentiate the "elite" young doctors from the wider mass of medical school students[21]. The proponents of clinical practice and experimental medicine, like Victor Balthazard, Dean of the Paris Faculty, regretted that the PCN was insufficient to ensure a solid scientific education for students who were, at the time, overwhelmingly coming from literary studies. Tepidly reformed by Victor Balthazard, Gustave Roussy and André Mayer in the early 1930s, the PCN was also criticized, for quite opposite reasons, by the Dean of Lyon, Jean Lépine and by the Dean of Montpellier, Gaston Giraud: both were still strongly in favor of educating humanistic, cultured physicians. The former saw "a real danger that faculties become mere technical schools" and the latter praising, as late as 1944, "the usefulness of extended humanities for future physicians"[22].

At the same time, new projects were created, that broke with these ancient debates and reset the idea of relationships between physicians and human and social sciences. This is the case, for example, of the "French foundation for studying human issues" (*Fondation française pour l'étude des problèmes humains*) founded in 1941 with Pétain's support, by Alexis Carrel, who won the 1912 Nobel Prize in Medicine. Following several visits to the Rockefeller Institute in New York, Dr. Carrel published a book in 1935 titled "*L'homme, cet inconnu*" (Man, The Unknown) that received worldwide recognition. It is a sort of eugenicist plea in favor of the creation of a "science of man" with medicine at the core, encompassing both human sciences and social sciences[23]. Weaving connections between attempts to subordinate human and social sciences to medicine and other programs, creating a tight link between biology and medicine on one hand and humanity on the other hand would probably be a hazardous exercise that requires more in-depth analysis that we cannot undertake here. Nonetheless, it is clear that the Second World War was a moment of crisis, both for the humanities and for medicine. This explains in particular the post-1945 regulatory movement in medical ethics and deontology.

Without further venturing into the many meanders of the history of the complex and ambivalent relationships, as we just explained, between the humanities and medicine in France, we must take one final step in understanding the medical education reforms of the 1990s. At the end of the 1980s, human sciences and medicine created a new alliance to face the unprecedented health threat posed by HIV. As explained by C. Tourette-Turgis, AIDS brought physicians face to face with unparalleled issues and forced them to rethink the care function that was shaken by an epidemic they failed to eradicate using "conventional" medical treatments[24]. Discovering this "inability" of scientific medicine resulted in a mutation in healthcare: it could no longer be restricted to the clinical model, but needed to tap into the resources of psychology, philosophy and sociology to be redefined as listening and *accompaniment*. How can we accompany or assist patients without treatment? What about patients who ignore their serology status? Or patients who have difficulties managing their treatment? Or patients on their way to recovery, who wish to regain a place in society? These were questions that demanded answers and for which science and medicine had not yet provided any. The political helplessness and clinical upheaval created not only by AIDS, but also, more generally, by the

21 The information below was taken from PICARD, J.-F., MOUCHET, S., *La Métamorphose de la médecine*, Paris: PUF, "Science, histoire et société", 2009, p. 16 sq.

22 Cited by PICARD, J.-F., MOUCHET, S., *op. cit.*, p. 17.

23 CARREL, A., *L'Homme, cet inconnu*, Paris: Plon, 1935.

24 TOURETTE-TURGIS, C., *L'activité de maintien de soi en vie et son accompagnement: un nouveau champ de recherche en éducation. Habilitation à diriger des recherches en Sciences de l'éducation, spécialité formation des adultes*, Paris: Routledge, 2013, p. 15.

increase in chronic diseases, thus partly explain how the idea of an urgent need to reintroduce the humanities into medical schools emerged in the 1990s and 2000s.[25]

A MAJOR TURNING POINT IN THE 1990S: THE RETURN OF THE HUMANITIES IN THE MEDICAL CURRICULUM

The teaching of the humanities in medical schools reached a significant turning point in the early 1990s. At that time, curricula were almost exclusively based on experimental sciences and mathematics, with the addition of a few courses in law, economics and public health all of which was almost always assessed by means of multiple-choice questions (QCMs). In a few rare cases, some deans implemented experimental programs aimed at opening the medical curriculum to human and social sciences. This was the case at the Bobigny medical school at Université Paris XIII, created in 1968, where Pierre Cornillot created a module in 1976 titled "Man and His Environment" for first cycle students: it intersected biology, sociology, anthropology and psychology[26]. In the same department, Serge Lebovici launched a multidisciplinary program covering psychoanalysis, anthropology and sociology in 1983-1984. In Tours, a cycle of theme-based lectures was organized in 1988; they were open to students as well as to professors and pertained to medicine and human sciences. Led by Philippe Pagros upon the request of Dean André Gouazé, these lectures often feature renowned anthropologists, historians or philosophers and, most importantly, are the object of a mandatory editorial-style assessment (free commentary of a text on the lecture theme of the year, and a summary of the text)[27].

On March 18, 1992, a decree enacted the most important reform of the first cycle of medical school since the implementation of the *numerus clausus* in 1971. Jean Rey, former dean of the Necker faculty, adviser to the minister of National Education, was the father of this crucial reform, at a time when the status of the first year of medical studies (PCEM 1) was questioned: many already criticized the inadequacy of the program and the "human mess" it often created. Effective at the beginning of the 1993 school year, the 1992 decree stated in Article 8 that the programs of the first cycle and of the first year of the second cycle must include "foreign languages, epistemology, psychology, medical ethics and deontology". The first year (PCEM 1) had to include a module of "general culture" on philosophy and the history of science, among other disciplines. This module had to be imperatively graded and the test coefficient related to it had to be at least equal to 10% of the total coefficients of the exam. In the second year of the first cycle, 80 to 100 hours per year of additional classes were at the choice of the student and could pertain to law and economics, anthropology, sociology, computer science, philosophy of the sciences, history of medicine, or expression and communication techniques. As noted by Lauran Visier, even though few medical schools seized the opportunity to offer human science classes after PCEM 1, the requirement of implementing a "general culture" module was highly prescriptive: those who did not comply with the decree on this point could put faculties at risk of cancellation of an examination "on which legal pressure was strong"[28].

25 WORMS, F., *Le moment du soin. À quoi tenons-nous?*, Paris: PUF, "Éthique et philosophie morale", 2010, p. 117.

26 NEUMAN, D., "Bobigny: 25 ans d'expérience en sciences humaines et sociales" in BONAH, Ch., RASSMUSSEN, A., *op. cit.*, p. 9.

27 BAGROS, Ph., "Les sciences humaines en médecine à Tours", Journées de Tours, 18-20 mai 2012, Histoire des sciences médicales, 46(4), 2012, p. 348. (Online: http://www.biusante.parisdescartes.fr/sfhm/hsm/HSMx2012x046x004/HSMx2012x046x004x0347.pdf, last access June 6, 2019.]

28 VISIER, L., "Vingt ans d'enseignement des SHS dans les études médicales en France", Bioethica Forum, 4(4), 2011, p. 144.

On April 21, 1994, the year in which the first French bioethics law was enacted, a new decree changed the situation even more: the "general culture" module was renamed "human and social science module" and its share in the exam total coefficients increased from 10% to 20%. Consequently, from 1994 to 2009, "human and social sciences" are the highest coefficient in the PCEM 1 exam and play a crucial role in the selection of future physicians. A decree dated May 2, 1995 details the methods of teaching human and social sciences in PCEM 1. First, this program had to allow "the acquisition of basic tools in sociology, social psychology, demography, national, European and international law, economics, communication and information", as well as "the study of society's great ethical challenges": philosophy, history of sciences and epistemology, cited as essential in 1992, were replaced with medical ethics in 1995. The 1995 decree also required that schools organize exams that were *fully* written, with double correction, for the human and social science classes: this was a small revolution in the organization of PCEM 1 exams that, until then, were almost always in the QCM format. Lastly, the 1995 decree stated, in a rather ambiguous fashion, that the teaching of human and social sciences had to be dispensed "with the assistance of academics from the disciplines in question" and assessed "with the assistance of the academics who were involved in the teaching". As noted by Laurent Visier, this could have indicated that the mandatory teaching of general culture and human and social sciences was then mostly provided by physicians. This rather informal program was—and for a large part, still is—based on local arrangements, people with good intentions, the areas of interest of a few professors, relationships between various UFRs (French education and research units) and universities within a city"[29]. Obviously, this implies significant territorial disparities, since such "arrangements" are much easier to implement in large cities, that host the universities, academics, and resources enabling them to achieve the necessary collaboration for these interdisciplinary programs. In 2006, 78% of human and social sciences in medicine professors came from university hospitals and only 10% were academicians from human and social sciences specifically recruited for this function[30]. It is difficult to assess the situation in 2019, but there is a good chance that the issue that arose in 2006 has not been fully resolved. Since then, very few human science teaching positions have been created in medical faculties and lecturer positions in history, philosophy and anthropology in medical faculties are morphed into professorships; this could be seen as a hindrance to the interdisciplinary character of medical humanities professors and to the emergence of a dedicated "world" of teaching and research.

NEW QUESTIONING STARTING IN THE 2000S

After a few years of idleness, the purposes and methods of teaching ethics and human and social sciences in medicine were reexamined in the early 2000s in three meaningful publications: indirectly, in the 2000 Lecourt report, and directly in the 2003 Cordier report and in the 2004 Opinion #84 of the National Consultative Ethics Committee (Comité Consultatif National d'Éthique, CCNE), which were more centered on teaching medical ethics. Even though the legitimacy and relevance of these teachings were never disputed, three questions were central to the thought process that followed: (1) How should human sciences and ethics in medicine be taught? Should we include this teaching in clinical practice, combine it with internships and practical experience, or continue teaching it academically? (2) How can we avoid transforming these fields of study, which are supposed to provide young doctors with a potential for critical and reflective openness, particularly in the first year of studies? (3) How can these studies in humanities and ethics impact future physicians' profile?

The Lecourt report, presented in February 2000, insisted on the "urgency" of implementing a teaching program in philosophy of sciences in scientific curricula, with the support of philosophers, particularly in medical schools[31] Such recommendations may have helped the promotion of history and philosophy of sciences as well as of epistemology in PCEM 1 in some medical schools; the Paris-Diderot University played a pioneering role in this regard. Likewise, the Cordier report (2003) made the case for better attention to ethical refection in the initial education of healthcare providers[32]. The report insisted on the need to "embody" ethics and teach it in the form of *questions* rather than precepts. It recommended a sense-awakening "preparatory" internship on medical ethics that would take place between the baccalaureate (high school) and the PCEM 1, as well as an upward rebalancing of the share of human sciences in medicine; it also suggested the option for students with backgrounds other than PCEM 1 to directly enroll in PCEM 2. Other recommendations in this report seem to still be valid today: creating seminars common to all future healthcare providers during the second cycle, organizing mandatory brainstorming seminars in ethics during internships; creating and diversifying complementary studies (university diplomas, in-depth diplomas (DEA)) in ethics and human sciences for those who wish to become "advisers in ethical reflection" within their clinical practice, and opening *ad hoc* interdisciplinary departments in medical schools.

The CCNE Opinion #84 on medical ethics education (2004) also addressed and developed the main points suggested in the Cordier report[33]. The notion of "awakening" to ethics, developed in the Cordier report, triggered reservations on the part of the CCNE, which notes that the hourly volume and the teaching and selection methods in PCEM 1 are in practice not well suited to a logic of "awareness" and realization. Additionally, the CCNE stated that the teaching of ethics in PCEM 1 could be more relevant if it focused on the study of some exemplary and specific clinical cases and on an introduction to epistemology and the values of scientific research. More generally, the CCNE Opinion offered a notion of medical ethics significantly different than that described in the Cordier report: rather than an intersubjective and existential ethics close to Levinas theories, the CCNE recommended a deliberative, rational ethics based on discussions of shared principles that should be taught to medical students in academic as well as critical mode. According to the CCNE, this teaching should be provided by human science professors and not by "advisers in ethics" with a hospital and academic background. In any case, it is mandatory, according to the CCNE, that professors involved in this teaching hold a doctorate evidencing expertise in both human sciences and medical sciences; additionally, the creation of positions of MCUs (academic lecturer, *maître de conférence universitaire*) and PUs (university professors, professeur des universités) should be encouraged.

THE 2009 REFORM AND ITS REPERCUSSIONS: A DOWNTURN FOR THE HUMANITIES IN HEALTHCARE

From 2009 to 2011, French medical studies underwent an in-depth overhaul. A decree dated October 28, 2009 created the PACES (first year common to healthcare studies) in which the 1994 human and social

29 *Ibid*., p. 145.

30 Administration Universitaire Francophone et Européenne en Médecine et Odontologie (AUFEMO), *Les enseignants en sciences humaines et sociales: qui sont-ils?* 2006.

31 LECOURT, D., "L'enseignement de la philosophie des sciences", rapport au Ministre de l'éducation nationale, de la recherche et de la technologie, février 2000, p. 27.

32 CORDIER, A., "Éthique et Professions de santé", *op. cit.*

33 Comité Consultatif National d'Éthique (CCNE). "Avis sur la formation à l'éthique médicale", *Opinion #84* [Rapporteur: P. Le Coz], April 2004.

sciences module (SHS) was replaced with the "UE 7" titled "*Santé, Société, Humanité*" (Health, Society, Humanity, HSH). This teaching unit (UE) is structured into four main components: "human and social sciences" (anthropology, history, philosophy, sociology, psychology, epistemology, economics, law, and political science), "Man and his environment " (the great reigns of the living world, evolution and biodiversity, and environmental mutations), "public health" (epidemiology, emergency medicine, health economics, legal medicine etc.), and "analytical and synthesis skills." In addition to the introduction of human sciences in schools of pharmacy, three elements should be highlighted:

1. The extreme heterogeneity of contents being taught within the UE 7 that hinders the legitimacy of human sciences in medicine as they seem to be drowned in a highly eclectic program, and which makes it very difficult to know what proportion of the UE 7 program is actually dedicated to human sciences or ethics since universities are a priori free to divide UE 7 schedules as they see fit;
2. The disappearance of the rule of completely written human science examinations: from now on they have to be organized "at least in part, as essays";
3. The disappearance of the obligation to weight human sciences at 20% of the total coefficient of the PACES examination. It should be noted that today, the share of human sciences in this exam is, on average, slightly over 13% while some schools even reduced it to the 10% required in 1992.

According to Laurent Visier, such changes do not necessarily mean a regression, but rather accentuate the diversity of situations from one school to another[34]. A more positive point is the implementation, on March 22, 2011, of mandatory core courses in HSH in the second and third years of the first cycle (Degree in general education in medical sciences, DFGSM). It is complemented with a quota of free education units (*Unités d'Enseignement Libre*, UEL) not necessarily on biology or medicine, such as ethics, philosophy, and health law. Additionally, these UELs (*Unités d'enseignement libre*, electives) can "be an actual path offered by the structure in charge of education and be the beginning of a double curriculum that will be pursued throughout the master's level." Consequently, the humanities and ethics are no longer a mere selection tool for the PACES; they are studied in depth during the first cycle, where the core courses address themes like "human beings facing suffering and death", "experiences and representations of the body, the disease, and the treatments", "relationships between care providers and patients", "health policies and systems", and "education in the scientific approach and epistemology."

After the PACES and the first cycle, the second cycle of medical studies underwent a reform enacted by a decree dated April 8, 2013. The new diploma in in-depth medical science education (*Diplôme de Formation Approfondie en Sciences Médicales*, DFASM), which corresponds to an "externship", is divided into a core program and a "multi-year customized program" allowing students to "expand or [...] complete their knowledge and skills in areas that are not strictly medical", which implies that it is possible and even recommended for "externs" to learn human science and ethics. In fact, ethics and reflexivity are mentioned as core skills that should be acquired during the DFASM. Plus, the program insists on practical training through internships where students must record issues they encounter in notebooks in order to "pursue their education in ethical reflection". The DFASM is structured according to the main medical fields and integrates ethics in most teachings. Medical ethics is also a sub-item of UE1 titled "Learning medical practice and interprofessional cooperation"; other sub-items are dedicated to the "relationship between physician and patient" and to the care system and social security organization. While ethics are very present, human and social sciences have

34 VISIER, L. Collège des sciences humaines et sociales en santé, "Enquête sur l'UE7 (SSH) dans la première année des études de santé", *Summary*, January 28, 2011.

almost disappeared, which explains why they are nonexistent today in the second cycle in France or present in the form of optional courses or UEL.

The most recent reform of human and social sciences in medicine took place on June 12, 2018; it defines health service methods for healthcare students. Health service is a theoretical and practical course on health prevention and promotion, followed by a practical program with predefined populations; it is taught in the third year of the first cycle of medical studies (DFGSM3) and ends with an assessment of this practical program. In most cases, the theoretical course and practical program are integrated to the HSH teaching units, although there is no increase of the hourly volume or of budget. In some schools, such as Bordeaux or Bobigny, for example, it seems the preparation of health service was clearly combined with HSH teaching and it would be interesting to know the outcome of this in the medium and long term. As of now, we have little information on this very recent plan; therefore, it is difficult to know whether it can reinforce the teaching of the humanities in health or if it may divert them from their critical and reflexive objective by directing them more towards prevention and communication.

To conclude this contextualization, we must include a brief summary of the regulatory developments we described above. We note the following:

1. A real progress in extending human and ethical sciences teaching beyond the PACES, including by implementing a core HSH program in the DFGSM even though it does not include a minimum hourly volume.
2. A significant decline in the weight of human and social sciences teaching in the PACES examination in terms of coefficients and the regrettable elimination of the requirement for fully written exams to assess these teachings.
3. A growing heterogenization of contents and objectives of HSH education, which dilutes their legitimacy, scatters their potential for questioning and reflexivity, and favors a superficial overview of a large number of topics without any relevance or link between them.
4. A prudent absence of specific measures favoring the creation of positions or institutional structuring of the humanities and ethics in medicine education, which can generate numerous territorial disparities.
5. The scarcity of pedagogical innovations and of *consistent* practical interdisciplinarity for HSH teaching: despite numerous proposals, which are often relevant and rarely adopted, it appears that the important issues reported in the Cordier report and the CCNE Opinion #84 from the early 2000s have not been resolved or are at least still present today.

INTERNATIONAL OVERVIEW: HISTORICAL AND CONTEXTUAL ASPECTS

FIRST EXPERIENCES IN AMERICA: *THE BIRTH OF THE MEDICAL HUMANITIES*

The medical humanities: an American story

The term "medical humanities" appeared for the first time in the United States in 1948[35]. In the first half of the 20th century, following the release of the major Flexner report on medical education in the United States and Canada (1910), medical schools clearly did not prioritize humanities: Flexner advocated, above all, the unification and improvement of scientific standards in medical studies, which at the time were extremely variable. Therefore, it was only after the Second World War that some Anglo-Saxon precursors (primarily American, but also Canadian, British and Australian) began promoting medical education with a greater emphasis on the humanities. For instance, in 1951, Canadian professor H. B. Van Wyck published a pioneering article on the role of the humanities in physicians' education[36]. In 1952, the first attempts to integrate "the humanities" in medical education were made in Cleveland, Ohio, at the Case Western Reserve University School of Medicine which offered, among other topics, an optional course in the history of medicine[37]. At about the same time, British physician Hugh Barber suggested the use of literature to introduce medical students to the intricacies of human nature, which he believed they needed to familiarize themselves with to become good doctors[38]. Such early efforts were characterized by the idealistic image of the physician who was "an honest man" or "a gentleman" like, for instance, William Osler, a physician who advocated a "re-humanization of medicine" through culture and liberal arts; he felt that medical practice was an "art" that could only be properly practiced by educated men with "noble" characters, skilled not only in sciences but also in the humanities[39]. We can find the same concept of the medical humanities, seen as the ethics of the caring "character", in E. E. Reinke who in 1937 suggested a rebalancing of "technical" and scientific teaching of medicine with a classic "liberal" education[40].

Starting in the late 1960s, the medical humanities made a fresh start that brought them to the forefront in the 1970s. In 1967, the school of medicine of Pennsylvania State University developed a program including ethical, spiritual and social elements in its medical curriculum for first cycle students. This resulted, for the first time, in the creation of a "Humanities Department" ***within*** the school of medicine; it was in charge of theology, philosophy, and history courses applied to medicine, while literature courses were added to the program in 1969[41]. 1969 was also the year the *Society for Health and Human Values* was created; it promoted humanist values in American departments and schools of medicine. In 1998, the Society was integrated into the *American Society for Bioethics and Humanities* which showed, once again, the porosity of the fields of bioethics and the medical humanities in the American environment[42]. We note that this was not the case in the United Kingdom where the creation of mandatory courses in ethics and law for medical students remained rather distant from the dynamics specific to the medical humanities. This is why, according to Alan Bleakey, it seemed unlikely that the teaching of medical humanities, still largely excluded today from the mandatory medical curriculum in the United Kingdom, could easily be "plugged into" the current teachings of ethics and law[43].

According to K. Ludmerer, the medical curriculum in the United States evolved in the 60s and 70s as a result of two concomitant trends that facilitated the launch of new "humanities" courses in medical schools. First, the rise of political protest around the Vietnam War and the civil rights movement opened the way to social and ethical responsibility and adaptability of physicians who progressively left the narrow sphere of exclusively scientific expertise. Second, the growing freeing of health economics during the same period, which changed the basis of physician-patient relationships, the latter being increasingly asked to act as a consumer capable of resorting to the courts to assert their rights: this is known as the "judicialization" of medical issues. It resulted in a rethinking of the way in which physicians interact with their "clients-patients"[44]. Both trends set the scene for vivid debates that took place in the 70s between defenders of a "humanistic" medicine opposing the omnipotence of techno-scientific medicine, and the "silent majority" of skeptical doctors unconvinced by the plan of medical progress other than scientific, which was sometimes stated in very vague terms[45]. In 1973, an Institute of Medical Humanities was founded at the University of Texas in Galveston, which was primarily interested in relationships between medicine and literature. Anne Hudson Jones joined the Institute in 1979 and was then one of the first literature professors teaching in a school of medicine. Today, the Institute offers humanities studies integrated into the standard four-year curriculum for future physicians in the United States (Medical Schools) as well as master's and doctorate degrees specifically dedicated to the medical humanities. The North American Journal of Medical Humanities was created in 1979. It provided a necessary exchange platform for this emerging field.

However, the United States did not hold the monopoly on initiatives of the 1970s: Australia and Argentina also participated in teaching innovations. As early as 1976, the University of La Plata in Argentina developed an optional medical humanities program (literature, anthropology, history of medicine, music and dance) that has been progressively improved and strengthened until today despite the country's economic and financial troubles[46].

The years 1980-1990 open a period of consolidation for American medical humanities, with the publication, in 1984, of an influential report by the "Hastings Center", the largest bioethics institute in the United States. The report, titled "The Place of the Humanities in Medicine", was written by Eric Cassell a physician

35 BLEAKLEY, A., *op. cit*., p. 12. Everything below is based on the work of Alan Bleakley.

36 VAN WYCK, H. B., "Humanities in Medical Education", *Canadian Medical Association Journal*, 64, 1951, pp. 254-260.

37 BLEAKLEY, A., *ibid*., p. 14.

38 BARBER, H., *The Rewards of Medicine and Other Essays*, London: HK Lewis, 1959, p. 78.

39 WARNER, J. H., "The Humanising Power of Medical History: Responses to Biomedicine in the 20th Century United States", *Medical Humanities*, 37, 2011, p. 92.

40 REINKE, E. E., "From the Archives: Liberal Values in Premedical Education", *Academic Medicine*, 78, 2003 [The Journal of the Association of American Medical Colleges, 1937].

41 HAWKINS, A. H., et al., "Humanities Education at Pennsylvania State University College of Medicine, Hershey, Pennsylvania", *Academic Medicine*, 78, 2003, pp. 1001-1005.

42 BLEAKLEY, A., *op. cit*., pp. 14-15.

43 *Ibid*.

44 LUDMERER, K., *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*, Oxford: Oxford University Press, 1999.

45 BLEAKLEY, A., *op. cit*., p. 13.

46 ACUNA, L. E., "Teaching Humanities at the National University of La Plata, Argentina", *Academic Medicine*, 2003, 78(10), pp. 1024-1027.

specialized in ethics[47]. The Arnold P. Gold Foundation, a public foundation created in 1988, facilitated the financing of medical humanities.

The foundation supports various research, teaching or public engagement projects inspired by a "humanist" or humanitarian approach of medical professionalism, but also by medical humanities in a broad sense[48].

In the early 1990s, medical humanities gained even more visibility and tended to exceed the peripheral and "ancillary" dimension in which they were too often confined. In 1992, the school of medicine of the University of Missouri-Kansas City opened a specialized bioethics and medical humanities department called the "Sirridge Office of Medical Humanities"; it provided *mandatory* teachings, as either core or optional courses integrated to the general medical education and no longer limited to a series of optional courses aimed at a small number of interested students[49]. At about the same time, New York University (NYU) and Columbia University created medical humanities departments and programs that are highly influential today; this is particularly true for the narrative medicine program at Columbia, led by Rita Charon whose works have recently been translated into French. A bit hesitant in the 1970s, "narrative" medicine, largely based on an almost literary analysis of medical "cases", is characterized by a focus on the uniqueness of a patient's narrative and social and cultural contexts, but also by the use of literature as a mean to enlighten medical practice. Narrative medicine was definitively standardized by Kathryn Montgomery Hunter who gave it an "epistemological" accent in her 1991 book *Doctors' Stories: The Narrative Structure of Medical Knowledge*[50]. Among other topics, the book included a critique of medical education that, in her opinion, did not give enough space to the "literary" skills, in the broadest sense, of physicians who are rendered unable to develop a "narrative" thought attentive to each patient's unique story. Narrative medicine gained even more visibility thanks to the work of Rita Charon; this explains why the medical humanities were understood very early in the United States and elsewhere, through the theoretical prism of *narrative-based medicine* as opposed to *evidence-based medicine*.

In the early 2000s, it seemed as if the medical humanities had reached real academic recognition in the field of medical studies. As an example, we cite the publication, in October 2003, of a special issue of the journal *Academic Medicine*, entirely dedicated to the teaching of the medical humanities (vol. 78, n°10). Even though the medical humanities have undeniably made their place in the American medical education environment, their boundaries are not fixed. Today, the medical humanities are broadening their scope and tend to change their name in favor of "health humanities", a more inclusive term. Hence, in the 20th century, medical humanities acquired a solid institutional weight in the United States, most often deployed within medical schools, which allowed for the creation of truly interdisciplinary entities that are adapted and fed by clinical practice. This clearly differs from the British environment where medical humanities often remain within the literary departments of their universities.

47 CASSELL, E. J., "The Place of the Humanities in Medicine", Hastings Center, NY, 1984.

48 BLEAKLEY, A., *op. cit.*, p. 17.

49 See description online: http://med.umkc.edu/md/curriculum, last consultation on June 6 2019.

50 HUNTER, K. M., *Doctors' Stories: The Narrative Structure of Medical Knowledge*, Princeton, NJ: Princeton University Press, 1991.

The current place of medical humanities in American medical studies

However, the current image of the medical humanities education in the United States must be complemented. Unlike French faculties, American medical schools do not offer studies immediately after high school. Students must first obtain a bachelor's degree or baccalaureate, corresponding to the French "license", and generally taking three or four years of studies at the undergraduate level, then pass a standardized test, which is an entrance exam called the Medical College Admission Test (MCAT). Every medical school creates their own list of prerequisite classes that a candidate must have taken during the bachelor's degree in order to be "admissible": biology, chemistry, physics, mathematics, in some cases a class evidencing writing skills, etc. The undergraduate major is of no importance; they must only prove that they took the *prerequisite coursework* to enroll. Among these prerequisites, some universities require a course in the medical humanities: the prestigious Johns Hopkins University School of Medicine, for example, requires candidates to have taken at least 24 hours of courses in the humanities (English, history, classical literature, foreign languages, philosophy, art), social sciences (sociology, economics, political science, anthropology), and behavioral sciences (including psychology)[51]. Likewise, Emory University requires a minimum of 18 hours of classes in the humanities and social sciences. Prerequisites at the University of Pennsylvania and Stanford University include courses in social and behavioral sciences as well as courses favoring expression and communication. At Harvard, the humanities are not included in the prerequisites, even though it is clearly stated that a course in the humanities is recommended to satisfy the medical school requirements in terms of written expression. In 2011, 52% of accredited American medical schools required that candidates take courses in the medical humanities or social sciences prior to applying[52]. Today, increasingly more students are opting for a pre-medical baccalaureate centered around the humanities either as a minor or a major of their degree. Moreover, in 2009, 15% of applicants to American medical schools held a baccalaureate with a major in the human and social sciences[53]. Today, pre-medical education offering optional certificates, specializations, majors or minors in the humanities abound in the United States; in March 2019, 85 universities provided such programs (see Fig. 1)[54].

51 See the description online: https://www.hopkinsmedicine.org/som/admissions/md/ application_process/prerequisites_requirements.html, last consulted on June 6 2019.

52 BANASZEK, A., "Medical humanities courses becoming prerequisites in many medical schools", *Canadian Medical Association Journal*, 183(8), 2011, E441-442.

53 WERSHOF SCHWARTZ, A., *et al.*, "Evaluating the Impact of the Humanities in Medical Education", Mount Sinai Journal of Medicine, 76(4), 2009, pp. 372-380.

54 LAMB, E. G., BERRY, S., JONES, Th., Hiram College, "Health Humanities Baccalaureate Programs in the United States", Mars 2019. (Online: https://www.hiram.edu/wp-content/uploads/2019/03/Health-Humanities-Program_2019_final.pdf, last consulted on June 6 2019.]. See also LAMB, E. G., BERRY, S., "Snapshots of Baccalaureate Health Humanities Programs", Journal of Medical Humanities, 38, 2017, pp. 511-534.

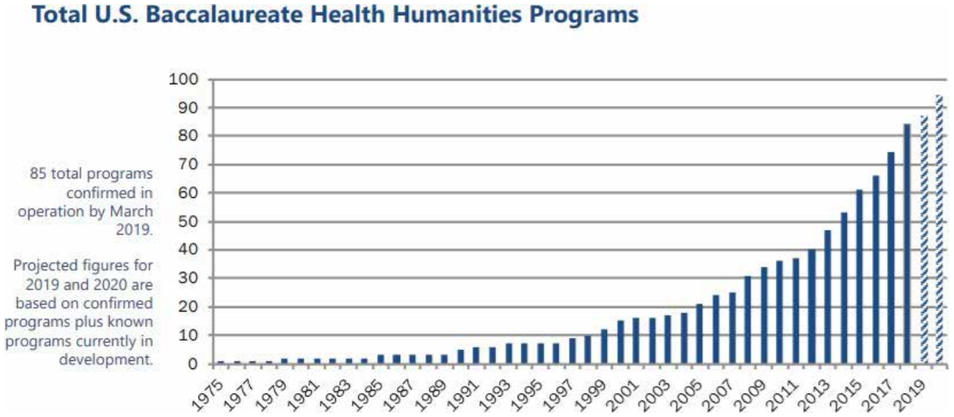

Fig. 1 - Numerous baccalaureate programs in the medical humanities in the United States since 1975 (Note: 2020 projections are based on programs currently being developed).
Source: Hiram College (se # 44).

Minoring in Medical Humanities or Health Humanities seems to be the most suitable format for universities (in more than 50% of cases); the reason is probably that it allows for a more balanced distribution of classes between the humanities and the many scientific disciplines among the medical schools' prerequisites. For instance, Harvard offers a bachelor's degree in History of Science with an option in "Medicine and Society" for students who wish to pursue studies in a medical school[55]. Conversely, Columbia's program titled "Medicine, literature and society" (a major) appears to be more ambitious: it allows students to move on to literary and anthropological as well as medical and economic studies.

When they are done with pre-medical studies, students enroll in a school of medicine where they generally receive the title of "Doctor of Medicine" (MD) after four years. Upon completion, they embark on a three to seven-year program supervised by a more experienced doctor in a particular hospital or clinic in order to acquire skills in a medical specialization (residency). After that, most join a medical practice or hospital; some undergo additional training (fellowship) in specific research areas (neurosurgery, neonatalogy, etc.) prior to fully pursuing their career. As we stated above, several American medical schools offer advanced education in the medical humanities (Columbia, Duke, Johns Hopkins, etc.) which generally are not mandatory, but are part of a specialization path freely chosen by students, who are most often required to write a research paper on a medical humanities topic. Consequently – and this is not surprising in view of the American university system – it appears that medical schools favor the freedom of choice for students designing their educational path and do not impose mandatory courses in the humanities that are sometimes not very well received[56].

Even though the medical humanities seem to have more institutional visibility in the Unites States than in France because of their particular history described above, it absolutely does not mean that the medical humanities are taught more extensively and even less that this teaching is uniformly dispensed in the United States. Because of the quasi-total autonomy of universities and faculties, which are often free from any governmental coordination at the federal or state level, medical humanities education remains highly

55 See online description; last consulted on June 6, 2019: https://histsci.fas.harvard.edu/ academics/undergraduate-program.

56 SHAPIRO, J., et. al., art. cit., 2009.

diverse and is rarely the object of official or standardized assessments[57]. Moreover, the disparities inherent to the American university system in general also exist in medical humanities education which are scarcely - or not at all - represented in the central and north-western states, and over-represented in the east coast states which host the most prestigious - and richest - American universities[58].

THE AMBIGUITIES OF BRITISH MEDICAL HUMANITIES

Even though they are largely under American influence, the British medical humanities have different roots, including the crucial "art therapy." Art therapy originated in the pioneering work of painter Adrian Hill in the 1940s and was significantly developed in post-war Great Britain. This explains why the medical humanities were often mistaken—and still are today—for this discipline: more than in other countries, visual and performing arts are an important part of the nebulous "medical humanities" in the United Kingdom. According to Alan Bleakley, this also results from the combined influence of two physicians, Robin Philipp and Kenneth Calman; the former advocates the relevance of using arts to promote health; the latter studied the integration of the humanities into medical education[59]. Early initiatives, driven by these two actors in the 1990s, were characterized by highly enthusiastic idealism aimed at returning "humanity" to medicine by connecting health to happiness for both healthcare providers and patients. According to Bleakley, medical humanities were a mean to increase patients' and all citizens' well-being; the term "humanities" was used either in the sense of greater "Kindness" from physicians or as a sort of pleasant counterpoint to the rigorous, "hard" medical sciences. At least that was the general feeling at the 1998 and 1999 Windsor Conferences on Medical Humanities[60], where their critical and truly scientific characteristics seem to have taken a back seat. As observed by Bleakley, the educational directions that resulted from these conferences remain very vague: they varied from the temptation of mandatory humanities courses integrated into medical education, to the less constraining idea of an *intercalated degree*, obtained between the first and second study cycles and thus remaining optional.

In fact, recommendations by the General Medical Council (GMC), the British medical board responsible for defining major directions and standards for medical education in the United Kingdom, also seem hesitant in this regard. Coinciding almost exactly with the French calendar, the framework for medical studies created in 1993 by the GMC required optional teaching modules, including subjects such as the history of medicine or literature. Unlike in France, the medical humanities remained an optional teaching and did not become part of the core program for medical studies. However, the GMC reaffirmed the importance of the medical humanities in 2003, although still optional for universities, while there was no mention of specific budget or staffing resources for such courses[61]. In its recommendations, the GMC made a clear distinction between the medical humanities and ethics and law: the latter remained a mandatory part of the core

57 WEAR, D., "The Medical Humanities: Toward a Renewed Praxis", Journal of Medical Humanities, 30, 2009, pp. 209-220.

58 LAMB, E. G., BERRY, S., JONES, Th., Hiram College, op. cit.

59 BLEAKLEY, A., op. cit., p. 25.

60 See PHILIPP, R., et al., Beyond the Millennium: A Summary of the Proceedings of the First Windsor Conference, London: Nuffield Trust, 1999; PHILIPP, R., et al., Arts, Health and Well-Being. From the Windsor I Conference to a Nuffield Forum for the Medical Humanities, London: Nuffield Trust, 2002.

61 KIRKLIN, D., "Acquiring Experience in Medical Humanities Teaching: The Chicken and Egg Conundrum", Medical Humanities, 28, p. 101.

courses during that period[62]. Nonetheless, in 2009 the GMC appeared to stray from its initial enthusiasm: its recommendations no longer mentioned the medical humanities and included a rather significant reduction in the volume of optional modules which were specifically dedicated to the humanities.

This shows that the teaching of the medical humanities received little institutional support in the United Kingdom, which partly explains the great diversity of studies offered by universities with a few pioneering departments and others totally ignoring the topic. Among the universities at the forefront, we note UCL (University College London) and the University of Durham, both opening research centers in medical humanities in the late 1990s, and the University of Swansea, in Wales, the first university in the UK to offer a Masters' degree in medical humanities, in 1997. The faculty of medicine born from a collaboration between the University of Exeter and the University of Plymouth in the 2000s also played a crucial role and constituted a unique instance of a *mandatory* medical humanities course in the UK until the recent cancellation of this collaboration. Today, British medial humanities programs remain, in the vast majority of cases, specialized and optional courses leading either to intercalated bachelor's degrees (thus requiring a one-year or longer suspension of medical studies) or post-graduate Master's (MA) usually geared towards graduate medical students. For example, this type of program is offered by the Universities of Bristol, Exeter, and King's College for intercalated BAs and by Universities of Birkbeck, UCL, Canterbury and York for Masters of Art.

As is the case in the United States, the wide autonomy of British universities complicates any assessment of medical humanities education: every university has its own traditions and specificities. In general, there are few studies on the diversity of teachings and assessment methods in British schools of medicine[63]. Therefore, we can conclude that mandatory medical humanities programs are extremely rare or even nonexistent from what we could observe; most universities opt for modules in "Communication", ethics and deontology, law and general public health (social medicine). For example, the humanities as such are absent from the Oxford and Cambridge Schools of Medicine brochures, although the latter school offers a larger focus on the ethical and socio-cultural aspects of medical education[64]. Although medical humanities education is much more diverse in the UK than in France, it is not the case for research, which appears to be flourishing in this field thanks to funding from the Welcome Trust (a wealthy health and biomedical research foundation), adequately structured and well-represented in the country, even though it is often linked to human science departments rather than medical schools, as we already pointed out.

62 DOYAL, L., "Medical ethics and law as a core subject in medical education", British Medical Journal, 316(7145), 1998, pp. 1623-24.

63 DEVINE, O. P., HARBORNE, A. C., MCMANUS, I. C., „Assessment at UK medical schools varies substantially in volume, type and intensity and correlates with postgraduate attainment," BioMed Central Medical Education, 15: 146, 2015.

64 See online descriptions, last consulted on June 6, 2019: https://www.medsci.ox.ac.uk/study/medicine pour Oxford et https://www.undergraduate.study.cam.ac.uk/courses/medicine for Cambridge.

IN CONTINENTAL EUROPE: WHAT IS THE LEGACY FOR "THE HUMANITIES" IN MEDICAL SCHOOLS?

Large European medical schools share a common history that dates from the Middle Ages, in which the humanities were often a prerequisite to medical studies. This is why these schools are, in a way, facing the same issue: how to reinvent the place of the humanities in medical education.

Italy and Spain: the primacy of the history of medicine and biomedical ethics

The Italian situation is not very different from the Anglo-Saxon environment, contrary to what one might think[65]: the debate on introducing medical humanities into medical schools started in the early 1990s, at about the same time as in France and the United Kingdom. Today, medical humanities teaching is recommended at national level, although differently applied depending on departments, often by reason of lack of human and financial resources on the one hand, and interdisciplinary and inter-professional collaboration on the other hand[66]. While research in ethics and medical humanities is significant, teachers in medical humanities do not appear to have come together at the national level into an equivalent of the French "Colhum", for instance. Consequently, medical humanities are evidently not widely taught or, at least, they are ancillary in most departments; they offer few ECTS (European Credits Transfer System) credits; they are often optional and do not receive great institutional recognition outside of better-considered subjects such as the history of medicine[67]. Since medical ethics remain linked to the medical-legal sector, there is no dedicated medical humanities section within higher education. However, the picture is not that somber: in Italy, teachings in human sciences and ethics are generally offered to medical students during the first years of their curriculum; still, the history of medicine and, to a lesser degree, biomedical ethics, have a place that could be seen as overwhelming compared to literature, social sciences or art which are for the most part absent from these programs. The situation is very similar in Spain where ethics teaching appears more often than the history of medicine, unlike in Italy where, in 80% of the cases, ethics are integrated into another subject (public health, legal medicine)[68]. In both countries, there is a wide gap between private and public universities: the former are systematically offering - optional or mandatory - courses in medical humanities, which is not the case for the latter.

Germany: History, medical theory and ethics (GTE)

In Germany, higher education is decentralized and organized at the discretion of the Länder. The federal government only delivers the *Approbationsordnung für Ärzte* (ÄApprO) a sort of regulation describing the minimum knowledge to be acquired by medical students to practice. The term "medical humanities" isn't commonly used in German higher education. This is probably because the development of non-scientific programs in medical schools followed a logic quite different than that of the Anglo-Saxon model. Although some universities already had institutes or chairs of history of medicine linked to German medical schools during the inter-war years, as in Leipzig, Würzburg or Fribourg, the movement only generalized as of the

65 FIESCHI, L. et al., "Medical Humanities in Healthcare Education in Italy: A Literature Review", Annali dell'Istituto Superiore di Sanità, 49, 2013, pp. 56-64.

66 Ibid.

67 PATUZZO, S., CILIBERTI, R., "Medical Humanities. Recognition and reorganization within the Italian University", Acta Bio-Medica, 88(4), 2017, pp. 512-513.

68 OREFICE, C., PEREZ, J., BANOS, J.-E., "The presence of humanities in the curricula of medical students in Italy and Spain", Educacion Médica, 20(S1), 2018, p. 81.

1970s: that is when most German universities offer an optional lecture course in the history of medicine and a mandatory medical terminology course assessed by QCM[69]. In the 1980s, this history course is complemented with medical ethics teaching, sometimes dispensed by medical historians (as in Münster), or by philosophers (as in Mainz; in this case, the course is called "Theory of Medicine"), within philosophy departments or through dedicated programs (e.g. The Göttingen "*Akademie für Ethik in Medizin*"). In the 1990s, "Institutes of history of Medicine" changed names and became "Institutes of Medicine History and Ethics"; the first of these entities was created in Cologne in 1994[70]. It may be noted that, unlike in Switzerland at the same time, ethics was linked to the activity of preexisting Institutes of Medicine History. As is the case in the UK, Italy and France, this period is one of renewal culminating in 2002 with the enactment of a new *Approbationsordnung* which creates a new *mandatory* cross-cutting module, the GTE (*Geschichte, Theorie und Ethik der Medizin*), which includes courses in history, "theory" (i.e. essentially philosophy) and medical ethics. The 2002 ÄApprO describes the knowledge of "intellectual, historical and ethical foundation of the physician's professional behavior" as a crucial objective. In Germany, medical studies are divided in two phases: one two-year phase of theoretical, pre-clinical curriculum (*Vorklinik*) ending with the first part of the *Staatsexamen*, and a four-year theoretical and practical curriculum (*Klinik* and *Praktisches Jahr* for the last year), validated by the second part of the *Staatsexamen*. The "GTE" program usually takes place during the second phase of medical studies and includes a lecture course, sometimes complemented with interactive seminars or workshops[71]. Classes are 1 to 6 hours per week and are generally aggregated within one semester[72]. Themes are extremely diverse and vary according to departments: the most frequent are the history of medicine under Nazism, the history of ancient and medieval medicine, the study of concepts of disease and health, medicine epistemology, as well as, most important, end-of-life ethics, patient autonomy and some specific bioethics issues[73]. The extensive autonomy of German universities in terms of curriculum largely explains the differences observed between the various GTE programs, since they also depend on local collaboration dynamics, whether GTE teaching involves anesthesiology, hospice, psychiatry etc. departments as is often the case[74].

For example, in 2012 at Ulm University, the program included a 10-hour introductory seminar in the fourth year (organized within one day), a 1-hour per week lecture course in the fifth year (for a total of 10 hours of class), and a 14-hour follow-up seminar dispensed over two days[75]. Compared to other subjects, these 34 hours of teaching are significant: the hourly volume is almost the same as for dermatology, for instance. It appears that Ulm University focuses more on the "theory" (philosophy) of medicine than other entities, with a real attempt by professors to unify a teaching that is often fragmented between its three components.

In every university, "GTE" teaching is followed by a mandatory assessment prior to the second part of the *Staatsexamen* at the end of the sixth and last (?) year of studies. In most - not all - universities, a professorial chair is exclusively dedicated to GTE teaching. The course organization varies: within the three components, ethics often has priority (50%, on average, of the teaching volume), followed by history (35%) and "theory" (15%). This distribution also applies to the assessment: ethics has the largest place here as well. The assessment generally (in 50% of cases) consists of an QCM exam, sometimes complemented with essays, oral presentations in the classroom, or case studies[76]. Optional opportunities for further study also exist: for example, the University of Würzburg offers an extensive curriculum in human sciences based on the abandoned "*Philosophicum*" model, an initial course in philosophy and the humanities validated by an examination giving access to the German medical curriculum until the middle of the 19th century and replaced with the "*Physicum*" (*Vorklinik*)[77].

The main issues faced by German medical schools pertain to the scarcity of positions dedicated to GTE teaching (an issue shared by many French schools), insufficient hourly volume (much lower than in France and, most important, absent from the first cycle of studies)[78], and the lack of recognition of the GTE by physicians but also by students, which seems to be a problem in all countries described here.

Belgium: two examples resembling the French case

In Belgium, human and social sciences teaching in the medical schools of the French Community (*Communauté française*) seems to be very similar to the French system. In this article, we will only give two examples: the *Université Catholique de Louvain* and the *Université Libre de Bruxelles*.

At the *Université Catholique de Louvain*, the teaching of ethics is extensive, as is the case at the Université Catholique de Lille in France. The "bachelor's" in medicine of UC Louvain, which corresponds to the first cycle of studies, lasts three years and includes an important module called "Contextual Approach to Health and Illness" in the first year. There are classes in philosophy (30 hours), epidemiology and public health (50 hours), statistics (50 hours) and psychology (50 hours); the total hourly volume of this program far exceeds the average 65 hours allocated to the UE 7 of the French PACES, even if we do not take into account the teaching of statistics which is not part of UE 7 in France. In the second and third years, (mandatory) modules to be chosen in human sciences are also part of the curriculum, with a significant predominance of psychology. In Louvain, following the "Bachelier", the "Master's in medicine" (corresponding to the French DFASM) lasts three years and gives an extensive place to ethics, sociology and medical law taught in the first year (two classes of 15 and 24 hours). An interdisciplinary module aimed at teaching the "care relationship" is also integrated into the curriculum. It corresponds in part to the French UE 1 of the DFASM called "Learning Medical Practice and Interprofessional Cooperation". These teachings are continued and detailed in the second year of the "Master's" based on internship experiences; students are invited to share the issues they faced during their clinical internship. Several optional courses are offered, including courses involving the performing arts (film, theater). Finally, during the first year of the "Master's", UC Louvain adds a mandatory 15-hour course in "Religious Science" on themes mixing Christian theology, medical ethics, and health.

At the Université Libre de Bruxelles (ULB), the first year of the "Bachelier de médecine" includes a 46-hour "human science" course mixing psychology and epistemology; as in Louvain this course is mandatory

69 HICK, Ch., "Éthique médicale ou histoire de la médecine? Le nouveau contexte allemand de l'enseignement des sciences humaines et sociales en médecine", in BONAH, Ch., RASSMUSSEN, A., *op. cit*., p. 56.

70 Ibid., p. 57.

71 SCHULZ, S., et al., "How Important is Medical Ethics and History of Medicine Teaching in the Medical Curriculum? An Empirical Approach towards Students' Views", *German Medical Science Journal of Medical Education*, 29(1), 2012, D8.

72 SCHILDMANN, J., et al., "History, Theory and Ethics of Medicine: The Last Ten Years. A Survey of Course Content, Methods and Structural Preconditions at Twenty-nine German Medical Faculties", *German Medical Science Journal of Medical Education*, 34(2), 2017, D23.

73 Ibid.

74 Ibid.

75 POLIANSKI, I. J., FANGERAU, H., "Toward "harder" medical humanities: moving beyond the 'two cultures' dichotomy", *Academic Medicine*, 87(1), 2012, pp. 121-126.

76 SCHILDMANN, J., *art. cit.*

77 See BOHRER, Th., *et al.*, "Medizinstudium: Die Schwester der Medizin", Deutsche Ärzteblatt, 107(51-52), 2010; BOHRER, Th., et al., "Zur Notwendigkeit der Philosophie im Medizinstudium", *Deutsche Medizinische Wochenschrift*, 143(17), 2018, pp. 1272-75.

78 Schulz *et al., art. cit*., regret that the teaching of GTE is not dispensed earlier in the German medical curriculum, particularly in the first semester of studies.

and complemented with a 24-hour course in public health and health economy. Here again, the total hourly volume is slightly over that of the French UE 7 even though the difference is less significant than with the Université de Louvain. In addition, it should be noted that the distribution of teaching hours favors human sciences over public health, which is not systematically the case in France. In the second and third years of the "Bachelier", human science courses are absent from the standard curriculum offered by ULB, while most French medical schools still require minimum human science and ethics education after PACES. At ULB, "Master's" students follow a 50-hour interdisciplinary course in social and legal medicine that describes the Belgian healthcare system, apparently without ethical or philosophical components.

WHAT ARE THE CHALLENGES FOR "MEDICAL HUMANITIES" OUTSIDE OF WESTERN COUNTRIES?

Our overview of medical humanities teaching essentially focused on western countries; however, this does not mean that the issue of (re)introduction of "humanities" into medical schools is exclusively a western issue. Moreover, it is totally false to pretend that this is an "issue for rich countries", a sort of pedagogical luxury reserved for only developed countries. Introducing the medical humanities into physicians' education in less developed countries should not be delayed; on the contrary, the case of healthcare systems where resources are limited and health services absent or rare shows that the medical humanities are never a luxury and always a central part of the "general intelligence" of complex situations faced by health professionals[79]. Where technical or administrative aspects of healthcare are missing (lack of means, political instability and chronic conflicts, uneven territorial fabric of health infrastructures, patient therapeutic wandering because of a need to multiply recourse to obtain care, etc.), human and social sciences are all the more necessary to learn how to manage the guidance of patients, their pain, and their distress, as noted by Marie Cauli. Human science tools enable physicians to adapt their practice to such difficult social and economic environment, such family situations, such cultural specificities. In this sense, "humanities" could provide physicians with the reflexive skills they need to nourish and fine-tune their care methods and professionalism threatened by a defective system. In particular, anthropology and sociology can teach us precious concepts on the numerous ways of adapting care *in context*. If healthcare professionals have a role to play in the development of society, if they have a "social responsibility" as maintained by OMS[80], it cannot be adequately developed without the support of the medical humanities. Therefore, strengthening human and social sciences in medical schools is necessary, not only in the Northern, developed countries; on the contrary, it appears to be a real opportunity to concretely improve doctors' education and care quality in less developed countries. Since 2010, several initiatives have been conducted in this regard by the *Fonds de Solidarité Prioritaire* (FSP, Priority Solidarity Fund) of the French Ministry of Foreign Affairs in 17 countries in Africa and South-East Asia. The Mother-Child FSPs in Dakar and at Gaston Berger University in Saint-Louis (Senegal) were able to finance an educational project using a cultural and anthropological approach to disease and care, as well as teachings in perinatalogy aimed at restoring consideration of the vulnerability specific to sick children[81]. A similar project conducted in partnership with the NGO *Santé Diabète* is currently underway at the University of Bamako;

79 CAULI, M., "L'apport des SHS dans la formation des professionnels de santé en Afrique: une expérience dans le cadre du FSP mère/enfant", Santé publique, 6(25), 2013, pp. 857-861.

80 BOELEN, Ch., "Consensus mondial sur la responsabilité sociale des facultés de médecine", Santé Publique, 23(3), 2011, pp. 247-50.

81 CAULI, M., art. cit.

the Chair of Philosophy at the hospital headed by Cynthia Fleury supported their school of medicine in the implementation of health humanities education, with a particular focus on the issue of chronic diseases[82].

"Exporting" the medical humanities, for instance in the context of projects of development aid such as those described above, is in itself paradoxical and should be carefully considered. Are the "humanities" European? The question of "universal" humanities and humanism is doubled in the medical humanities, because they must not only adapt to the multiplicity of every care *situation*, but also to the singularity of every care relationship. So, how can we describe care and values in the plural without reducing their scope? Although they can undoubtedly claim to enlighten medicine from a perspective of a general and not only specific "humanist" knowledge, the medical humanities are supposed to infuse into the practice of health professionals the ideas and values of a culture and should always be also set in context[83]. We should promote teachings that include human and social sciences into future physicians' education; however, let us avoid creating a new type of imperialism in the process. The challenge of the medical humanities is precisely to remain outside of plain relativism while striving to adjust to every region of the world, every country, every local tradition and, in fine, every individual, while keeping a common requirement of doing the best we can with what exists[84]. For example, this logic of cultural contextualization led to the creation, in January 2019, of a University Diploma called "Ethics and Health Practice: The Contribution of Creole Societies" at the Université des Antilles, in collaboration with *Espaces de Réflexion Éthique Régionaux de Guadeloupe et de Martinique*.

Obviously, the effort to contextualize the medical humanities is not easy and could be rapidly blocked if it is not supported by universities and States. The examples of China, Taiwan and Hong Kong are quite clear on this point. Y. Qian *et al.* present the teaching of the medical humanities in China as aimed at a "humanistic" and "moral-oriented" education for future physicians which requires "self-discipline" and the knowledge of the "practicalities" of the medical profession. These rather diverse elements clearly indicate a view of the medical humanities that differs from the idea currently accepted in the United States or in France, for example. However, Qian's article appears to consider Chinese and American "medical humanities" as similar, since he continuously compares the latter to the former while regretting China's "delay" in this matter, which could only make sense by comparison to an international "standard' whose relevance we precisely question here. Nonetheless, medical humanities education is far from non-existent in China since the 2000s: in the ten largest universities in the country courses in "social medicine" and public health are generally dispensed with, in some cases, classes in philosophy, sociology, history or psychology as is the case at Tsinghua University or Fudan University, for example. Based on European criteria, the most exhaustive program is likely that of the University of Beijing where an "Institute of Medical Humanities" was created in 2008[85]. In Taiwan and Hong Kong, the medical humanities are also represented in medical schools: they were introduced in the 1990s-2000s within more general reforms of health and education systems[86].

82 Chaire de Philosophie à l'Hôpital, Rapport d'activité 2016-2018, Paris, 2019.

83 BLEAKLEY, A., op. cit., p. 33.

84 For an example of culturally "contextualized" medical humanities, we can refer to an experiment conducted by the medical school of Alfaisal University in Riyadh: modules on the history of Arab Middle-Age medicine, Arab and Muslim poetry and "Muslim medical ethics" were added to the medical curriculum. ABDEL-HALIM, R. E., ALKAT- TAN, K. M., "Introducing medical humanities in the medical curriculum in Saudi Arabia: A pedagogical experiment", Urology Annals, 4(2), 2012, pp. 73-79.

85 QIAN, Y., HAN, Q., YUAN, W., FAN, C., "Insights into medical humanities education in China and the West", Journal of International Medical Research, 46(9), 2018, pp. 3507-3517.

86 WU, H. Y.-J., CHEN, J. Y., "Conundrum between internationalization and interdisciplinarity: reflection on the development of medical humanities in Hong Kong, Taiwan and China", MedEdPublish, 7(3), 2018, 46.

However, as noted by H. Y-J. We *et al.*, the medical humanities are struggling to emerge fully, whether in China, Taiwan or Hong Kong[87]. With the new competitive international environment for universities and research institutions, the pressure on these academic systems complicates inter-disciplinary collaboration and investments in truly critical and contextual research in the medical humanities. While biomedical and clinical research receives much larger institutional funding and support[88], the lower probability of being able to publish interdisciplinary work (compared to strictly disciplinary work), as well as the lack of specialized professors, are all parameters that limit the development of the medical humanities in China. Last, the weight of ranking and competition logic between universities gave way to a set of metrics to quantify their greater or lesser "success"[89]. It favored "hard science" departments within Chinese universities, over human and social science departments. This of course affects the quality of medical humanities education. The same schemes of competitions and ranking among universities tend to reduce the funding allocated to medical humanities education, whose outcomes are considered impossible to assess; like other types of teachings difficult to evaluate through standardized and systematic methods, the medical humanities are left aside by many universities[90].

It appears that "assessment" would be the solution to integrating human and social sciences in medical curricula, even in competing academic environments, in particular medical ethics which is seen as an inescapable input channel for the cognitive aspects of the medical decision. We will address this issue further in this paper.

87 Ibid.

88 YUN, X., GUO, J., QIAN, H., "Preliminary thoughts on research in medical humanities", BioScience Trends, 11(2), 2017, pp. 148-151.

89 CHOU, C. P., LIN H. F., CHIU, Y., "The impact of SSCI and SCI on Taiwan's academy: an outcry for fair play", Asia Pacific Education Review, 14, 2013, pp. 23-31.

90 WU, H. Y.-J., CHEN, J. Y., art. cit.

MAP OUTLINE OF ETHICS AND HUMANITIES TEACHING IN FRENCH MEDICAL SCHOOLS

An analysis of the national and international context of ethics and health humanities education shows a wide spectrum of issues faced today by governments, universities, professors and students when implementing human and social sciences or ethics education within medical schools. We should now delve deeper into these issues of which we merely scratched the surface. This presupposes that we can rely on a handful of recent, trustworthy information, a sort of 'map' of health humanities, which we will briefly describe here.

TEACHING HUMANITIES IN MEDICAL SCHOOLS: TRENDS, SYMPTOMS AND IDIOSYNCRASIES

Methodological clarification

The information we present below, which constitutes the backbone of what we would readily call a "cartographic survey" of humanities and ethics education in French medical schools, is not the result of a formal and systematic statistical survey, and even less the result of an "evaluation" of this teaching. We only wanted to gather enough relevant information to see major trends, highlights and recurrent symptoms, while trying to adopt as broad and exhaustive a perspective as possible, which is why we chose to focus on all 39 French medical schools. Since we cannot pretend to encompass the entire landscape of health studies in France in this preliminary survey, we have only focused on medical departments and schools.

Medical ethics and the health humanities are the primary object of this survey. We consider that these two essential and non-identical dimensions, as recalled above, deserve to be analyzed separately while being kept together: ethics and the humanities both nourish and must nourish the medical act, each in its own way. Consequently, we will use the term "ethics and the humanities in health" (EHH) to describe the various teachings involving human and social science content in medical studies.

We have relied exclusively on documents available online for free consultation. We primarily used official documents validated by the UFR (*Unité de Formation et de Recherche*, university department for teaching and research, i.e. a school) council of the concerned department or by the President of the University. Among these documents, we preferred texts that define the Testing Methods (Modalités de contrôle de connaissances, MCC) of the 2018-2019 and, in some cases, 2017-2018 academic year. MCCs set the conditions and parameters for examinations which students must take in terms of ECTS (European Credits Transfer System), coefficients, schedule, duration, assessment and compensation. They must be approved by the University Board of Directors and must imperatively be available to students, which makes them a very convenient source of information for an investigator: they are public and likely reliable since legally binding. When freely available online, we also read "teaching booklets", "syllabi", and "programs" for the 2018-2019 academic year. These documents contained lists of courses offered by the departments for each year or for each cycle of studies; this provided a more qualitative insight into the data collected. When neither MCCs nor booklets or syllabi were available online for certain schools or study levels, we supplemented our mapping

survey with information found directly on the schools' institutional websites or, very marginally, with information from student associations or private services websites ("boîtes à colles", private tutoring entities), in the last case cross-referencing our sources as much as possible.

Consequently, we can only warn our reader of the temporary character of the general picture we are about to draw here. While it may be sufficiently comprehensive to be used as a basis for a meaningful analysis, it cannot provide sufficiently solid and secure *foundation* and should be confirmed and supplemented with subsequent investigations and surveys.

Status, hourly volume and distribution of ethics and the humanities in health (EHH)

The first year of medical studies, from PCEM 1 to PACES

SCHOOL	TOTAL HOURLY VOLUME IN 1996 (H) [SHS][1]	TOTAL HOURLY VOLUME IN 2019 (H) [HSH]	HOURLY VOLUME DEDICATED TO EHH[2] (H)	HOURLY VOLUME NOT DEDICATED TO EHH (H)	TEACHING PERIOD
AIX-MARSEILLE	60	64	-	-	S2
AMIENS	70	74	-	-	S2
ANGERS	60	135.66	55.66	80	S1 + S2
ANTILLES	-	64	30	34	S1 + S2
BESANÇON	56	-	-	-	S2
BORDEAUX	62	60	30	30	S1 + S2
BREST UBO	60	58	-	-	S2
CAEN	60	74	32	42	S2
CLERMONT-FERR.	74	70	44	26	S2
CORSICA	-	72	40	-	S2
DIJON	92	57	-	-	S2
GRENOBLE	76	-	-	-	S2
GUIANA	-	62	30	32	S1 + S2
LA REUNION	-	64	-	-	S2
LILLE	78	63	-	-	S1 + S2
LILLE - UNIV. CATHO.	60	54	-	-	S2
LIMOGES	60	70	-	-	S1 + S2
LORRAINE	83	68	21	47	S2
LYON EST	60/66[3]	64	-	-	S2
LYON SUD	60	64	-	-	S2
MONTPELLIER	76	65	-	-	S2
NANTES	80	-	-	-	S1 + S2
NICE	70	64	-	-	S2
PARIS DESCARTES	60	64	-	-	S2
PARIS DIDEROT	60/90	68	46	14	S2
PARIS EST - UPEC	62	55	-	-	S2
PARIS SUD	61	80	-	-	S2
PARIS XIII BOBIGNY	80	-	-	-	S1 + S2
POITIERS	80	-	-	-	-
REIMS	60	71	-	-	S2
RENNES	89	70	-	-	S2
ROUEN	88	64	-	-	S1 + S2
SAINT-ÉTIENNE	72	52	-	-	S2
SORBONNE UNIV.	60/68	60	-	-	S2
STRASBOURG	90	64	43	21	S2
TOULOUSE (P)[5]	90	47	-	-	S2
TOULOUSE (R)[6]	90	47	-	-	S2
TOURS	90	62	-	-	S2
UVSQ	60	46	-	-	S2
OVERALL PICTURE	AVERAGE: 70.6	AVERAGE: 65.2	-	-	S2: 71.8% S1+ S2: 28.2% S1: 0%
	MAX.: 92	MAX.: 135.66			
	MIN.: 56	MIN.: 46			

Fig. 2 – Changes and breakdown of the hourly volume of human and social sciences teaching in the first year in medical schools (1996-2019).

[1] Data from a survey conducted by AUFEMO in 1996, referenced by Louis ARBUS, Yves LAZORTHES and Daniel ROUGÉ in BONAH, Ch., RASSMUSSEN, A. (ed.), *Sciences humaines*, *op. cit*., p. 31.
[2] EHH: Ethics and Humanities in Healthcare.
[3] We provide two values when concerned schools originate from the aggregation of several schools existing in 1996. For example, the medical school of Paris-Diderot University, was created in 2005 from the grouping of UFRs Xavier Bichat and Lariboisière-Saint-Louis; these education and research units did not dedicate the same hourly volume to "general culture" teaching in 1996.
[5] Toulouse (P): Toulouse Purpan School of Medicine.
[6] Toulouse (R): Toulouse Rangueil School of Medicine.
Note: UVSQ: Université de Versailles-Saint-Quentin-en-Yvelines

On average, the total hourly volume dedicated to teaching UE 7 "Health, Society, Humanity" in PACES today is 65.2 hours, according to collected data, compared to 63.8 hours in 2010-2011—the year PACES was implemented—and 70.6 hours and in 1996 for teaching human and social sciences, at the time in first year medical schools (PCEM 1). Excluding the Angers "PluriPass", which offers over 135 hours of courses in human and social sciences, the average hourly volume falls to 63 hours in 2019, or 1 hour less than in 2010. We have opted to exclude the pilot scheme launched in Angers in 2015 for two reasons: first, the total hourly volume of "non-scientific" UEs includes 40% of remote teaching or e-learning, which is significantly higher than in

most schools; second, the "PluriPass" is not a classic PACES: it is a "basic", multi-disciplinary program giving access to various curricula, not necessarily within the healthcare path (law, economics, mathematics, etc.). The choice made in Angers to decompartmentalize the PACES by strongly emphasizing human and social sciences, law and economics, particularly by taking advantage of online education, is therefore an exception in the landscape of the humanities in health education.

If we exclude the Angers "PluriPass", the typical gap in the series is reduced by half, from 15 to slightly under 8. Therefore, the spread is rather low, with almost 85% of schools with a total teaching hourly volume between 55 and 80 hours in 2019, compared to 94% in 2010[91]. Based on data available for 1996, 2010 and 2019, there is, on average, a clear decline in the total hourly volume of teaching human and social sciences; more schools fell below 55 hours of teaching (0 in 1996, 5 in 2019). However, one should not draw hasty conclusions here: in 1996, mandatory Social and Human Science (SHS) education was only present in the first year, which is no longer the case as of 2011 when SHS became part of the core curriculum of the DFGSM, as we indicated above. Nevertheless, in 1996 and until 2009, teaching in PCEM 1 only pertained to human and social sciences; starting in 2009, it included a large number of disciplines and subjects other than the latter (biology, clinical psychology, public health and epidemiology, for example). This is why we tried to precisely identify, whenever possible, the hourly volume dedicated to ethics and the humanities in health within the UE 7. This "specific" hourly volume seems rather variable depending on the schools and it is difficult to draw reliable conclusions given how little information we collected. It is generally not easy to clearly identify the detail and specific nature of the courses in UE 7: titles, and hourly volumes can be vague and unclear. We can simply note that the UE 7 is often split between a "public health" division and a "human and social science" division; schools present the module titled "Man and His Environment" in various ways, either from an anthropological or biological perspective. In some schools, the "public health" division is still rather "medical", as is the case, for example, at the Antilles school, where programs mostly pertain to epidemiology, legal medicine, occupational medicine and emergency medicine; therefore, it is irrelevant to speak of UE 7 as a "human sciences" or "humanities" Education Unit.

Today, HSS teaching is dispensed in the second semester of the academic year in almost 72% of the schools. In any case, it is never taught only during the first semester and, in 28% of the cases, it is taught during the entire academic year. The split between semesters 1 and 2 often matches the disciplinary division between HSS and Public Health. The share of tutorial classes (*travaux dirigés*, TD) in the total hourly volume is rarely mentioned, probably because the UE 7 is primarily taught in lecture courses or seminars, even though some schools organize at least one TD for UE 7, to address methodology issues (among other things), as is the case in Lyon Est, for example. Likewise, the share of remote teaching (*enseignement à distance*, ED) or *e-learning* is difficult to assess systematically. We can simply stress that a precise evaluation of HSS e-learning would be useful. According to M. Gaillard and N. Lechopier, the case of Lyon Est (4 hours of e-learning in 2019) showed that in-person, non-video-transmitted classes are important for students; half of them think that broadcasting courses in multiple amphitheaters is detrimental to their learning[92].

91 VISIER, L. Collège des sciences humaines et sociales en santé, "Enquête sur l'UE7 (SSH) dans la première année des études de santé," summary note cited above.

92 GAILLARD, M., LECHOPIER, N., art. cit., 2015, p. 28.

The first cycle (DFGSM2, DFGSM3)

SCHOOL	DFGSM2			DFGSM3		
	EHH	MANDATORY (H)	OPTIONAL (UEL[1], ETC.)	EHH	MANDATORY (H)	OPTIONAL (UEL1, ETC.)
AIX-MARSEILLE	YES	20	1 UEL	NO	0	0
AMIENS	-	-	-	-	-	-
ANGERS	YES	12	1 PATH (65H)	YES	YES	UEL(S)
ANTILLES	-	-	-	-	-	-
BESANÇON	NO	0	0	YES	21	0
BORDEAUX	NO	0	0	YES	20	-
BREST UBO	YES	16	2 UEL	YES	36	2 UEL
CAEN	YES	0	5 UEL	-	EI[2]	-
CLERMONT-FERR.	YES	20	0	YES	39	-
CORSICA	-	-	-	-	-	-
DIJON	YES	0	2 UEL	YES	32	-
GRENOBLE	YES	0	3 UEL	-	EI	-
GUIANA	-	-	-	-	-	-
LA REUNION	NO	0	0	YES	40	1 UEL
LILLE	YES	25.25	6 UEL	YES	21.25	6 UEL
LILLE - UNIV. CATHO.	-	-	-	-	-	-
LIMOGES	-	-	-	-	-	-
LORRAINE	-	-	-	YES	0	1 UEL (30H)
LYON EST	YES	34	UEL(S)	YES	15	-
LYON SUD	NO	0	0	YES	24	-
MONTPELLIER	YES	0	2 UEL (48H)	YES	16	-
NANTES	NO	0	0	YES	76	-
NICE	YES	20	0	YES	0	1 UEL (RESEARCH)
PARIS DESCARTES	YES	0	2UEL (35H)	YES	0	1 PATH (35H) ET 2 UEL
PARIS DIDEROT	YES	20	-	YES	16	-
PARIS EST - UPEC	NO	0	0	YES	44	-
PARIS SUD	YES	-	UEL(S)	NO	0	0
PARIS XIII BOBIGNY	NO	0	0	YES	-	-
POITIERS	NO	0	0	YES	52	-
REIMS	YES	30	0	NO	0	0
RENNES	YES	0	3 UEL	YES	YES	UEL(S)
ROUEN	-	EI	-	YES	-	-

SCHOOL	DFGSM2			DFGSM3		
	EHH	MANDATORY (H)	OPTIONAL (UEL[1], ETC.)	EHH	MANDATORY (H)	OPTIONAL (UEL1, ETC.)
SAINT-ÉTIENNE	YES	34	1 UEL (22H)	YES	24	1 PATH
SORBONNE UNIV.	NO	0	0	YES	10	-
STRASBOURG	YES	11	-	YES	12	1 UEL
TOULOUSE (P)	YES	27	0	NO	0	0
TOULOUSE (R)	YES	27	0	NO	0	0
TOURS	NO	0	-	YES	36	-
UVSQ	YES	16	0	NO	0	0
OVERALL PICTURE	YES: 53.84% NO: 25.64% ABS: 20.51%	AVERAGE (MANDATORY TEACHING) 22.3[3]		YES: 64.10% NO: 15.38% ABS: 20.51%	AVERAGE (MANDATORY TEACHING) 29.68[3]	

Fig. 3 – Breakdown and hourly volume of ethics and the humanities in health teaching in second and third years of the first cycle of medical studies (2019).

[1] UEL: Unité d'enseignement libre (elective). The hourly volume of UELs varies from one school to another, and is often not displayed, which is why we have not reported it here.
[2] EI: Integrated teaching. EHH education (Ethics and the Humanities in Healthcare) is integrated into other programs of a different nature (e.g., ethical or deontological aspects of a specific pathology can be studied within the medical program dedicated to that pathology).
[3] This average is calculated by only taking into account the schools where EHH is actually taught in the concerned year.

Since 2011, HSH teaching is part of the DFGSM core program, which explains why all medical schools, or at least those for which we have data, have implemented a mandatory program involving ethics and the humanities in healthcare, either in DFGSM2 or in DFGSM3. In most cases, this teaching is only offered during one of the two years (usually in DFGSM3); however, some schools such as Strasbourg, Paris Diderot, Lyon Est and Lille have chosen to spread the core courses over the two years. In the second year (DFGSM2), the total hourly volume of core courses is, on average, 22 hours. On average, it amounts to slightly over 29 hours in DFGSM3. Over the entire DFGSM, excluding PACES, mandatory courses in HSH totals, on average, about 33 hours, which is low in view of the ambitious objectives set by the March 22, 2011 Decree. While the spread is rather low for HSH teaching in PACES, where there is a quasi-national standard in terms of hourly volume, the spread is much higher for the DFGSM2 and DFGSM3 years (standard spread higher than 17). Among schools for which data is available, in DFGSM (excluding PACES), 10 dedicate a total hourly volume for HSH teaching lower than 23 hours while in 6 schools this volume is twice as high.

However, this high heterogeneity should be put into perspective, by taking into account the importance of optional courses in human science and ethics taken by a small majority. These optional courses are usually offered for both years; students must make their choices from one single list which remains the same for both years DFGSM2 and DFGSM3. The hourly volume and, consequently the investment required by optional courses can vary significantly: some UEL are only scheduled for about ten hours while others can be closer to 20 hours. Moreover, other electives require much more investment from students, such as the Ancient Latin and Greek classes offered by the Lille school of medicine, that give a very "literal" meaning to the term "humanities in healthcare." Some schools also offer "paths" specializing in ethics and the medical humanities with rather heavy schedules, such as Angers and Paris Descartes, for example.

Consequently, the teaching of ethics and the humanities in healthcare in the first cycle is a fragmented, irregular and fluctuating program, depending on the schools. Contrary to the UE 7 of PACES where programs are, on average, around sixty hours, the hourly volume of HSH teaching is halved starting in DFGSM2. Since

the humanities in healthcare should not be reduced to a mere selection tool for the first year exam, the place and structure of this teaching in the first cycle must be revisited to allow it to become more relevant and consistent with applied medical ethics that should imperatively be addressed in the second cycle, when students begin their hospital internships.

The second cycle (DFASM)

SCHOOL	DFASM1			DFASM2			DFASM3		
	EHH	MAND.[1] (H)	OPTIONAL	EHH	MAND. (H)	OPTIONAL	EHH	MAND. (H)	OPTIONAL
AIX-MARSEILLE	NO	0	0	NO	0	0	NO	0	0
AMIENS	-	-	-	-	-	-	-	-	-
ANGERS	YES	0	UEL(S)	YES	0	UEL(S)	YES	0	UEL(S)
ANTILLES	-	-	-	-	-	-		-	-
BESANÇON	YES	1 MODULE	-	-	-	-	-	-	-
BORDEAUX	NO	0	0	YES	0	1 UEL (30H)	-	EI	-
BREST UBO	-	EI2	-	-	EI	-	NO	0	0
CAEN	YES	253	-	NO	0	0	NO	0	0
CLERMONT-FERR.	YES	0	1 PATH (15H)	NO	0	0	-	EI	-
CORSICA	-	-	-	-	-	-	-	-	-
DIJON	-	EI	-	NO	0	0	NO	0	0
GRENOBLE	YES	1 SESSION	-	-	-	-	-	-	-
GUIANA	-	-	-	-	-	-	-	-	-
LA REUNION	-	-	-	-	-	-	-	-	-
LILLE	NO	0	0	NO	0	0	NO	0	0
LILLE - UNIV. CATHO.	-	-	-	-	-	-	-	-	-
LIMOGES	-	-	-	-	-	-	-	-	-
LORRAINE	YES	-	-	NO	0	0	YES	0	2 UEL
LYON EST	-	EI	-	NO	0	0	NO	0	0
LYON SUD	NO	0	0	NO	0	0	NO	0	0
MONTPELLIER	YES	0	2 UEL	YES	1 SEMIN.	-	-	-	-
NANTES		EI	-	-	-	-	-	-	-
NICE	NO	0	0	NO	0	0	NO	0	0
PARIS DESCARTES	YES	15	0	NO	0	0	YES	1 SEMIN.	0
PARIS DIDEROT	YES	0	1 UEL (30H)	YES	0	1 UEL	YES	0	1 UEL
PARIS EST - UPEC	NO	0	0	-	-	-	-	-	-
PARIS SUD	-	EI	UEL(S) MASTER	NO	0	0	NO	0	0

SCHOOL	DFASM1			DFASM2			DFASM3		
	EHH	MAND.[1] (H)	OPTIONAL	EHH	MAND. (H)	OPTIONAL	EHH	MAND. (H)	OPTIONAL
PARIS XIII BOBIGNY	-	-	-	-	-	-	-	-	-
POITIERS	NO	0	0	-	-	-	-	-	-
REIMS	YES	0	UEL(S)	-	-	-	NO	0	0
RENNES	YES	0	2 UEL	YES	0	2 UEL	YES	0	2 UEL
ROUEN	NO	0	0	-	-	-	-	-	-
SAINT-ÉTIENNE	YES	0	1 UEL (HISTORY)	-	-	-	-	-	-
SORBONNE UNIV.	-	EI	-	-	-	-	-	-	-
STRASBOURG	YES	10	3 UEL	YES	0	3 UEL	NO	0	0
TOULOUSE (P)	YES	2 WORKSHOPS	-	YES	2 WORKSHOPS	-	YES	1 WORKSHOP	0
TOULOUSE (R)	YES	2 WORKSHOPS	-	YES	2 WORKSHOPS	-	YES	1 WORKSHOP	0
TOURS	NO	0	0	NO	0	0	NO	0	0
UVSQ	-	-	-	-	-	-	-	-	-
OVERALL PICTURE	YES: 33.33% NO: 23.08% ABS: 43.59%	MAND: 6 SCHOOLS		YES: 15.38% NO: 30.77% ABS: 53.85%	MAND: 1 SCHOOL		YES: 12.82% NO: 35.89% ABS: 51.28%	MAND: 1 SCHOOL	

Fig. 4 — Breakdown and hourly volume of ethics and humanities in health teaching in the second cycle of medical studies (DFASM) (2019).

[1] Mand: Mandatory course.
[2] Integrated teaching See No. 2, Fig. 3.
[3] In Caen, the mandatory courses must be chosen between two 25-hour modules.
Note: Some schools, including in overseas departments, do not offer DFASM programs, which explains the lack of data regarding these schools.

The extremely fragmented nature of data collected for the second cycle (Figure 4) is a clear indication of how the humanities are of lesser importance in the second cycle of medical studies. The limited quantity of available information shows that, in most cases, teaching the humanities and ethics is not a crucial element of valuation or promotion for medical schools. Since courses in ethics and the humanities are not legally required in the second cycle, they are generally reduced to a few hours scheduled here and there, except in a few rare cases. In DFASM1, 6 medical schools offer mandatory courses in ethics or in human and social sciences. Only a handful of schools offer optional courses. One-third of the schools offer mandatory and optional EHH courses in the first year of the second cycle; 15% offer them in the second year, and only 13% in the third year. The third year is generally fully dedicated to preparing the *Épreuves Classantes Nationales* (ECNi, admissions exams allowing students to choose their specialization in the third cycle).There is practically no time left for human sciences, except for ethics subjects that could be part of the exams. Therefore, ethics is not only non-existent in the second cycle: it is often a sub-component of some UEs, such as UE 1 "Learning Medical Practice and Inter-professional Cooperation. It may also be taught as part of specific teaching blocks, along with deontological or legal matters, for example regarding medically assisted procreation (UE 2), hospice care (UE 5) or organ transplant (UE 7). The Toulouse medical school is an exception insofar as it offers education in medical ethics as a full-fledged, mandatory program in the second cycle, focusing on the decision-making aspects of ethics and subject to evaluation as part of the certificate of clinical skills93. In compliance with the 2013 Decree, it highlights, for almost all UEs, the importance of addressing "technical,

relational and ethical issues in the event of adverse development." However, it is difficult to quantify the exact hourly volume dedicated to these issues in each UE and the share of ethical thinking during hospital internships. Both Toulouse schools of medicine have implemented mandatory clinical ethics workshops that last 1 hour and 45 minutes; they are organized in the various disciplines of hospital internships[93]. In groups of 5, students must present a real or fictive clinical case based on their internship experience by mobilizing classic clinical ethics principals; each group's presentation is then open to discussion: the teaching is intentionally meant as one of the dimensions in learning clinical decision-making.

On this point, one of the main challenges for ethics and the humanities in the second cycle is precisely finding the right balance between teaching nourished and oriented towards practice, which characterizes *externship*, and academic teaching in line with the first cycle. This balance could emerge through a deeper *customization* of the student's path: they could choose to expand, in the classroom, the elements that appeared crucial during their internships; this implies that they could be offered education in ethics and the humanities in health that would be mandatory but open to students' interests and needs. For instance, they could take an optional UE dedicated to ethics in the second cycle, which would give them the option to revisit the philosophical bases of ethics as applied to the clinical field and to the health decision-making.

Weight in the PACES examination and assessment methods for EHH teaching

The PACES examination: methods and weight of human science assessment in the first year

SCHOOL	ASSESSMENT METHODS	ASSESSMENT DURATION (MIN)	ECTS	% OF TOTAL COEFF/
AIX-MARSEILLE	QCM[1], QR[2]	60	-	14.29%
AMIENS	QCM, QR	180	8	12.50%
ANGERS	QCM (MAJORTIY), QROC	>60	13	25%
ANTILLES	-	120	-	10%
BESANÇON	-	-	8	-
BORDEAUX	QCM, QROC[3]	120	9	10%
BREST UBO	QCM, QR (TEXT CONTRACTION, 2 ESSAYS)	210	10	11.67%
CAEN	QCM, QR (TEXT COMMENTARY AND ANALYSIS)	180	10	13.89%
CLERMONT-FERR.	QCM, QR	120	8	11.11%
CORSICA	QCM, QROC	120	8	13.33%

93 NASR, N., "Enseignement de l'éthique dans le tronc commun du deuxième cycle des études médicales: de la mise en place de l'enseignement jusqu'à l'évaluation", *Presentation at the 8th Conference of the Communication Collège des humanités médicales (COLHUM)*, Paris, Université Paris-Diderot, June 27-28, 2019.

SCHOOL	ASSESSMENT METHODS	ASSESSMENT DURATION (MIN)	ECTS	% OF TOTAL COEFF/
DIJON	QCM, QROC	45	-	11.43%
GRENOBLE	-	120	8	14.28%
GUIANA	-	-	8	-
LA REUNION	QCM, QR (DOCUMENT COMMENTARY AND ANALYSIS)	90	6	14.29%
LILLE	QCM, QR (ON PROGRAM OF WORKS)	120	8	20%
LILLE - UNIV. CATHO.	QR, QROC, QR	150	8	14.29%
LIMOGES	QCM, QR	-	8	
LORRAINE	-	-	-	
LYON EST	QR (ESSAY)	180	-	13.33%
LYON SUD	QR (GUIDED ESSAY)	150	-	12.90%
MONTPELLIER	QCM, QR, QROC	180	-	15.63%
NANTES	-	150	-	11.67%
NICE	QCM, QR	60	8	13.33%
PARIS DESCARTES	-	180	-	13.33%
PARIS DIDEROT	QR (EPISTEMO., ETHICS, PSYCHO.), QCM (PUBLIC HEALTH)	>255	-	18.33%
PARIS EST - UPEC	QCM, QR	90	8	15.15%
PARIS SUD	QCM, QROC	105	11	13.33%
PARIS XIII BOBIGNY	-	-	8	-
POITIERS	-	120	-	13.33%
REIMS	QCM, QR	150	8	14.75%
RENNES	QCM, QROC	90	8	11.43%
ROUEN	QCM, QROC	90	-	16.67%
SAINT-ÉTIENNE	QR	60	8	12.31%
SORBONNE UNIV.	QCM, QR	90	-	13.33%
STRASBOURG	QCM, QROC	-	8	11.36%
TOULOUSE (P)	QCM, QR (TEXT CONTRACTION, QUESTIONS, SYNTHESIS)	120	-	13.33%
TOULOUSE (R)	QCM, QR (TEXT CONTRACTION, QUESTIONS, SYNTHESIS)	120	-	13.33%
TOURS	QCM, QR	180	8	13.89%
UVSQ	QCM, QR	120	8	13.50%
OVERALL PICTURE	-	AVERAGE: 124.8	8 ECTS: 46.2% > 8 ECTS: 15.4% ABS.: 38.4%	AVERAGE: 13.83%

Fig. 5 — Assessment methods and weight of human and social sciences teaching in the PACES examination (2019)

[1] QCM (QCM): Multiple choice questionnaire.
[2] QR: Essay question (variable length answer).
[3] QROC: Question requiring a short open answer (precise and concise).

Human and social sciences courses are usually tested in PACES within the UE 7, except in rare cases where they are also part of specific UE courses, such as in Paris, for example (8 hours of courses, tested by QCM together with other subjects during a 1-hour exam). If UE 7 is taught in S1 and S2, the testing is done in two steps, with two separate exams: one in S1 and the other in S2. The exam duration is highly variable: from 45 minutes in Dijon (where HSH teaching is coupled with foreign language learning) to over 4 hours in Paris DIDEROT.

The 2009 decree states that schools must test HSH teaching "at least partly in the form of essays", which explains the presence of QR or QROC exams in all universities, even though QCM testing remains the norm because of its lower cost in materials[94] and its greater uniformity. "True" written exams such as commentaries, essays or dissertations, are not customary and stand out from the rest of the examinations which are systematically given in the form of QCMs, resulting in a double duality between human sciences and biomedical sciences[95]. Tests based on document study or a predefined program based on books are also rare. Most QRs—and, even more, QROCs—are limited to an organized restitution of knowledge, structured by a network of keywords that students must memorize in the short term and be able to define. This method is rather convenient for teachers and markers since testing grids are easy to create, schematically: a given definition is either right or wrong; the required keywords are in the answer, or they are not, etc. There are also more open QRs, that result in a longer exam. They are more aimed at assessing students' debating, problem-solving and thinking skills. For example, at Lyon Est, the UE 7 is assessed by a 3-hour dissertation on topics such as "Is it possible to prescribe happiness?" Or "Are we all equal in the face of disease?"[96]. As noted by M. Gaillard and N. Lechopier, the students' opinion on this type of exams is rather divided: on the one hand, they regret that the UE 7 only too rarely escapes mechanical learning and cramming logic that prevails throughout the exam; on the other hand, they seem wary of the correction that they find "subjective", even "arbitrary" for exercises that are less uniform than QCMs[97]. In any event, it is clear that "open" essay tests such as dissertation imply that students can practice mastering a complex methodology that can only be acquired gradually. Therefore, imposing an essay-type examination to validate the UE 7 is not enough; on the contrary, it could be counterproductive without student monitoring to meet these requirements.

In terms of weight in the admission examination, human and social sciences have a valuable place: they account for 8 ECTS in three-fourth of the schools for which we have data, and amount, on average, to 13.8% of the total exam coefficient. Again, if we exclude the Angers PluriPass where human and social sciences, law and economics have a significant share in the exam (25%), the average weight of SHS falls to 13.5%, with 5 schools above 15%, only 1 at 20%, and 8 below 12%. However, no school reports a weight below 10% in UE 7. In most schools, the weight of HSH fluctuates between 12% and 15% with low dispersion. Compared to the years 1994-2009, when human and social science weighting had to be 20%, we note a marked decline; it should be noted that current HSH teaching is not limited to the human and social sciences.

The specific role played by human and social sciences in the ranking of students in the PACES admission exam is difficult to assess in general and depends on all the parameters described above. On the one hand, introducing SHS in the first year did not favor high school graduates other than those coming from

94 Essay tests must be subject to double correction, which is not the case for QCMs for which correction is automated.
95 VISIER, L., "L'impact des sciences humaines et sociales dans la sélection des futurs médecins", in BONAH, Ch., RASSMUSSEN, A., *Sciences humaines…*, *op. cit.*, p. 41.
96 GAILLARD, M., LECHOPIER, N., *art. cit.*, 2015, p. 31.
97 *Ibid.*

scientific paths; they remain ultra-minorities in medical schools[98]. On the other hand, according to the survey conducted by Laurent Visier in 2004 at the University of Montpellier, the influence of the "SHS factor" in the selection of future physicians is important although not significantly higher than other UE factors[99]. Therefore, it would be wise to question—or at least submit to statistical analysis—the widespread idea that SHS are a "discriminating" discipline for students.

After PACES: from DFGSM to DFASM

SCHOOL	DFGSM2			DFGSM3		
	DURATION (MIN)	METHODS	ECTS	DURATION (MIN)	METHODS	ECTS
AIX-MARSEILLE	120	-	2	0	/	-
AMIENS	-	-	-	-	-	-
ANGERS	>240	QCM, QROC, QR (ESSAY)	-	-	-	-
ANTILLES	-	-	-	-	-	-
BESANÇON	0	/	-	-	-	1
BORDEAUX	0	/	-	-	CC: SYNTHESIS OF A BOOK/ ARTICLE	-
BREST UBO	120	QROC (QUESTIONS ON TEXT)	3	-	-	1
CAEN	0	/	-	-	-	-
CLERMONT-FERR.	-	-	2.5	-	-	5
CORSICA	-	-	-	-	-	-
DIJON	0	/	-	90	CC[1] & CT[2]: QR	4
GRENOBLE	-	-	-	-	-	-
GUIANA	-	-	-	-	-	-
LA REUNION	-	-	-	45	QCM, QROC, QR	-
LILLE	150	QR, QROC	-	-	-	-
LILLE - UNIV. CATHO.	-	-	-	-	-	-
LIMOGES	-	-	-	-	-	-
LORRAINE	-	-	-	0	/	-
LYON EST	X	CC	-	-	-	6
LYON SUD	0	/	-	90	-	6

98 FAUVET, L., MIKOL, F., "Profil et parcours des étudiants en première année commune aux études de santé", Études et Résultats, MENESR et DREES, N°0927, Juillet 2015.

99 Please refer to the result of the analysis by Laurent VISIER in BONAH, Ch., RASSUMSSEN, A., *Sciences humaines*, *op. cit.*, although they should ideally be updated.

SCHOOL	DFGSM2			DFGSM3		
	DURATION (MIN)	METHODS	ECTS	DURATION (MIN)	METHODS	ECTS
MONTPELLIER	0	/	-	60	QCM	-
NANTES	0	/	-	-	-	-
NICE	30	-	2	-	-	-
PARIS DESCARTES	0	/	-	0	/	-
PARIS DIDEROT	150	QCM	3	120	QR (2)	4
PARIS EST - UPEC	-	-	-	-	CC & CT	6
PARIS SUD	150	QR (2)	2	0	/	-
PARIS XIII BOBIGNY	-	-	-	-	-	4
POITIERS	-	-	-	90	QCM	-
REIMS	-	-	-	0	/	-
RENNES	0	-	-	-	-	-
ROUEN	-	-	-	QCM	-	4
SAINT-ÉTIENNE	-	QCM, QR	3	-	-	2
SORBONNE UNIV.	0	/	-	X	CC	1
STRASBOURG	45	QCM, QROC	-	-	-	-
TOULOUSE (P)	45	QCM	-	0	/	-
TOULOUSE (R)	40	QCM	-	0	/	-
TOURS	0	/	-	0	CC	4
UVSQ	60	-	-	0	/	-
OVERALL PICTURE	AVERAGE: > 91 MIN:			-		

Fig. 6 — Assessment of mandatory courses in ethics and humanities in health in the second and third years of the first cycle of medical studies (DFGSM) (2019).

[1] CC: Assessment through continuous testing.
[2] CT: Assessment through final testing (exam).

The scattered data we have collected on the assessment of the HSH module and more generally of the mandatory courses in the humanities and ethics in the second and third years of the first cycle confirm the limited space and poor visibility of these subjects after the PACES. Regarding the use of essay questions, the observations made above on the PACES year also apply here; QCM tests tend to be all the more widespread as the 2011 decree does not require that departments test HSH teaching in the form of "essay" questions, even minimally. Some departments use assessment through continuous testing rather than a final examination; the methodology for this testing is rarely specified in the data we collected. Lastly, the very low number of ECTS allocated to courses in the humanities indicates that their weight in medical education is limited and that they are considered less important than other subjects.

We found even less information in the second cycle. The assessment methodology for the rare courses in ethics and the humanities still offered in the DFASM was, in most cases, impossible to examine. Some one-time courses are validated in face to face testing while others require more involvement on the part of the students. However, these courses are generally electives that only concern a handful of students. Consequently, it may be necessary to create a national roadmap for the second cycle, setting out clear objectives and procedures, including testing, for all medical schools. The COLHUM recently suggested the creation of a "core base" of humanities in the second cycle, validated by "a national, mandatory 'essay' examination

included in the final exam in the 5th year", which is similar to the German model described above[100]. Testing methods suggested by the COLHUM are fairly flexible: the exam could be in the form of a dissertation, an analysis of video clips, or a well-argued account of a clinical experience; it should be corrected by a national team of graders who are experts in SHS and include hospital practitioners. Although these suggestions need to be refined, we fully approve the idea of a firm shared "base" for the humanities in the second cycle, since they are still today plagued by a lack of institutional recognition.

Another version of this assessment at the end of the second cycle, centered on medical ethics – already applied in the Toulouse medical schools – could be in the form of an essay (whose topic would change every year) on a clinical situation that created an ethical issue for the student, including the problem-solving process, with a rubric and anti-plagiarism software. In Toulouse, this assessment is part of the certificate in clinical skills, the score of which has been incremented from 25 to 30 to include ethics, and is thus weighted at one-sixth of the overall score (presented by Nathalie Nasr at the 2019 COLHUM Conference).

Complementary education (Master's degrees and university diplomas)

SCHOOL	MASTERS			DU, DIU, ...[1]
	TARGETED MASTER (FLÉCHÉ) EHH[2]	COLLABORATION WITH ANOTHER UFR/ UNIVERSITY	MASTER TITLE	NUMBER OF TARGETED PROGRAMS (FLÉCHÉES) EHH
AIX-MARSEILLE	YES	-	MASTER IN "MEDICAL HUMANITIES"	2
AMIENS	NO	/	/	2
ANGERS	NO	/	/	1
ANTILLES	NO	/	/	1
BESANÇON	NO	/	/	1
BORDEAUX	YES	-	MASTER IN PHILOSOPHY, "CARE, ETHICS AND HEALTH (BORDEAUX III)	1
BREST UBO	YES	-	MASTER IN "ETHICS, CARE AND HEALTH"	1
CAEN	YES	YES	MASTER IN PUBLIC HEALTH, "ETHICS IN HEALTH" PATH "ETHICS IN HEALTH"	-
CLERMONT	NO	/	/	2
CORSICA	-	-	-	-
DIJON	NO	/	/	1
GRENOBLE	NO	/	/	1
GUIANA	-	-	-	-
LA REUNION	-	-	-	-
LILLE	NO	/	/	-
LILLE - UNIV. CATHO.	-	-	MASTER IN "INNOVATIONS IN HEALTH" UNDER DEVELOPMENT (SEPT. 2020)	7
LIMOGES	NO	/	/	1
LORRAINE	-	-	MASTER IN PUBLIC HEALTH, "ETHICS IN HEALTH" PATH "ETHICS IN HEALTHCARE, PUBLIC HEALTH, AND NEW TECHNOLOGIES"	2
LYON EST	YES	YES	MASTER IN "LOGICS, HISTORY AND PHILOSOPHY OF SCIENCES AND TECHNIQUES" (LYON I, LYON III) / MASTER IN PHILOSOPHY "CULTURE AND HEALTH" (LYON III)	1 (LYON III)
LYON SUD	NO	/	/	1
MONTPELLIER	YES	-	MASTER "HEALTHCARE, THE HUMANITIES, SOCIETY"	1
NANTES	YES	YES	MASTER "ETHICS"	-
NICE	NO	/	/	2
PARIS DESCARTES	YES	-	MASTER IN "MEDICAL ETHICS, HEALTHCARE AND BIOETHICS"	1
PARIS DIDEROT	YES	YES	MASTER "LOPHISS", DOUBLE CURRRICULUM ENS MEDICINE-HUMANITIES (USPC)	0
PARIS EST - UPEC	YES	YES	MASTER IN PHILOSOPHY, "APPLIED MEDICAL AND HOSPITAL ETHICS" (PARIS EST UPEM-UPEC); MASTER IN "THE MEDICAL HUMANITIES (RESEARCH)	1
PARIS SUD	YES	-	MASTER IN "ETHICS" (COUPLED WITH ERER)	-
PARIS XIII BOBIGNY	NO	/	/	0
POITIERS	NO	/	/	3
REIMS	NO	/	/	1
RENNES	NO	/	/	2
ROUEN	NO	/	/	2
SAINT-ÉTIENNE	YES	YES	MASTER IN "MEDICINE AND SOCIAL SCIENCES" (ENS LYON); MASTER IN "HEALTH CHALLENGES AND POLICIES" (SCIENCES PO LYON, VETAGRO SUP LYON)	-
SORBONNE UNIV.	NO	/	/	0
STRASBOURG	YES	-	MASTER IN "ETHICS" (COUPLED WITH ERER, SEVERAL PATHS); MASTER IN POLITICAL SCIENCES "HEALTH, ENVIRONMENT, POLITICS" (IEP STRASBOURG/SCHOOL OF MEDICINE)	-
TOULOUSE (P)		-	-	-
TOULOUSE (R)	YES	YES	MASTER IN "HEALTHCARE AND RESEARCH ETHICS" (TOULOUSE I, II, III)	1

Fig. 7 — Additional teaching programs in ethics and in the humanities in health within or outside of French medical schools (2019).

[1] University diplomas (Diplômes universitaires, DU), inter-university diplomas (Diplômes inter-universitaires, DIU), short programs, certificates, etc.
[2] We are not taking into account Masters exclusively pertaining to public health. However, the "Ethics" paths of some public health Masters are part of the scope of our survey.

100 "COLHUM, Sur la formation en SHS dans le futur 2e cycle des études médicales", 16 January 2019. (Online: https://colhum.hypotheses.org/809, last consulted on June 6, 2019.]

A growing number of Masters specifically dedicated to the humanities in healthcare or to medical ethics have been implemented recently in most large university cities. Therefore, it is fortunate that this type of education is increasingly accessible to students in this country, even though several Masters remain only open to healthcare professionals who are already active and wish to acquire specific knowledge in ethics or the humanities. The topics most frequently addressed by these Masters are medical ethics, the notion of "care" and its various philosophical ramifications, and the political and technological challenges of tomorrow's healthcare services. However, many medical schools remain on the outskirts of this movement: a least 18 universities are not offering a master's degree in ethics and in the humanities. Some Masters, such as the Master in "Medical Humanities" at Aix-Marseille University, are organized directly by the medical school, while others are linked to other UFRs or universities in the same city, such as in Bordeaux, where the Master in "Healthcare, Ethics and Health" open to medical students is taught by Bordeaux-Montaigne University (Bordeaux III) in lieu of Bordeaux University of which the medical school is a part. It is also the case in Lyon, where the Master in "Culture and Health" is part of Lyon III University. Conversely, at Paris-Diderot University, the "Lophiss Master" is part of the Department of Science History and Philosophy in a collaboration mechanism between UFRs. Even though an evaluation of the concrete modalities of these inter-university and inter-UFR collaboration mechanisms is difficult, such cross-cutting initiatives should certainly be encouraged. Medical schools would benefit from building bridges with human science department if they can't create a department of humanities of their own. Lastly, some Masters in Ethics are combined with regional ethical thinking entities (Espaces de Réflexion Éthique Régionaux, ERER) that serve as exchange platforms between hospitals, medical schools and ethics education programs. This is the case at Paris Sud and in Strasbourg.

The creation of masters in the humanities in health and medical ethics and the increasing number of continuous education programs (DU, DIU, etc.) dedicated to these subjects, should be hailed as a breakthrough. Although it is regrettable that several masters degrees are still anchored in a different discipline—usually public health —, these "complementary" but necessary teaching programs show that the humanities can be something other than a selection tool in the first year, or a polish intended to restore the image of the biomedical sciences. Masters and DUs give the humanities in health a new institutional role anchored both in their professionalizing dimension for practitioners and in their potential for enriching research. Moreover, these programs have the advantage of being often accessible to healthcare professionals, physicians or others. While these programs are optional and offer rich parallel paths, they are still chosen by a minority of students. For these paths to be traveled more in the future, they should be better promoted, supported and valued throughout the entire country by the higher education system.

Teachers, teaching programs, research

SCHOOL	SHS TEACHERS[1]	SHS TEACHERS AFFILIATED/NOT AFFILIATED WITH THE MEDICAL SCHOOL[2]	SHS DEPARTMENT PART OF THE MEDICAL SCHOOL
AIX-MARSEILLE	YES	1 PU[3] PHILOSOPHY	DEPT. HUMAN AND SOCIAL SCIENCES
AMIENS	YES	1 MCU[4] HISTORY OF SCIENCES	EPISTEMOLOGY, HISTORY OF SCIENCES AND TECHNIQUES UNIT
ANGERS	YES	1 MCU HDR PHILOSOPHY 1 MCU SOCIOLOGY	NO
ANTILLES	NO	/	-
BESANÇON	-	-	-
BORDEAUX	YES	1 PU PHILOSOPHY, 1 MCF SCIENCES OF EDUCATION NOT AFFILIATED: PU/MCF ANTHROPO., SOCIO., ETHICS	NO
BREST UBO	YES	1 MCU SOCIOLOGY [1 MCU ANTHROPOLOGY, CANCELLED] NOT AFFILIATED: 1 MCF PHILOSOPHY	NO
CAEN	YES	1 MCU SOCIOLOGY	NO
CLERMONT	-	-	-
CORSICA	NO	/	-
DIJON	YES	NOT AFFILIATED: 1 MCF SOCIOLOGY	-
GRENOBLE	-	-	-
GUIANA	-	-	-
LA REUNION	-	-	-
LILLE	YES	1 MCU PHILOLOGY 1 MCU ANTHROPOLOGY	NO
LILLE - UNIV. CATHO.	YES	ETHICS TEAM (EA 7446): PHILO., SC. OF EDUCATION	-
LIMOGES	-		-
LORRAINE	YES	1 MCU LAW 1 MCU SOCIOLOGY	NO
LYON EST LYON SUD	YES	1 PU, 1 MCU HDR, 2 MCU PHILOSOPHY, 1 MCU HISTORY OF SCIENCES, 1 MCU ANTHROPOLOGY.	COLLÈGE DES HUMANITÉS ET SCIENCES SOCIALES
MONTPELLIER	YES	1 PU SOCIOLOGY, 1 MCU PHILOSOPHY	DEPT. OF HUMAN AND SOCIAL SCIENCES IN MEDICINE
NANTES	YES	NOT AFFILIATED: 1 MCF PHILOSOPHY	NO
NICE	YES	NOT AFFILIATED: 1 PU PHILOSOPHY	DEPT. ETHICS AND HUMAN SCIENCES
PARIS DESCARTES	-	LEM TEAM (EA 4569) CERMES TEAM3	-
PARIS DIDEROT	YES	NOT AFFILIATED: SEVERAL MCF IN PHILOSOPHY, HISTORY OF SCIENCES, ANTHROPO., LITERATURE, ETC.	DEPT. OF HISTORY AND PHILOSOPHY OF SCIENCES (SEPARATE FROM THE SCHOOL)
PARIS EST - UPEC	YES	1 MCU PHILOSOPHY, UPEC/UPEC TEAM NOT AFFILIATED: 1 MCF HDR PHILOSOPHY	-

SCHOOL	SHS TEACHERS[1]	SHS TEACHERS AFFILIATED/NOT AFFILIATED WITH THE MEDICAL SCHOOL[2]	SHS DEPARTMENT PART OF THE MEDICAL SCHOOL
PARIS SUD	YES	1 PU MEDICAL ETHICS + ETHICS SPACE TEAM/ES3 EA1610	DEPT. OF RESEARCH IN ETHICS
PARIS XIII BOBIGNY	YES	IRIS TEAM (UMR 8156): SOCIO., LAW, ETC.	-
POITIERS	-	-	-
REIMS	-	-	-
RENNES	YES	1 MCU PHILOSOPHY	NO
ROUEN	YES	NOT AFFILIATED: 1 PU SOCIOLOGY	-
SAINT-ÉTIENNE	YES	NOT AFFILIATED: TRIANGLE TEAM (UMR 5206): SEVERAL MCF SOCIO./SC. POLITICS	-
SORBONNE UNIV.	YES	1 PU PHILOSOPHY 1 MEDICINE/ETHICS RESEARCHER	DEPT. OF ETHICS
STRASBOURG	YES	1 PU HISTORY, 3 MCF HISTORY, SEVERAL ATER/POST-DOC.	DEPT. OF HISTORY OF LIFE SCIENCES AND HEALTH
TOULOUSE (P)	-	-	-
TOULOUSE (R)	-	-	-
TOURS	YES	2 LECTURERS IN PHILOSOPHY	-
UVSQ	YES	1 MCU HDR PHILOSOPHY	-

Fig. 8 — SHS teachers in French medical schools: overview (2019).

[1] Human and social sciences teachers (philosophy, sociology, history, political science, law, literature, etc.) teaching in the first and second cycles of medical studies.
[2] We make a distinction between teachers directly affiliated with the medical school (i.e. hired by the medical school) and those who teach in the medical school while being affiliated with another institution or a different UFR within the same university.
[3] PU: University professor (*Professeur des Universités*).
[4] MCU: University Master Lecturer (*Maître de conférences des Universités*): this acronym is generally used for master lecturers who are hospital practitioners (MCU-PH). We are using this acronym to make a distinction between master lecturers affiliated with medical schools (MCU) and master lecturers affiliated with other UFRs (abbreviated as MCF).

Today, most schools—25, according to our survey, or maybe more if we take into account the missing data—hire teachers trained and specialized in human and social sciences. Only 20 schools have certified teachers *qualified* for human and social sciences who are members of the school faculty, while in other cases teachers are affiliated with different schools or universities, most often with Human Science UFRs of the same university. Therefore, it appears that inter-UFR or inter-university collaboration is increasing, which confirms what we described above regarding master's degrees. However, it is advisable that in the long term, medical schools hire teachers-researchers in the humanities specifically responsible for participating in future physicians' education, so that the latter can devote themselves to enriching, through research, a high quality humanities program that would not be "stuck on" medical studies but integrated as an inherent element of medical studies. In this perspective, targeted financing from the Ministry of Higher Education could be beneficial if we design a mixed system in which financing is not automatically allocated by the Ministry, but dependent on schools' proposals in line with research and teaching programs they wish to develop. Based on the new skills in human and social sciences that will need to be taught and assessed at the end of the second cycle as part of the "Objective and Structured Clinical Exams" (Examens Cliniques Objectifs et Structurés, ECOS) foreseen in the ongoing reform, it would be advisable for all medical schools to have teachers specializing in the humanities instead of barely 20 of them as is the case today. We think this is essential to guarantee not only the quality of teaching and assessments, but also some geographic equity between schools. It is also worth pointing out that we can reasonably expect that the anticipated changes in medical school programs will result in an increase of the number of physicians who have a complementary education in human and social sciences; with the help of their non-physician colleagues specializing in human and social sciences, they will be able to provide this education in medical schools as part of *onsite* clinical reasoning and decision-making practice. There is currently a shortage of physicians with such qualifications.

As shown by a 2006 study by the AUFEMO (*Administration Universitaire Francophone et Européenne en Médecine et Odontologie*, Francophone and European University Administration in Medicine and Odontology), university hospital teachers were generally much more numerous in the past (78%) and taught almost half of the humanities programs. Based on the data we collected, it is difficult to precisely describe how the situation has evolved since then. Obviously, these programs are still conducted or coordinated by physicians in many medical schools, particularly in PACES, but we could assume that the share of non-physician teachers has grown and, more importantly, is increasingly institutionalized. Actual humanities departments have been created in some medical schools; moreover, where fifteen years ago there were mostly PRAG (Professeur agrégé, associate professor) and contract positions, there are more and more master lecturer positions dedicated to teaching the humanities in health. Nonetheless, professor positions are still rare, which raises the question of the progress and structure of teaching careers in the humanities within medical schools. Additionally, SHS teachers in medicine who are qualified for conducting research are also rare, which is another sign of the recent character of this field of study.

The most frequent subjects taught by teachers in SHS in medicine are philosophy and sociology, followed by the history of sciences, anthropology and law. Some schools place greater emphasis on social sciences, such as in Bordeaux, where PACES courses, in particular, are centered on anthropology, sociology and the history of health, while others have teams who are more diverse or more oriented towards the humanities. Some schools advertise a clear specialization, as in Strasbourg where the history or science and medicine is particularly well-represented, or at the Université Catholique de Lille, where the ETHICS (EA 7446) unit focuses on research in medical ethics and three chairs of ethics have been created since 2015 ("Ethics, technology and transhumanisms", "The Ethics of Influence", "Law and Ethics of Digital Health"). In general, several universities host laboratories or research units that provide experts able to participate in physicians' education. This is the case at Paris Descartes (*Laboratoire d'Éthique Médicale et de Médecine Légale*, EA 4569; *Centre de Recherche médecine, Sciences, Santé, Santé mentale, Société*) and in Lyon (S2HEP, *Sciences, Société, Historicité, Education, Pratiques*, EA 4148). Therefore, a network of research and teaching emerges in most large university cities. They include the humanities departments of the schools of medicine, certain other schools or education institutions, research laboratories specializing in the humanities and ethics, and, in some cases, the Regional Ethical Reflection Entities.

However, a clear gap remains between major schools that have their own SHS teaching teams or benefit from the proximity of laboratories or universities employing experts as in Paris, Lyon and Strasbourg, and the "small" schools in the rest of the country and in overseas departments that have fewer students and smaller teaching teams dedicated to SHS or biomedical subjects. This explains the shortage of data for most of these schools such as Poitiers, Reims, Grenoble and Limoges.

The tricky question of teaching contents. Unifying and "dialecticizing" the teaching of the humanities: two major challenges

This paper is not intended to fully address the issue of teaching contents in ethics and the humanities in health: they vary greatly from one school to another, and they are difficult to evaluate in view of the scarcity of freely available information on this topic. Likewise, we do not wish to list the numerous teaching innovations implemented in France and abroad over the last few years in the

area of the humanities in health. Many successful initiatives have incorporated cinema, literature and even music in healthcare studies. Even though they remain on the sidelines of the core curriculum, these initiatives should be encouraged: any sustained pedagogical experimentation and interdisciplinary effort will help identifying the most relevant teaching methods for this fragile field of study.

Regarding the content of SHS teaching in the core medical curriculum, two major pitfalls appear to be recurrent:

1. The significant heterogeneity and the lack of consistency between contents taught over the entire initial course of medical studies;
2. The risk of robbing the humanities in health from their specific issues and humanistic character since they are seen by students in passive ingestion mode and mechanically restored following a more or less intense cramming phase.

These two pitfalls demand two initiatives: unifying ethics and the humanities education using a flexible, but strong thread; "dialecticizing" this teaching to promote a critical, living, dialogical usage of the contents while always keeping them in perspective and *actively* incorporated. Unifying the teaching in ethics and in the humanities does not mean casting them into an ideological mold. Unifying and dialecticizing go hand in hand: the unity of education we need to implement is not a doctrinal "alignment", but a dialectic and reflexive unity. Therefore, we should remind teachers in the humanities in medicine that their mission is not to preach established opinion, however brilliant they may be, much less a medical "morality" or a sort of knowledge base mixing good values and general culture. Even though the scope of the humanities in health may and should be ethical, their horizon is intellectual before being moral : they must first address argumentation, interpretation and intellectual rigor. Consequently, contents offered in humanities courses should be carefully adapted, crafted, and honed by qualified teachers who have a solid academic education in this field and are able to present relevant areas of questioning rather than their personal theories or precepts received from their masters.

The multidisciplinary character of teachings in the humanities in health is crucial. It is also highly hazardous. Offering a convincing multidisciplinary teaching program is indeed much more constraining than teaching a course defined by traditional milestones based on methodology and theory for a single discipline. Creating multidisciplinary programs is time-consuming and requires significant investment by teachers; otherwise, they will be nothing more than a modest veil of disordered perspectives. There is no *evidence* in communicating knowledge: it must be based on an agreement, a recognition process; it must be constructed, negotiated, *legitimated*. Even though they seem simple, these reflections are extremely complex in practice, which explains why many schools choose to base their programs on the disparate nature of the humanities in health, particularly in PACES where subjects, topics and actors pass through without contact or consulation. Other schools, on the contrary, try as much as possible to follow a thematic guideline in these teachings even if it means leaving out certain aspects of the curriculum. This is the case in Lyon Est where an annual theme is selected in PACES, and at the Université Catholique de Lille, where the teaching of the humanities and ethics is geared towards medical professionalism. In PACES, courses are based on a multi-year theme (cancer, disability, etc.) from which the teachers implement various areas of reflection (on technology, the future of health systems, the care relationship, etc.). In the second and third years, courses are linked to the internship programs and the experience of care practices, in a perspective of "experiential learning" (situational exercises, role playing, self-assessment) intentionally continued in the second cycle, where students receive more in-depth education in clinical ethics.

This approach obviously fosters unity and consistency, although the price for this is a necessary restriction of the pedagogical and methodological teaching framework. This led some schools to consider another option: using a program based on works, as at Université de Lille II, which constitutes a common reference for all stakeholders. In the same line, using a syllabus, as customary in English-speaking schools, a sort of "road map" that provides the course plan, session program and preparatory readings in advance, could help students to find their way through a path that they too often perceive as confusing, baffling, because it is "catch-all". One can also only assume that an introductory course is highly necessary, covering all topics addressed and linking them into a common issue cluster from which students could more easily find their way around.

Indeed, "conceptualization" is essential: it will determine the reflexive and critical potential of the teaching of the humanities in health. However, handouts and photocopies are often considered of quasi scriptural value. The reason is that they are the only sources of content targeted by the tests leading to the admission exam: they define the criteria of what must be "known", meaning being able to *regurgitate*, by heart and unmistakably. As a result, we see paradoxical "commodification" and "dehumanization" of the humanities, particularly in PACES, caused by the teaching and assessment system that govern them. At a time when our healthcare systems and the relationship between patients and healthcare providers seem unable to resolve the crisis they are in, it is urgent to look beyond the logic of the standardization of humanities teachings and favor a logic of dialectization that will provide a fresh lease on life that is critical, perhaps vital, to healthcare. This implies, of course, that we think of different methods of testing, primarily in PACES, that focus more on argumentation, analysis and synthesis skills, which are indissociable from methodological student supervision to help them succeed. We can only hope that the ongoing reform of the first cycle of medical studies take into account these observations; we are adding those of Canguilhem which are, as usual, premonitory:

> Isn't it surprising that medical education addresses all topics, except the essence of medical practice, and that one can become a physician without knowing what a physician is and should be? At the school of medicine, you can learn the chemical composition of saliva and the vital cycle of intestinal amoeba of the kitchen cockroach, while there are subjects certain to be permanently absent from these studies: patient psychology, the vital meaning of disease, the obligations of a doctor in relationships with patients (and not only with colleagues and with the investigating judge), disease and medicine psycho-sociology, etc.

"OUTSIDE THE WALLS" WHAT TEACHINGS ARE AVAILABLE OUTSIDE OF MEDICAL SCHOOLS?

Although teaching the humanities in healthcare is increasingly present in medical schools, with the limitations we described, it is also flourishing elsewhere. We are compelled to mention a constellation of similar initiatives "outside of the walls" of schools of medicine that beautifully participate in the richness and renewal of a rapidly expanding field.

At the university: overview of the humanities in healthcare outside of medical schools

Several departments of human science today offer courses in the humanities in healthcare to medical students and often to human science students. We already mentioned the case of some departments partnering with medical schools to offer Masters degrees in the humanities, philosophy or ethics, as at Bordeaux-Montaigne University (Master in "Care, Ethics and Health"), at Lyon III University (Master in "Culture and Health"), at Toulouse University (Master in "Ethics in Healthcare and Research", horizontal across the three universities, Toulouse I, Toulouse II and Toulouse III) or at Paris-Est Marne-la Vallée (Master in "Medical Humanities", Master in "Medical and Hospital Applied Ethics"), where the Hannah Arendt Interdisciplinary Laboratory of Political Studies (*Laboratoire Interdisciplinaire d'Étude du Politique Hannah Arendt* LIPHA), in a *cotutelle* agreement with Paris-Est Créteil University (UPEC), include a large division of research in ethics. The Sorbonne Nouvelle University (Paris III) offers a one-year university diploma in "Medical Humanities" to all medical students in universities starting from the second year of studies, as well as to already-practicing healthcare professionals. The share of arts and literature in this DU is significant, which is relatively rare in the landscape of the French medical humanities and should be noted.

We also want to mention the example of the Conservatoire National des Arts et Métiers (CNAM) where a Chair of Humanities and Health was created in 2018 as part of the National Pedagogical Team 12, "Health, Solidarity". The chair aims at filling a need for education and research in human and social sciences as applied to the fields of health and care; it promotes an innovative approach to the healthcare practice and to the contemporary mutations of hospitals. With a new model for healthcare education, it is in line with a logic of theoretical and professional openness aimed at structuring and creating a space for exchanges where field experiences, expert theories and societal reflection could be shared.

Born almost at the same time as the Chair of Humanities and Health of the CNAM, the program "Médecine-Humanités" of the École Normale Supérieure (ENS, Paris), a school which traditionally offers multidisciplinary programs, also offers a curriculum in the humanities for some second year medical students recruited based on their records and grades on two short tests, one oral and one written. As a sequel to the "Médecine-Sciences" program opened in 2005, the "Médecine-Humanités" program is sponsored by the Bettencourt-Schueller Foundation—dedicated, among other causes, to financial aid for students—is a part-time program allowing students to obtain, in addition to the classic medical curriculum, a Master in the humanities (philosophy, literature, social sciences, etc.) and a Diploma from École Normal Supérieure. Along with an access to the ENS courses, a specific seminar is offered to the students participating in the program—dedicated in 2018/2019 to the topic of birth—conducted by physicians as well as human science experts.

At the hospital: the non-academic entities offering ethical reflection

In the complex geographic fabric of thinking initiatives in ethics and in the humanities in healthcare, the crucial role played by the Espaces de Réflexion Éthique Régionaux (ERER) should be emphasized. Established by the law of August 6, 2004, ERERs execute missions of education, documentation and information and organize numerous meetings, exchanges and events cross-cutting several disciplines. They are affiliated with university hospitals (centres hospitalo-universitaires, CHU) under supervision by the regional health agencies (Agences Régionales de Santé, ARS). As confirmed by the 2018 Bioethics *États Généraux*, the ERERs play an important role in the "life" of ethics at the regional level, including by linking universities, health institutions and medical-social institutions. Their current and future role in teaching the humanities in healthcare should not be underestimated, particularly their participation in the creation of local work groups and in continuing education for healthcare professionals.

At the hospital level, local clinical ethics committees could also play a significant role. These advisory committees offer a discussion space to practitioners, where they could draft various proposals and recommendations in ethics, targeting the entire institution or specific cases seen as "difficult" by caregivers. Again, these local committees could be a place where awareness and education—self-education— to practicing ethics could really push the humanities in health forward. In general, hospitals today are increasingly hosting training and discussion in ethics platforms, such as "ethics coffee shops": one-time conferences and yearly seminar cycles are now frequently organized in hospital environments and no longer only in classrooms or university auditoriums. It is as if ethics and the humanities have reconquered the clinical practice from which they had been excluded, probably because of misunderstanding. It is as if hospitals had to reclaim their role as promoters of human and of the humanities by teaching these disciplines as close to clinical practice as possible. As an example, some teaching programs by a network of UPEM researchers are now offered at the premises of the Piété-Salpêtrière hospital, under the name "École Éthique de la Salpêtrière".

Hybrid and innovative schemes: emergence of a recent teaching ecosystem and research in the humanities and healthcare

Stretching the return movement of the humanities and, in particular, philosophy, to hospital environments even more, the "Chair of Philosophy at the Hospital", an association based at the "Psychiatry and Neurosciences" of the Paris GHT (Regional hospital group), has been conducting teaching and research events in hospitals, particularly Sainte-Anne and Hôtel-Dieu, since January 2016. The Chair is "reinventing healthcare practice as a shared exercise between physician and patient, between the hospital and the rest of society, particularly schools and universities", including by reintroducing the humanities at the core of healthcare and at the core of hospitals in crisis that also need to be treated. Treating, streamlining and reconstructing hospitals implies that they become a shared space, a common ground. Therefore, the Chair tries, whenever possible, to make its actions open to all and to connect with a maximum number of actors in healthcare and the humanities, whether public or private: the University of Patients, the program titled "La Personne en médecine" (the individual in medicine), the Hospinommics chair, the iLumens Laboratory, and the design agency "les Sismo" (see Fig. 9). In addition, the Chair of Philosophy has launched numerous initiatives in France and abroad by implementing agreements, for instance, with the Clermont-Ferrand university hospital (CHU) (offering a university diploma), the Saint-Antoine hospital in Paris (creation of a Chair of Humanities and Health), and the Bamako hospital, in partnership with the Health Diabetes NGO. However, the Chair of Philosophy is not only a communication platform between existing institutions: it is an educational entity with its own doctoral system primarily affiliated, when it is a *tutelle* (parent entity), with the CNAM's "Abbé Grégoire" doctoral school and able to enroll doctoral students from partner institutions (PSL-ENS Lettres et Sciences, PSL-Mines ParisTech), etc.) for a *cotutelle* degree.

The Chair of Philosophy is also closely associated with another mechanism, the University of Patients, affiliated with the school of medicine of Sorbonne Université. Even though the University of Patients is not, strictly speaking, an entity targeting the education of future healthcare professionals in ethics and in the humanities, we should not ignore this major example of how healthcare relationships are changing. The University of Patients offers a range of diplomas, not to medical students, but, as the name implies, to *patients*, and specifically to expert patients from the associative sector. Created in 2009, the University of

Patients today counts more than 120 patients among its “students” or alumni. Beyond the simple delivery of a diploma in therapeutic education, the University of Patients expands patient expertise by validating their *professional* role within the healthcare practice, as pivotal elements in the guidance of other patients, as well as healthcare providers.

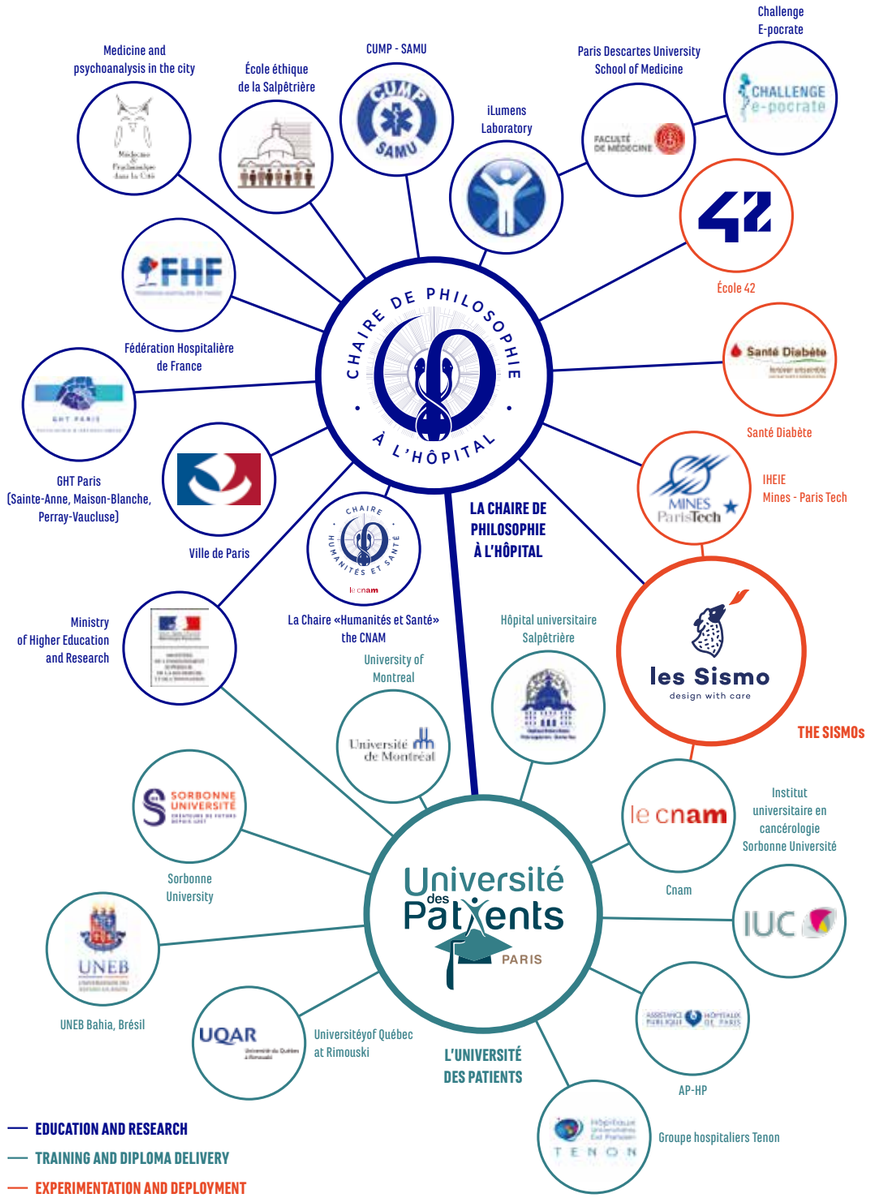

Fig. 9 — *Chair of Philosophy at the Hospital and the University of Patients: overview of an ecosystem*
Source: Chaire de Philosophie à l'Hôpital, Rapport d'activité 2016-2018, Paris, 2019.

The University of Patients and the Chair of Philosophy play a paradoxical role, foreign but not marginal, “excentric” but not peripheral, that questions the traditional systems governing knowledge and power sharing. Their ecosystem displays, in contrast, the often-obsolete institutional parameters of the French education

system. If we must renovate hospitals and the training of future healthcare providers, we have to deconstruct the web of knowledge-power relationships that block the sharing of critical and reflexive knowledge and skills; authority and intimidation dynamics too often plague universities, as do expertise confiscation, devaluing experiential and profane knowledge, and rigidly making learning overly academic. Therefore, redefining the teaching of the humanities within healthcare studies also includes an institutional and political dimension that we should certainly not ignore, since healthcare should actually be a *shared* function.

A TENTATIVE CRITICAL ASSESSMENT

Based on the picture we have just painted, and despite its obvious loopholes, we can try to highlight some key points, which we have simply classified in two categories: one for positive qualities and merits, and one for shortcomings and weaknesses.

First, the merits:

1. HSS teaching is mandatory in PACES (common 1st year program in health studies), which exposes French students to multiple aspects of human and social sciences. In addition, most faculties allocate a large amount of time to this teaching. This is almost a national standard. It is important to mention that this approach sets France apart, in a positive way, in the international educational landscape of health humanities.
2. The recent development of master's degrees and short modules (DU, DIU, Certificates, etc.) in the areas of ethics and the humanities is very encouraging. Moreover, interdisciplinary, inter-faculty, and inter-university collaboration mechanisms are appearing everywhere, accelerating progressive expansion and institutionalization of the scope of the health humanities.
3. Several innovative projects, although too often located in the Paris area, serve as examples today by creating a dynamic ecosystem that generates numerous teaching and research opportunities and provides new visibility to the health humanities.
4. Meanwhile, academic research in ethics and health humanities has gained structure and institutional recognition (chairs, dedicated research units, etc.). Moreover, it has facilitated the emergence of a specifically French corpus on the approach of care and health that could provide a solid and unique theoretical foundation to the teaching of the humanities within medical studies.

As for the weaknesses, the list is slightly longer:

1. As stated before, the volume in terms of time and content that is allocated to human sciences during the first year has significantly decreased compared to the period from 1994 to 2009.
2. The fragmented and diverse character of health humanities studies, particularly in PACES, remains a problem that is detrimental to the legitimacy and credibility of human and social sciences, whose importance is often underestimated by physicians and medical students.
3. The fact that, with a few exceptions, humanities and ethics courses are practically absent in the second cycle should also be questioned and rapidly resolved, even more so since externship is a crucial phase to integrate these courses into clinical practice studies; this is necessary if the humanities and ethics are considered not only as abstract, theoretical content, but as a set of resources that *effectively* feeds the decisions and practice of healthcare professionals. In particular, we think that ethics should be taught during the 2nd cycle as a major component of the cognitive processes of a medical decision. This key aspect of ethics in the health decision-making process should be linked to the SHS teachings acquired by students, which currently happens primarily in the 1st cycle.
4. Standardized testing and "cramming" or, on the contrary, the lack of assessment of the health humanities in medical schools, often seem to achieve a goal that is contrary to their initial ambition: some teachers—and students—today denounce the "dehumanization" of studies that should be conducive to critical thinking.
5. Human and social studies, particularly in PACES, often leave students confused: they are not receiving sufficient guidance, they face unreasonable ingestion of content, even in human sciences; many are still doubting the usefulness and relevancy of health humanities, while others even mistrust or even reject these courses.
6. The persistence of non-critical teachings provided by teachers untrained in human and social sciences is detrimental to the quality of education in the health humanities. Likewise, some faculties find it difficult to overcome the biomedical/human science dichotomy and formulate consistent, multidisciplinary content that is integrated into the common core of medical studies.

In addition, we find it important to promote dual programs for doctors specializing in HSS in medical schools. This appears to be particularly relevant for the decision-making aspects of medical ethics integrated with *in situ* clinical reasoning, taking into account, in particular, the degree of uncertainty that is underlying every clinical case, and the need to articulate ethical thinking and clinical expertise while identifying biases that could interfere with a decision. This is in line with a reflexive approach, taught and reiterated throughout the medical cursus until it becomes inherent to the cognitive processes of the future practitioner's decision.

This summary, however, must be complemented with a future-oriented "prospective" dimension of physicians' training. Therefore, we must now broaden the analysis by describing in detail the challenges and purposes of teaching ethics and the health humanities, while also identifying the main risks and issues it implies.

TEACHING ETHICS AND THE HUMANITIES IN HEALTHCARE: WHAT DOES THE FUTURE HOLD?

RISKS AND CHALLENGES

The risk of "denaturing" the humanities in healthcare education

The objectives of teaching the health humanities to future physicians are not always clear. Consequently, we must determine not only what they are not, but also what they *do not target*. One of the first risks posed by health humanities studies is teaching "bad" humanities, i.e. ancillary, ideological, humanities, gutted from their reflexive substance. The health humanities are not a pleasant "change of pace" from biomedical science studies. Their purpose is not limited to a "change of perspective" to give students a rest from rigorous "hard sciences", and they do not in any way constitute a sort of literary "addendum", however critical.

The health humanities are not part of a "personal development" or "moral perfecting" program; their purpose is not to create a medical "caste" fed with identical culture and values. The aim is to provide young doctors with education in humanities rather than humanistic science, which merely promotes a division between "hard" and "soft" sciences: they do not forge character, they produce knowledge, patiently carved and documented, that must be integrated into the scientific, biomedical content. The health humanities must absolutely be received and taught as a new moral order.

Nor are the health humanities a *decorum*, a luxury of speeches organized to sanctify the prestige of medicine, revisit its pitfalls, or preserve its legacy. Lastly, the health humanities do not feed a social utopia of perfect health, well-being, and happiness for humankind. We refuse to advocate for utilitarian humanities that would make healthcare providers and patients "feel better", but "critical" humanities, in the sense of the School of Frankfurt, that continuously mend healthcare practices and concept through an uninterrupted stream of reflection.

The development of critical humanities in medical schools requires vast multidisciplinarity, including (1) positions of human and social science teachers in health humanities studies, (2) a patient dialogue between disciplines to build a common cursus that is conceptualized, structured and consistent. This also implies that the complexity of human and social sciences should not be overwritten by a pretext of pedagogical simplification." This is particularly true for teaching the history of medicine, a subject that would benefit from being presented less as a succession of great phases and great figures of medical progress, almost in the manner of Auguste Comte, than as a field of possible investigation with a fragmented outline producing a rigorous although always temporary knowledge. Sadly, courses in the history of medicine are often restricted to a celebration of its Hippocratic origins, which are often unquestioned, followed by praise for the great men of the Renaissance and the 19th century revolutions while the role of women or more controversial figures (such as Alexis Carrel, mentioned above) or rich but ignored periods (such as the Late Middle Ages) are still absent from most handouts and textbooks[101]. These ideas also apply to the teaching of medical ethics which is frequently taught as standardized "principlism", applying the internationally known principles of Beauchamp and Childress (principles of autonomy, beneficence, non-maleficance and justice)[102] to all clinical cases that may arise. We do not question the validity of these principles; we do, however, dispute their teaching mode and use: if they should truly guide thinking and delineate the framework of ethical debates, a static doctrinal presentation cannot suffice. It is also imperative to discuss how to specify and weigh principles, confronting the approach by principles with a "case by case" or "casuistic" approach[103] which tends to treat each situation as a unique case; in other words, provide a critical, non-dogmatic presentation for ethics. That precisely is what is tricky[104].

The risk related to "receiving" the humanities in healthcare: rejection, loss of credibility, growing inequalities

There is a second risk, related to the question of the objectives and content of the teachings: their low level of acceptance or even outright rejection by future physicians in the event the prerequisites for proper transmission are not met. Even though a majority of students are probably "open" to learning health humanities, some, as we indicated, are vocally confused or even hostile to a teaching they feel is questionable in many respects[105]. Among the recurrent critiques, the first one is the accusation of "non-relevancy" because the humanities are seen as "impossible to practice" without concrete clinical applications, and "non-scientific", since their legitimacy as mandatory teaching could be subject to profound devaluation by students.

Therefore, the first steps of health humanities education should be in the area of epistemological critique to free health and medical studies from the rampant "scientism" that sometimes mutates into disdain for any form of rationale outside of modern experimental science standards. The idea is to avoid destroying the credibility of "non-physicians" and of those who do not have supposedly "expert" knowledge of the clinical reality. This is the condition for freeing critical expression that does not emerge spontaneously but must be practiced, constructed, carved into discussion and argumentation, which is more difficult in an environment where students are relentlessly subject to the rules of an assessment system and more generally prevailing "solutionism", where the "right answers" pre-exist the questions one asks oneself. Although students often criticize human and social science teachers, they also have great expectations for them, particularly in the first year. These teachings are, paradoxically, much more directly linked to the practical realities of care and the profession of physician than the highly theoretical courses of physics, chemistry and biostatistics that students must take in PACES[106]. By addressing social, psychological or ethical aspects of healthcare, teachings in the health humanities are therefore also designed to teach how to *provide care*. This explains both the strength and vulnerability of these programs, which are crucial in introducing students to

101 ABSIL, G., GOVERS, P., "Comment écrire l'histoire de la médecine pour les étudiants des sciences de la santé?" *Pédagogie Médicale*, 16(1), 2015, pp. 9-22.

102 BEAUCHAMP, T., CHILDRESS, J., *Principles of Biomedical Ethics*, Oxford: Oxford University Press, 1979. French translation: *Les principes de l'éthique biomédicale*, trad. M. Fisbach, Paris: Les Belles Lettres, 2008.

103 See, for example, GOFFI, J.-Y., "La nouvelle casuistique et la naturalisation des normes", *Philosophiques*, 28(1), 2001, pp. 87-107.

104 Regarding this point, see analyses by LE COZ, P., *L'Éthique médicale…*, *op. cit*., p. 53 sq.

105 SHAPIRO, J., *et. al*., *art. cit*., 2009.

106 SAUDER, Ch. et al., "Comment les enseignements de sciences humaines et sociales sont-ils perçus par les étudiants?" *in* BONAH, Ch., RASSMUSSEN, A. (éd.), *Sciences humaines…*, *op. cit.*, pp. 15-17.

the meaning of care and the practitioner's identity, while also being likely to generate deep disappointment.

One of the ways to limit such disappointment is, of course, to provide better guidance to students by ensuring support resources sized to the requirements of the studies and avoid leaving it to private services (called "*boîtes à colles*") to dispense teaching in the humanities that universities should be able to provide fully and adequately. Moreover, it is essential that universities fully assume the task of teaching the health humanities instead of merely validating the "general culture" dispensed to students, in order to avoid additional socio-economic discrimination already present in medical schools. The health humanities cannot risk discriminating against underprivileged populations: on the contrary, they should be an opportunity for all.

The question of inequalities must also be seriously addressed from a geographical point of view. The oft-lamented high heterogeneity of methods, contents and teaching situations between schools[107] is not really problematic; American, British and German universities have much more autonomy than in France and provide very diverse programs without this necessarily generating inequality. However, this diversity could increase preexisting geographic inequalities: between large and small cities, mainland and overseas territories, Paris and the rest of France. As we noted before, the uneven distribution of experts and research facilities in France could be a disadvantage to some schools and, consequently, to some students who do not have the same access to high quality teaching in the health humanities, and to opportunities in subjects they are interested in. This is why the solution is not necessarily to implement a "common program" at the national level or a policy for uniformity for ethics and the humanities in health studies; a better solution would be active support to each school, depending on their needs, to develop their educational offer in this field, and more than likely to create an assessment system for SHS and/or medical ethics studies at the end of the 2nd cycle of medical studies.

How can we assess the "usefulness" of the humanities in healthcare education?

A false issue is threatening the humanities

Many international articles note with regret the lack of outcome data necessary to evaluate the benefits of teaching the humanities in medical schools[108].

Since lack of data makes it impossible to answer the question of the "usefulness" of the health humanities, it could be one of the major obstacles to their development, since their soundness would have to be ascertained prior to implementation. We must clearly distinguish two aspects to this issue. On the one hand, the health humanities would be more successful with skeptics among doctors, deans, university presidents, and politicians if we could "demonstrate" that they allow students to obtain better results in their medical studies, for example, or that they ultimately improve patient satisfaction. On the other hand, however, submitting the health humanities to standardized assessment criteria extrinsically defining their value and scope is not obviously simple either.

Several contemporary figures of English-speaking *medical humanities* fiercely debated this very topic during the summer of 2010. Responding to a literature magazine noting the absence of measure on

107 ARBUS, L., et al., "Les raisons d'un programme commun", in BONAH, Ch., RASSMUSSEN, A. (éd.), *Sciences humaines…*, *op. cit.*, pp. 30-32.

108 TAYLOR, A., LEHMANN, S., CHISOLM, M., "Integrating humanities curricula in medical education: a literature review", Med-EdPublish, 6(2), 2017, p. 28.

the long-term effects of medical humanities education[109], Catherine Belling and Rita Charon were quick to denounce the "reductive tendency" inherent in all attempts to quantify the benefits of studies that resist and should resist standardization. What must be questioned is not "immeasurable" humanities studies, but the loopholes in the tools used to evaluate them[110]. In addition, Rita Charon highlights the paradox that obeying the restrictive rules of evaluation of the health humanities benefits seems contrary to their very purpose which is, according to her, to be attentive to the complexity and diversity of care situation, beyond any "reductionism"[111]. However, some American longitudinal studies conducted at Mount Sinai Medical School in New York have shown that students who completed a baccalaureate in the humanities prior to entering medical school succeeded as well as those who had taken a classic pre-medical cursus in "hard" sciences, or were even more competent than the latter in some fields, particularly in terms of communication with patients[112].

These questions are much less acute in France than in the Anglo-Saxon world, where outcome-based education has become more popular; however, they nonetheless remain unavoidable. "What would be the purpose of courses in the humanities in medicine?" "Are they really useful?": These questions are not foreign to the French environment and, moreover, have a long history, as we noted above. While we do not outright reject all forms of evaluation of education outcomes, we do see a significant risk in the kind of pressures that teaching can impose on the fragile field of the health humanities.

Indeed, evaluating the "usefulness" of the health humanities seems to us to be a *false problem*, for two main reasons:

1. The more health humanities education tends towards interdisciplinary integration and cross-curricularity, the more difficult it will be to precisely evaluate its specific contribution and benefits. In other words, to free their whole potential, the health humanities must invest and dialog with other disciplines, which makes it even more difficult to isolate them as distinctive variables in an evaluation process. This results in a paradox: the more the health humanities are open and integrated into the medical curriculum, hence being more "efficient", the more they must also be impossible to evaluate[113].
2. The dictionary definition of "usefulness" is vague and misleading. Indeed, regarding education, what is the meaning of being "useful"? Actually, were culture and art ever "useful"? As noted by M. Louis-Courvoisier, the real point is not whether health humanities are "useful", but how they could be *relevant* in future physicians' education[114]. Their reflexive potential does not depend on "results"—and what do we mean by "results"?—but on the way they are incorporated into medical studies in general.

Therefore, the lack of "evidence" as to the "usefulness" of the health humanities should not be dismissed as an argument for prudently restricting their funding or limiting dedicated teaching positions in this field. The lack of financial resources necessary to offer this teaching is certainly problematic. However, even more problematic is the lack of support for the health humanities. Piecemeal approaches, poorly structured

109 OUSAGER, J., JOHANNESSEN, H., "Humanities in Undergraduate Medical Education: A Literature Review", *Academic Medicine*, 85, 2010, pp. 988-998.

110 BELLING, C., "Sharper Instruments: On Defending the Humanities in Undergraduate Medical Education", *Academic Medicine*, 85(6), 2010, p. 940.

111 CHARON, R., "Commentary: Calculating the Contributions of Humanities to Medical Practice—Motives, Methods, and Metrics", *Academic Medicine*, 85(6), 2010, pp. 935-7.

112 WERSHOF SCHWARTZ, A., *et al.*, *art. cit.*, 2009; MULLER, D., KASE, N., "Challenging Traditional Premedical Requirements as Predictors of Success in Medical School: The Mount Sinai School of Medicine Humanities and Medicine Program", *Academic Medicine*, 85(8), pp. 1378-83.

113 BLEAKLEY, A., *Medical humanities…*, *op. cit.*, p. 224.

114 LOUIS-COURVOISIER, M., *art. cit.*, 2015, p. 7.

and insufficiently endowed in funding and personnel, can only maintain the humanities in their second-class status within medical schools. By doing too little and barely enough, we run the risk of destroying the credibility of a teaching that, without time and means necessary for its sound operation, can only exist as a futile and hollow surplus in the eyes of many doctors and students. We are aware that investing massively and blindly in the health humanities is not easy, but it should also be understood that letting them barely survive can only harm their development, which inevitably generates counter-productivity.

WHY THE HUMANITIES IN HEALTHCARE? STAKES AND PURPOSE OF A CRITICAL EDUCATION

As we already pointed out, there are many reasons in favor of studies in the health humanities, but they are also facing critical issues. Therefore, we will only summarize, under three main categories, the reasons why, in our opinion, the health humanities carry long-term benefits.

Why a "French healthcare school"?

The first issue in developing health humanities studies could be the most "strategic" one: it pertains to the international outreach and visibility of the university and of French research in this field. The significant growth of the health humanities in the world should not be ignored by France; in it, we should see an opportunity to join this global expansion movement of research and teaching while defending our own unique path. Today, there is room for rethinking care and health, thanks to continental and, particularly French, philosophy—with the works of Bachelard, Foucault and Canguilhem, among others—as well as other schools of thought and disciplines such as institutional psychotherapy or psychodynamics, for example[115].

The French health and care system created in 1945, which is currently relentlessly targeted—probably for good reason—by critics, still offers something valuable: the universal character of health and social protection, funding through social contribution, and the defense of equality in healthcare. In 2000, France was still ranked among the countries with the best health systems in the world, according to the WHO[116]. Our purpose is not to ignore the numerous limitations, pitfalls or hypocritical aspects of this system: weak investment in prevention, high focus on hospitals, excessive and often unnecessary medical consumption, etc. Our point is that France, thanks to philosophical and ethical analyses in medicine and healthcare that have been conducted for decades, can still defend the values of its care model, not by sinking into harmful conservatism, but by emphasizing widely and uniquely the teaching of the humanities and ethics to healthcare professionals. Such ambition appears all the more achievable since French medical schools are among those that value human sciences the most worldwide by dedicating substantial, mandatory education to them. By encouraging research initiatives and teaching programs that provide new visibility to health humanities, we may witness the emergence of a true "French school of healthcare."

115 FLEURY, C., TOURETTE-TURGIS, C., "Une école française du soin? An analysis of two cases of socio-therapeutic innovation: the University of Patients and the Chair of Philosophy at the Hospital", *Le sujet dans la cité*, 7(1), 2018, pp. 183-196.

116 See *World Health Organization*, The World Health Report 2000—Health systems: improving performance, Geneva: WHO, 2000.

How are today's mutations in medicine and healthcare threatening the humanities?

In view of continuous medical advances, biomedical sciences and human sciences should consistently maintain closer connections[117]. According to the WHO definition of health as "a state of complete physical, mental and social well-being",[118] today's medicine is increasingly focusing on the conditions of a state of stable and optimal health instead of just on curative treatments for specific pathologies. This is all the more true since the incidences of chronic and long-term diseases such as diabetes, for example, are clearly on the rise; it is no longer possible to care for and support patients as we did before. This new state of healthcare demands a double approach: on the one hand, a public and collective approach to health, which implies including a wide range of environment factors and parameters—in the widest sense of the term —and, on the other hand an increasingly individualized approach to treatment and care; this is the well-known "P4 medicine" project: predictive, personalized, preventative, and participatory. In the first case, medical research inevitably encounters social science: sociology of health determinants, anthropology of disease, health economics, and law. In this context, medical practice implies that we seriously take into account the socio-economic and cultural backdrop of populations or groups of persons. In the second approach, "P4 medicine" inevitably requires that we clear a new space for ethical and philosophical questioning. What is "a person" in medicine? What is caring if we cannot heal? How can we philosophically explain a medical decision that is increasingly based on technique? Is prevention equal to protection? The point is not to outright reject contemporary medical progress with "literary" disdain, but rather use the resources of human sciences to identify issues that science and technique alone cannot solve.

In short, if the humanities deserve a place in medical studies, it is because they are a key element of the preparation of physicians for their future practice. Eliminating them or leaving them on the back burner would mean depriving doctors of the intellectual and critical "equipment" they will undoubtedly need in order to cope, in full independence, with the major changes in biomedical sciences, i.e. artificial intelligence, genetic engineering, etc.[119] The health humanities also offer crucial resources for debate and discussion, for ethics and for patient guidance; all the more indispensable since physicians' tasks are less limited to a series of analyses, diagnoses and technical procedures.

The humanities and professionalism

Narrative medicine, promoted by Rita Charon, among other experts, insistently emphasizes the need for physicians to take into account, as much as possible, the uniqueness of each patient's experiences and narratives. The care relationship must be constructed based on the unique life story of a patient, always linked to a specific socio-cultural context, so as to avert any therapeutic wandering and delays and avoid simple miscommunication between healthcare professionals and between professionals and patients becoming

117 Regarding recent medical and research developments, see PICARD, J.-F., MOUCHET, S., *op. cit*., Ch. XII, p. 229 sq.

118 United Nations, WHO, *Official Records of the World Health Organization*, #2, p. 100. [Preamble of the Constitution of the WHO, signed on July 22, 1946 by representatives of 61 States and entered into force on April 7, 1948.]

119 Please refer to the contribution to the 2018 Bioethics États Généraux titled "Humanités médicales: pour une révolution des Sciences humaines et Sociales dans la formation des professionnels de santé." [Online: https://etatsgenerauxdelabioÉthique.fr/media/default/0001 /01/76bf4206cd9883ac80a0993073be6e1889ec3376.pdf, last consulted on June 6, 2019.]. Regarding artificial intelligence, please see a report by C. VILLANI, Rapport sur l'intelligence artificielle (IA). Donner un sens à l'IA, a report to the Minister of Higher Education, Research and Innovation, March 2018.

irreversible medical errors[120]. Additionally, if medical care is destined to be participatory, inter-professional and patient-oriented, we urgently need to develop listening, understanding and interpreting skills in physicians; training in the humanities would certainly foster this education.

The decline of empathy skills and the "moral erosion" of students and healthcare professionals, which is particularly palpable in the third year of studies and later, are indeed some of the elements most frequently mentioned to justify the addition of the humanities into the medical curriculum. The issue of medical empathy, abundantly discussed, is particularly worrying because it intersects two equally unacceptable phenomena: on the one hand, the standardization of a certain violence in healthcare institutions and the widespread temptation of resigning in the face of daily ethical problems and, on the other hand, the state of severe fatigue of many healthcare providers who are under pressure, whose "moral erosion" sometimes hides physical and moral distress that is also poorly addressed[121].

We are not claiming that human and social sciences would miraculously solve all these issues. It would indeed be dangerous to examine all the issues of our health systems from a perspective of the humanities and ethics, and we should particularly resist the temptation to link all health issues to ethics[122]. Nonetheless, we believe that the humanities can contribute to an in-depth revision—highly necessary today—of medical *professionalism*. While they cannot, and probably should not, make physicians "more human", as is often said, they are useful for transmitting skills, know-how and attitudes that more broadly foster ethics, communication and listening skills, benefiting physicians' identities and actions[123]. The purpose is to provide future healthcare professionals with not only intellectual tools stemming from human sciences, but also applied ethics and humanities that have been experimented, tested and "tamed" in hospital environments and in clinical practice.

120 XYRICHIS, A. and REAM, E., "Teamwork: A Concept Analysis'. Journal of Advanced Nursing", 61(2), 2008, pp. 232-41. Cited by A. BLEAKLEY, *op. cit.*, p. 9.

121 MARRA, D., *Rapport sur la qualité de vie des étudiants en santé*, a report to the Minister of Solidarity and Health, April 3, 2018.

122 CORDIER, A., "Éthique et Professions de santé", *op. cit.*, p. 64.

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SUMMARY TABLE

As a summary, we have gathered all the aforementioned points into a table that, at the risk of being simplified, should be more readable.

BENEFITS AND MERITS	SHORTFALLS AND WEAKNESSES
• Mandatory HSH course in PACES and in the first cycle, large hourly volume. • Significant development of master's degrees and short programs (DU, DIU, Certificates, etc.) in ethics and in the humanities • Increased interdisciplinary, inter-school and inter-university collaboration. • Examples of innovative mechanisms and ecosystems, better visibility for the health humanities. • Structured and institutionally recognized research in ethics and the humanities, in dynamic health.	• Decline of hourly volume and weight (coefficient) of HSH in PACES compared to the years 1994-2009. • Heterogeneous and dispersed character of health humanities studies, particularly in PACES, detrimental to the credibility of human and social sciences and to the quality of the studies. • With a few exceptions, absent in the second cycle, where the humanities and ethics are scarce, although externship appears to be a crucial phase requiring such elements of clinical learning. • Standardized testing and "cramming" inconsistent with the purpose of the humanities; "dehumanizing" teachings that are meant to be a vector of critical thinking. • Persistence of subjects taught by teachers who are not qualified; difficulties in surpassing the hard/soft science dichotomy in favor of multidisciplinarity. • Confusion and lack of guidance for students who face unreasonable ingestion of knowledge even in human sciences.

(LONG TERM) STAKES AND OPPORTUNITIES	RISKS AND CHALLENGES
• French research and teaching within the expanding field of "health humanities" gaining international visibility and promoting a French model of health humanities. • Training physicians and healthcare professionals in the future health challenges, including a growing role of human and social sciences; transmission of critical intellectual tools to enable physicians to meet these challenges. • Overhaul of medical professionalism through ethics and the humanities; development of new skills, in line with progress in biomedicine and medical practice.	• Misrepresentation of humanities studies, considered as ancillary, like courses in general culture, or worse, moral education, in a non-critical and illegitimate way. • Mistrust and dismissal of disciplines sometimes despised by physicians. • Growing geographical and, in some cases, social inequalities due to the lack of adequate support to schools and consistent guidance for students. • Detrimental pressure in outcome assessment for teaching that is required to be "useful". • Restrictions in funding and in teaching and research position creation; plethora of counterproductive half-measures.

HOW DO WE ARTICULATE CLINICAL ETHICS AND THE HUMANITIES IN HEALTHCARE?

Before concluding, we wish to clarify a residual, but persistent conceptual and terminological vagueness. We should not confuse medical ethics and the health humanities: the former should be understood as a dimension of clinical *decisions*, as a "cognitive" parameter, so to speak, of the medical reasoning and actions, in context, *hic et nunc*; the latter are, for the time being, a floating corpus of interdisciplinary contents, anchored in health and healthcare, with significant emphasis on tools and knowledge from human and social sciences. It is misleading to consider the health humanities outright "ethical"; believing that ethics is merely a matter of "humanities" or "humanity" is ludicrous. Clinical ethics and the health humanities should be linked; however, each discipline has its own characteristics. Likewise, we must also differentiate human and social sciences, which form a rather heterogeneous set of subject-specific knowledge. Medical ethics is certainly not innate "know-how": it must be fed by the humanities. Conversely, the humanities must feed ethics. However, this does not mean that skills in "ethics" and in the "humanities" can be considered interchangeable, which is often the case. In our view, ethics is the connecting point between human and social sciences, to which it is linked, and the practice of medical decision-making in which ethics plays a major role.

Human and social sciences should be mobilized to feed the implementation of a specific, relevant and consistent teaching program in "the health humanities." They should constitute a critical, continuous training that would foster the acquisition of various topics and skills (analysis, thinking, synthesis, communication and expression, argumentation, etc.) that could and should be reinvested in ethical decisions, in clinical practice, and as resources for *deliberation*, argumentation and critique. For example, a student should be able to explore economic, social, legal, ethical and, of course, clinical aspects of a specific "case" or issue. As a factor of deliberation, the ethical decision must use the critical strength of the health humanities, and conversely, ethical questions and decisions provide the constantly renewed opportunity of reflecting on medical practice. Ethics also fosters the humanities as the cornerstone of a reflexive medical practice that relentlessly reformulates, re-adapts and reevaluates its own knowledge and skills. In other words, the skills-based approach cannot do without reflexivity, and the core of such reflexivity is precisely located in the connection between ethics and the health humanities.

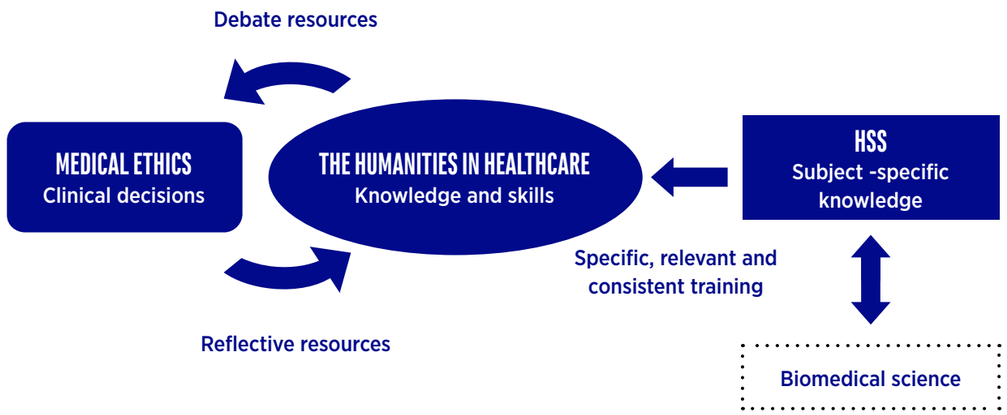

Fig. 10 — *Ethics and the healthcare humanities: what would be the ideal structure?*

IN PRACTICE: MULTIPLE ISSUES TO BE ADDRESSED

The very general perspective we adopted here should not conceal the wide area of concrete details that will ultimately constitute the reality of ethics and health humanities teaching (EHH). It is of course impossible to address all the implementation parameters and modalities for this program here, since it will have to be customized to the specific environment of each school. However, we will still present an overview of the most urgent issues based on the elements we have now.

Teaching methods:

1. Should EHH courses be mandatory, elective (mandatory choice within a list of potential courses), or optional (choice of not taking this course)? Although it seems advisable to build a base of common knowledge and skills in the humanities, the mandatory character of teaching also has limitations (it could mean much larger numbers of students, less interactive courses, mistrust by students if they are less diligent or poorly supported, etc.). Therefore, it is necessary to reflect on the concrete modalities of the mandatory character of EHH.
2. Should EHH education be spread over the entire course of study, while medical students are often overloaded in university programs and hospital internships? Conversely, should we organize a program in phases, delivered at certain key stages of the curriculum? In some cases, an intensive one or two-day seminar could be more efficient than a continuous but superficial spread[124]. One thing is certain: EHH should be present in the first year, as is the case today, and beyond, in the first cycle but also, preferably in the second cycle and during internship. However, PACES and the last year of the second cycle are actually admission exam years, the most heavily loaded for students, which runs the risk of mutating EHH into cramming subjects. Therefore, it would be better to take advantage of the current medical studies reform to insert EHH teaching and, more importantly, its assessment, at the most appropriate times in the curriculum. With this in mind, it would be best to reinforce ethics teaching in the second cycle in direct connection with clinical practice, in the form of workshops and on-site training, linking this program with Human and Social Science (HSS) courses acquired in the first cycle, even if this means adapting the HSS content in the first cycle to familiarize students with the fundamentals of ethical thinking during hospital internships. Too frequently, the fundamentals of ethics, including philosophy, are taught in medical schools during the first year, and few philosophy courses are offered in the second and third years, although this base is a preparatory phase to applied clinical ethics in the second cycle.
3. How can we link clinical training and EHH study? Should we promote the model of occasional participatory "workshops" in the second cycle, asking students to share their internship experiences, as is the case in several schools? Should we keep an academic approach in the second cycle? One thing is certain: ethics must be put to the test in medical practice and trigger ethical questioning in real-life situations, while at the same time transmitting knowledge and skills in deliberation and thinking, which presuppose a certain level of "academism." Teaching programs organized in interdisciplinary pairs (e.g. Physician and SHS teacher) on clinical sites could be an option. It is important to note that ethics in its applied aspects, integrated with reasoning and medical decision-making, is well-suited for evaluation at the end of the second cycle.
4. Along the same line, the question of which formats and teaching methods to use is also crucial.

124 See as an example, the Ulm University in Germany, cited above.

Should we increase the share of tutorial classes in the EHH hourly volume? Should we establish more "interactive" guidance for students to better encourage them to speak up?

Organizing multidisciplinarity and content and skills transmission:

5. Should we promote the creation of human science departments within medical schools, or is inter-school and inter-university collaboration sufficient to ensure EHH teaching? Where and how can positions for human science teachers in medicine be created, if needed?
6. What should be the education of SHS teachers in medicine, how should they be recruited and how should their careers be structured? Conversely, when hospital and university hospital practitioners participate in EHC teaching (particularly in ethics), in what way do they collaborate with SHS teachers?
7. What type of content should be taught at each level of medical studies? Should we promote "classic" and general human science teaching, as currently offered in literature or philosophy schools, or, on the contrary, adapt or "apply" such knowledge to medical students, even if this means removing such knowledge from their context or even simplifying them in the interest of "pedagogy"?
8. Should we teach more or less content? How can we find the right balance between, on the one hand, content that buries students under courses that are too long or too dense and, on the other hand, a program that is less dense, more flexible and more interactive, but runs the risk of appearing vague and less credible in the eyes of the same students? Would an optional UE in HSS or in ethics in the second cycle in addition to the mandatory common core course be an acceptable solution?
9. Lastly, should we create a "common program" for all universities, which would ensure a certain political "credibility" of HSS teaching, or, on the contrary, leave each school free to create its own training offer and methods as seen fit, even if that means multiplying bridges and "flexible" connections between schools, without imposing uniformity from above, which is always difficult to put in practice?

Evaluation modalities and docimology:

10. The question of evaluation modalities is also highly concerning since they can vary according to the years of study: second cycle students, for example, should not be evaluated like those in PACES. First, does every HSS program have to be validated by a formal evaluation such as a "final exam"? Couldn't we think of other ways to "recognize" participation in these courses, while not totally eliminating formal evaluations? One thing is certain: the docimological mechanism currently used determines to a large extent the mode of learning of students, as we pointed out above. This must absolutely be taken into account. If we want to give HSS the weight they deserve in the medical curriculum, we should not cut short efforts to establish an evaluation system for applied medical ethics, preferably integrated within the clinical skills certificate.
11. In practice, how do we reduce the weight of QCMs and QROCs in HSS teaching, which are "corrupting" as described above, although cost-effective and suitable for standardized evaluation demanded by examination of large groups? Should we favor oral exams? Or ongoing testing to evaluate students' personal commitment (mini-essays, surveys, creative projects, etc.)? Or short written exams including essays or dissertation? Or essay exams on a given theme in the form of homework, using anti-plagiarism software?

The question of skills:

12. We are adding one last observation, in line with the current reform of health studies. It promotes a skills-based approach to medical school studies. Unlike a mere transmission of academic knowledge, the skills-based approach targets the integration of this knowledge and seeks to verify that they apply in specific practical situations, based on predefined objectives. We must keep in mind that a skills-based approach should avoid at least two pitfalls: decontextualization and standardization. Segmenting medical practice into "skills" should not conceal the infinite diversity of experiences in terms of illness and care relationships: the acquisition of "skills" should not be limited, for the healthcare provider, to memorizing standard scenarios, to which reality would have to adjust, and calling for mechanical responses. Likewise, doctors should not ignore the social and institutional factors of health because healthcare does not only rely on individual "skills", but also, in all cases, on institutions.

TEN RECOMMENDATIONS

General recommendations:

1. The shortage of reliable and comprehensive statistical data on HSS education in medicine makes it difficult to accurately identify the gaps and needs of faculties in this area. Therefore, it is imperative that comprehensive, periodic studies be conducted in the future. It is even more indispensable to collect **qualitative data** on students' feelings and demands, at all levels, as well as from young interns, physicians and even patients, while avoiding the confiscation of this topic by "experts", whether they speak in the name of human and social sciences or in the name of biomedical science.
2. We need a consensus on the meaning and parameters of **the articulation of biomedical ethics** on the one hand (both clinical ethics and bioethics) and **the health humanities** on the other hand: these two aspects of the same teaching based on subject-specific knowledge of human and social sciences are not equivalent and should not be confused. In other words, we must identify a concrete methodology for multidisciplinarity, while paying attention to the role of human and social sciences in the various "skills" that future doctors need to acquire, if they are to be reduced to simple "black boxes", resulting in medical practice operating on detrimental standardized healthcare relationships and disease experience.
3. The humanities and ethics are two keys to medical professionalism: therefore, we must stop considering them as glossy humanism or "interesting", although hardly credible, entertainment. This is not about creating a new ideology or ethics; it is about embracing the powerful potential of skills and knowledge that ethics and the health humanities can bring to the table at a time when medicine and healthcare are undergoing both crisis and radical change.
4. HSS teaching should be **unified** and **dialecticized**, rather than "humanized": the point is to restore coherence, relevance and continuity to a teaching program that is too often eclectic and intermittent. Designed to promote critical reflexivity, HSS teaching should be better structured and, even more important, better problematized. This requires that experts in human and social sciences have a more central role within medical schools, to be able to develop a teaching program genuinely adapted to the requirements of medical training, in collaboration with teaching physicians, for applied medical ethics, for example.
5. We must encourage and support the creation of specialized master's degrees in the health humanities everywhere in France and provide medical schools with the means of true legitimation of these studies, so that they are no longer seen as a peripheral sub-domain of public health. In addition, these studies must be **accessible to medical students as well as to practicing healthcare professionals**. The development and reinforcement of master's degrees could be a **laboratory for multidisciplinarity**, initially tested and crafted through these relatively short programs and including a small number of students. Broadly speaking, research and teaching innovations in the humanities and health should be encouraged: this is imperative to ensure the **French influence** throughout international health humanities.
6. We must combat the gap of preexisting social and territorial disparities (Paris vs. rest of the country, metropolitan France vs. overseas territories, large vs. small cities). Contents and modalities of HSS teaching do not necessarily need to be uniform throughout the country. However, the chances of access to high-quality education that matches students' interests and expectations must be *equally distributed*. Consequently, smaller faculties should be assisted in the development of their offer in EHH education.

A few guidelines for an ethics and health humanities curriculum:

7. *Prior to the first cycle*, **continuity** should be ensured between secondary education and the new healthcare study program. If it should be possible to enroll in a medical curriculum from various paths, whether "literary" or "scientific", it would be advisable to prepare or at the least consider an interdisciplinary "alliance" between the humanities and medical science at the high school level. In other words, the "strategic" choice of options in the final year of secondary studies cannot deepen the old gap between hard sciences and soft sciences, literature and science, HSH and medicine. **There may be space for the health humanities in high school as well.**
8. *In the first cycle*, it is necessary to maintain a **substantial mandatory course in EHH in the first and second years** that is open and broad, although not heterogeneous, focusing on important philosophical, historical and sociological questions (i.e. the person, death, the body, scientific controversies, etc.), demanding and not "simplified" for the sake of being supposedly educational. This teaching would benefit from being evaluated in an **integrally written (essay-type) argumentative form**; we prefer dissertation and argumentative synthesis of (iconographic, scientific, literary, etc.) documents. In the third year, health services could get involved and ask students to write a mini-report, mini-thesis or any other personal work aimed at consolidating the academic knowledge acquired in the first and second years. This would result in a critical summary of their involvement or first venture into the medical-social world.
9. *In the second cycle*, the **elective** system (mandatory choice of a course from a list), which promotes learning in small groups, seems to be the best option. These teachings could be offered directly at the hospital, during internships, and be supervised by interdisciplinary pairs of medical and humanities teachers or by **triads of patients, clinical practitioners and human science experts**. Since undergraduate (first cycle) students already have a relevant knowledge base in HSS, the second cycle should focus on teaching **ethics as a key element of medical decision-making**, as well as taking a position and **practicing communication and deliberation**. Therefore, we could imagine an evaluation system based on class attendance, the presentation of clinical cases, and the writing of reports on human and social science conferences, seminars or books.
10. During and after internship, the ethical training of future doctors should be continued through mandatory workshops, for example, including multiple specialties. In general, we must stop seeing ethics and the health humanities as a sort of "preliminary" cultural knowledge: this is where we see the breach from the medieval tradition of *trivium* and *quadrivium*. Ethics and the healthcare humanities should be part of the continuing education of physicians, constantly mobilized, integrated, and studied by them like any other clinical skill.

LIST OF FIGURES

Appendix I: Questionnaire on the teaching of ethics in French medical schools. Status report in progress, conducted by the Deans’ Conference of Medical Schools.

TEACHING ETHICS IN MEDICAL SCHOOLS

The Deans’ Conference would like to have an overview of ethics education in French medical schools.
Therefore, we are sending you this online questionnaire which can be completed in less than 15 minutes.
We thank you for your participation.

Name and city of your medical school: .....

PACES

Human and Social Sciences (HSS) Law and Public Health (PH)
Number of hours in 2017-2018: ..... h
Within this hourly volume, are some hours dedicated to ethics: ☐ Yes ☐ No
If yes, number of hours ..... h

2ND AND 3RD YEARS

Is there an UE in Human and Social Sciences (HSS) Law and Public Health (PH): ☐ Yes ☐ No
If yes, number of hours in 2017-2018: ..... h
Mandatory UE ☐ Yes ☐ No
Optional UE ☐ Yes ☐ No

Within this hourly volume, are some hours dedicated to ethics: ☐ Yes ☐ No
If yes, number of hours ..... h
Teaching format:
Lecture (Cours Magistral, CM) ..... h
Tutorial classes (Travaux dirigés, TD) and/or Workshops ..... h
Flipped classroom ..... h
Other format: specify below ..... h

Was there a course assessment: ☐ Yes ☐ No
If yes, What were the methods of evaluation?

4TH, 5TH AND 6TH YEARS

Is there a UE in Human and Social Sciences (HSS) Law and Public Health (PH) ☐ Yes ☐ No
If yes, number of hours in 2017-2018: ..... h
Mandatory UE ☐ Yes ☐ No
Optional UE ☐ Yes ☐ No

Within this hourly volume, are some hours dedicated to ethics: ☐ Yes ☐ No
If yes, number of hours ..... h

Teaching format:
Lecture (Cours Magistral, CM) ..... h
Tutorial classes (Travaux dirigés, TD) and/or Workshops ..... h
Flipped classroom ..... h
Other format: specify below ..... h
In context workshops for students: ☐ Yes ☐ No
Student evaluation of the course: ☐ Yes ☐ No
Which format?

.....

Evaluations and testing methods (MCC)
Is there an evaluation of students in terms of specific knowledge and/or skills in ethics in the 2nd cycle following courses: ☐ Yes ☐ No
Methods?

.....

3RD CYCLE

Are certain hours identified as dedicated to ethics as cross-cutting education in the various specialties:
☐ Yes ☐ No
If yes, number of hours ..... h

Teaching format:
Lecture (Cours Magistral, CM) ..... h
Tutorial classes (Travaux dirigés, TD) and/or Workshops ..... h
Flipped classroom ..... h
Other format: specify below ..... h

In context workshops for students: ☐ Yes ☐ No
Student evaluation of the course: ☐ Yes ☐ No

Evaluations and testing methods (MCC)
Is there an evaluation of students in terms of specific knowledge and/or skills in ethics in the 3rd cycle following courses: ☐ Yes ☐ No

Did you create a specific ethics UE as part of the initial medical studies?
☐ Yes ☐ No
If yes, in the: ☐ 1st cycle ☐ 2nd cycle ☐ 3rd cycle

Do you think that in the next few years ethics education should be reinforced within the initial medical studies?
☐ Yes ☐ No

If no, is it for lack of funding? ☐ Yes ☐ No

If not, please explain:
Are there complementary ethics teaching programs in your school
DU/DIU: ☐ Yes ☐ No
If yes, please provide the title and person responsible for this program:

.....

Master M1: ☐ Yes ☐ No
If yes, please provide the title and person responsible for this program

.....

Master M2: ☐ Yes ☐ No
If yes, please provide the title and person responsible for this program

.....

Doctorate: ☐ Yes ☐ No
If yes, please provide the title and person responsible for this program

HUMAN RESOURCES

Over the last 10 years in your medical school, has there been any recruiting of a university hospital practitioner dedicated to ethics? ☐ Yes ☐ No
If yes, in what specialty (National University Council (CNU) where this person was hired):
☐ PU PH ☐ MCU PH p. 01

In your medical school, do you have one or more university hospital practitioners whose work is dedicated, in whole or in part, to ethics? ☐ Yes ☐ No p. 02
If yes, how many?

.....

Does the medical school use external teachers to teach ethics to medical students under an agreement, for example? ☐ Yes ☐ No
Over the next few years, do you intend to recruit a university hospital practitioner primarily to implement ethics and ethical research in your medical school? ☐ Yes ☐ No

Explanatory documents requested
Could you send us 2 or 3 documents that you provide to your students, for example as a basis for workshop activities? Or, a handout for example?

Do you have any comments or suggestions regarding the teaching of ethics in medicine?

.....

.....

.....

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Appendix II: poster by Nathalie Nasr *et al.* presented at the 2019 conference of the Collège des Humanités Médicales (COLHUM) on teaching ethics in the 2nd cycle of medical school and on the evaluation of students for ethical skills as part of the clinical skills certificate.

Enseignement de l'éthique dans le tronc commun du 2ème cycle des études médicales
De la mise en place de l'enseignement jusqu'à l'évaluation

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INTRODUCTION

Il y a un hiatus pour l'enseignement de l'éthique médicale après le 1er cycle avec peu de facultés de médecine en France qui délivrent un enseignement d'éthique entre la 2ème et la 6ème année.

Nous relatons ici la mise en place au cours des trois dernières années de l'enseignement de l'éthique médicale aux étudiants de 2ème cycle dans le cadre du tronc commun sous la forme d'ateliers avec participation obligatoire et une évaluation en fin du 2ème cycle dans le cadre du certificat de compétences cliniques dont la note a été incrémentée pour inclure l'évaluation des étudiants pour l'éthique médicale.

DEROULEMENT D'UN ATELIER

L'enseignement de l'éthique médicale commence dès le début des stages hospitaliers, en 4ème année, avec la participation obligatoire à au moins deux ateliers par an, lesquels sont organisés dans les différentes disciplines au cours des stages.

Un système d'émargement permet de s'assurer de la participation des étudiants aux ateliers. Les ateliers sont évalués par les étudiants près chaque session avec l'adaptation du format qui a pris en compte ce retour.

Le format des ateliers qui a été retenu et étendu aux différentes disciplines est le format d'atelier qui durent 1h et demi auxquels participent 25 étudiants au maximum, qui travaillent en petits groupes pour décrire une situation clinique qui leur a posé problème sur le plan éthique et leur cheminement pour y répondre.

Chaque petit groupe présente son cas clinique à tous les participants aux ateliers et répond aux questions de leurs camarades et des enseignants qui font des synthèses courtes à partir des données de l'atelier.

EVALUATION

Une évaluation a été mise en place qui comporte un devoir rendu dans une thématique donnée dans le cadre du certificat de compétences cliniques en fin de 2ème cycle, avec l'incrémentation de la note de ce certificat de 25 à 30 points pour inclure l'éthique médicale comme compétence clinique notée sur 5 points avec la moyenne qui correspond à 2.5 pts sur 5.

FORMATION DES ENSEIGNANTS

Une formation des médecins enseignants actuels et futurs de l'éthique médicale a été mise en place et est prévue pour être poursuivie en lien avec les enseignants de sciences humaines sociales et de droit dans le cadre de l'université fédérale de Toulouse, et en lien avec les enseignants de pédagogie en santé de Toulouse III

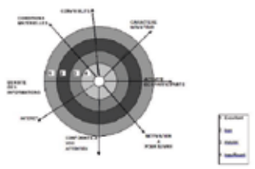
CONCLUSION ET PERSPECTIVES

L'enseignement mis en place répond à un besoin d'intégrer l'éthique médicale dans le cadre des compétences cliniques du futur praticien. L'évaluation des étudiants pour l'éthique médicale tel que nous l'avons intégrée dans le cadre du certificat de compétence cliniques participera à leur évaluation et à leur classement dans un contexte où dans le cadre de la réforme du 2ème cycle l'examen national classant est amené à être supprimé dans les prochaines années

Déroulement d'un atelier

- Durée : 1h 30 minutes, 2 fois, pour avoir 2 groupes. Unité de lieu avec le stage
- Etape 1: signent la fiche de présence
- Etape 2: rédigent par groupes de 5 environ un cas clinique qui leur pose question sur le plan éthique et leur cheminement pour y répondre. 30 mn
- Etape 3: restitution et discussion du cas cliniques avec tous les participants à l'atelier
- Etape 4: évaluation de l'atelier par chaque étudiant

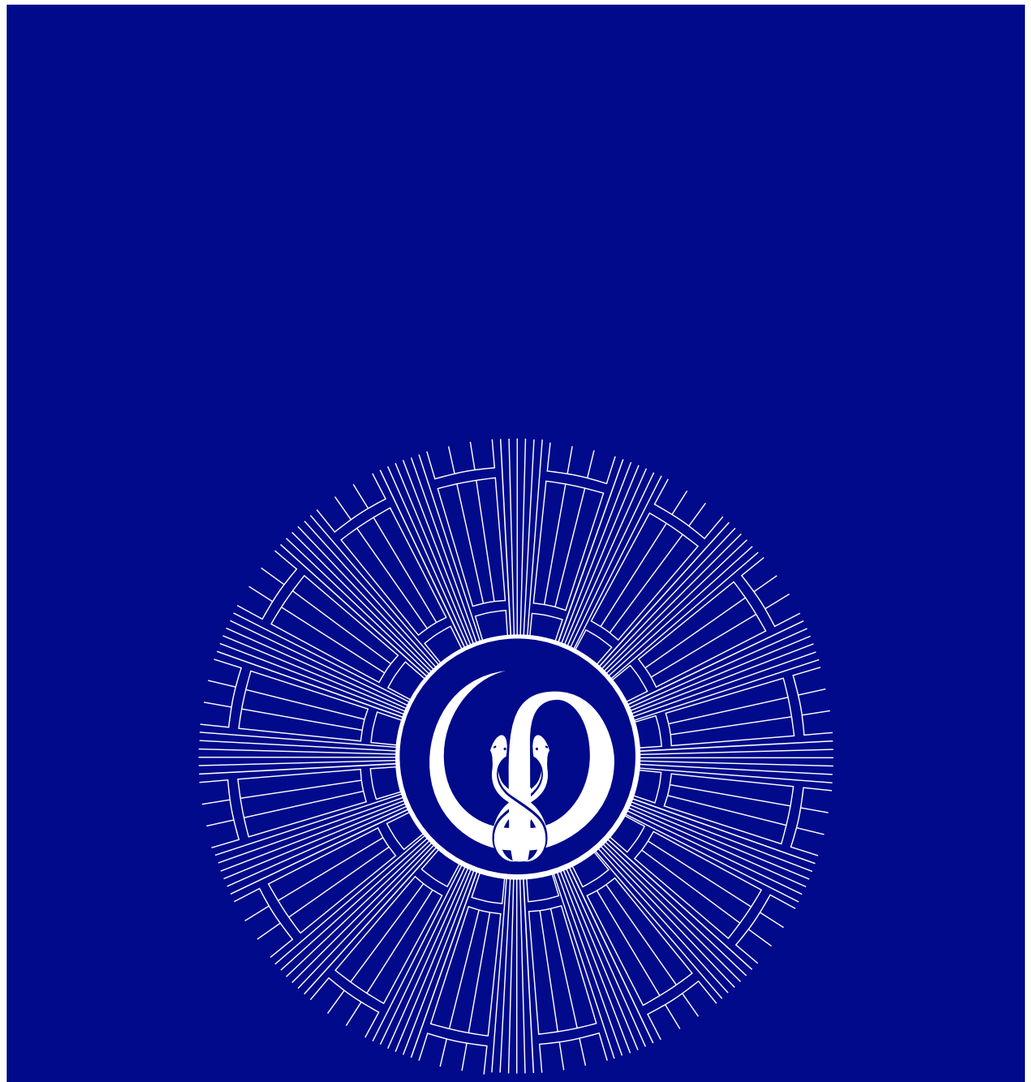
Evaluation des ateliers par les étudiants



Evaluation des ateliers par les étudiants

- Ateliers évalués comme excellents ou bons dans plus de 85% des cas
- Motivation à poursuivre
- N'aiment quand les enseignants parlent trop
- L'augmentation du nombre d'étudiants par atelier diminue les scores
- Evaluation faite à partir des ateliers en Neurosciences

- Evaluation des ateliers par les étudiants
- Homogénéisation du format pédagogique
- Extension aux différents pôles
- Définition des thématiques
- Mise à disposition des ressources
- Intégration au calendrier universitaire
- Rendu la présence obligatoire
- **Evaluation des étudiants**
- Formation continue des enseignants



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