# STORYAID.EU
# HUMANISM POLICY REVIEW

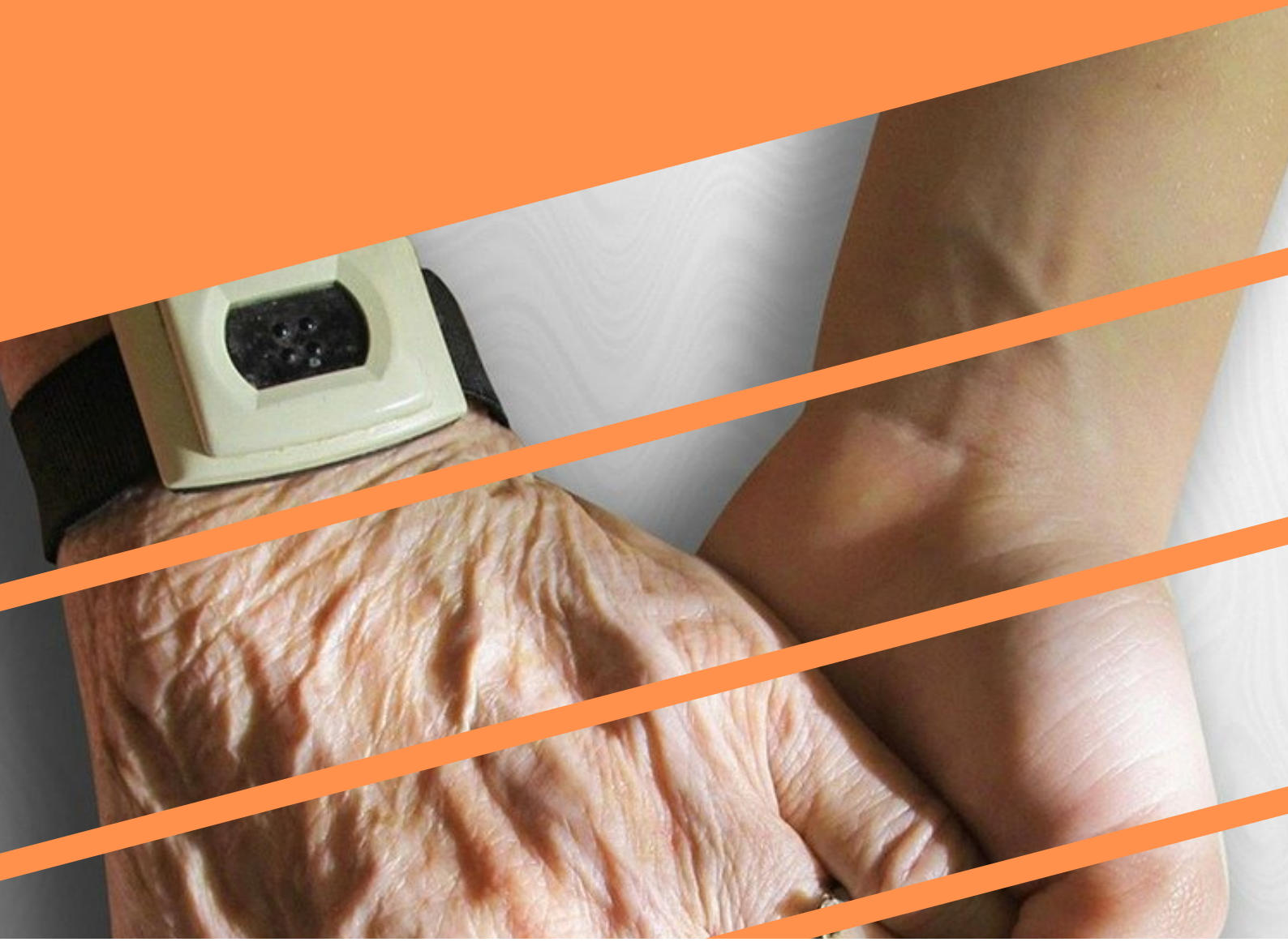
**ERASMUS+ PROGRAMME**

2014-2020

KEY ACTION 2: STRATEGIC PARTNERSHIP

**HUMANIZING HEALTHCARE EDUCATION THROUGH THE USE OF STORYTELLING**

AGREEMENT N°2019-1-ES01-KA203-065728



StoryAidEU
Humanizing Healthcare Education through the use of Storytelling
Medizinische Universität Graz
RGU ABERDEEN
WSEPiNM KIELCE
MTU
AGENFOR ITALIA
International Network for Health Workforce Education
Co-funded by the Erasmus+ Programme of the European Union

**ERASMUS+ PROGRAMME**

2014-2020

KEY ACTION 2: STRATEGIC PARTNERSHIP

AGREEMENT N°2019-1-ES01-KA203-065728

STORYAID - HUMANIZING HEALTHCARE EDUCATION THROUGH THE USE OF STORYTELLING

# Humanism Policy Review Report

October 2020

**Contents**

## Overview

This Policy Review was conducted over the first 12 months of the StoryAidEU project and consists of two parts. Part 1 involves desk-based research using the triple plus method to ensure the documents were collected in a thorough and systematic manner. Part 2 draws on semi-structured interviews with policymakers from across a number of EU states. This document outlines the background to the review, highlights the methodology of the desk-based research and interviews, outlines the results and, lastly, discusses findings and conclusions for the review. In relation to the future of the project, the report will be used by the leaders of all three intellectual outputs (IO1, IO2 and IO3) and the findings will inform synergy discussions and the development of training materials.

The StoryAidEU project aims to humanise healthcare education through the use of storytelling. It identifies how current healthcare training curricula rely on a comprehensive understanding of the bio-medical model of medicine but that it is critical for these to incorporate more rounded perspectives. To explore a new model of healthcare training, the project proposes that storytelling can become a crucial tool for educators to show the hidden and silent stories of patients, healthcare professionals, patients' loved ones, and vulnerable people who are receiving care. This approach is of paramount importance in a context where Europe is facing increased demand for health services due to ageing populations, rising patient mobility, and a diminishing supply of health workers caused by retirement rates that surpass recruitment rates. This is placing unprecedented pressure on the health workforce and storytelling has the potential to increase health professionals' capacity for self-reflection to help them cope with these pressures.

Storytelling can be used to ensure a holistic approach to healthcare professionals' education and this project aims to build a truly interprofessional approach to storytelling. There is strong evidence to support that effective interprofessional education (IPE) is an innovative strategy for enabling effective collaborative practice, making IPE a necessary feature for training a prepared health workforce. Furthermore, collaborative practice strengthens health systems and has been shown to improve health outcomes (WHO, 2010). The StoryAidEU project therefore proposes that storytelling will be highly valuable when used in an interdisciplinary environment, something which this project will support by creating an innovative multi-professional, inter-stakeholder approach to bridge the gap between current educational models and a more holistic model designed for the future.

## Background

### Humanism

The advantages brought about by the unprecedented developments in healthcare technology, documentation, and enhanced safety measures in recent years have also had the undesirable consequence of dehumanising patients (Suerias et al 2017). Many healthcare systems have pursued the improvement of care standards and patient safety through organisational measures which have been highly ineffective, and often resulting in unfulfilled expectations and neglected complaints from patients (Laska-Formeister 2016). Moreover, various authors have highlighted the difficulties of behaving compassionately in highly pressurised health and social care organisations. (Lown 2014, Mannion 2014, Hewison et al 2017). In short, there is a clear need for greater humanism in healthcare. While humanism is not a new concept it is one whose meaning needs to be clarified and evaluated if we are to understand what its implications are for designing and implementing healthcare reforms. Due to the broad nature of the concept and its wide-ranging relevance, the project team expected to find references to humanism in a wide number of healthcare policies but not a dedicated humanism policy for states or regions. In light of this, the Policy Review presented here has involved (i) conducting an exhaustive search of policy documents, academic literature and grey literature to ensure that the project identifies key policy initiatives relating to humanism and (ii) conducting in-depth interviews with policy actors to ensure that the perspectives of those actually involved in policymaking shed light on the challenges and opportunities of actually implementing healthcare reforms which reflect the principles of humanism.

## Part I: Desk Based Research

### Methodology

For the Policy Review search to be successful it was important to explore both academic and grey literature. Grey literature can be found in many forms such as government and non-governmental reports, conference presentations and projects, industry standards, documentation (from private or public sector) and other official documentation (Alberani et al, 1990). In order to search both academic and grey literature effectively Booth's (2013) triple plus strategy was implemented. This strategy provides a systematic method for searching literature and is particularly useful for finding policy related documents. Firstly, journal databases were used for academic sources. Secondly, specialist grey literature databases were searched. Finally, supplementary strategies, such as consulting Google Scholar, were examined.

Three databases were used to search for academic literature on the subject area. These were:

- Elsevier – ScienceDirect
- Springer/ICM
- Web of Knowledge

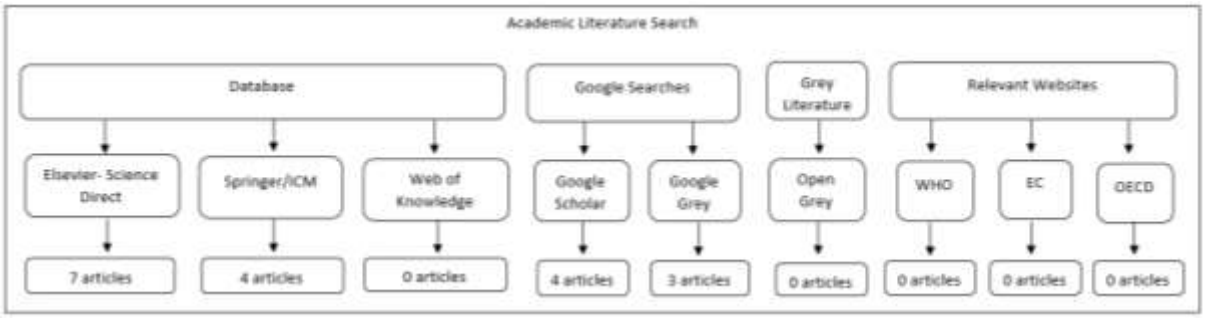
When searching for grey literature only one database was used:

- OpenGrey

Supplementary strategies included using Google Scholar, standard google searching and the websites of three large international organisations (the WHO OECD and European Commission).

### Search Strategy

The search terms were derived from the concept analysis undertaken as part of the wider StoryAidEU project. The terms were kept simple and we prioritised the terms 'healthcare' and 'policy' to ensure that results were as relevant as possible. Appendix A includes a full description of search terms used, the number of results from each search method and selected articles. In line with Booth's (2013) method databases were searched first, starting with Elsevier – ScienceDirect, which provided seven (7) articles that were relevant to the review. This search was partially duplicated for both the Springer/ICM and Web of Knowledge databases providing similar results in selecting a total of four (4) articles. Grey literature was searched next and was conducted using the Open Grey database. A similar search technique to the academic literature was implemented which produced no articles of relevance.




Maintaining Booth's (2013) strategy, supplementary search formats were attempted. Google Scholar was searched for supplementary sources finding 4 articles and this was followed up by a standard Google search which provided a further 3 sources of grey literature. Search terms followed a similar pattern to those of the preceding database searches. Lastly, the three relevant organisational websites that had been identified as useful by the consortium were investigated in more depth but these failed to provide further relevant articles on humanism. In total, 18 sources of information were identified

which had relevance to humanism and which could be used by policymakers to enable the implementation of healthcare reforms that reflect the principles of humanism.

### Data Mapping

The results of the search primarily came from publications in English-speaking countries with the United Kingdom and United States of America making up a large proportion of the data collected. This is likely due to the language used for project and search terms, and reflects one of the limitations of the search method. The data reflects multiple viewpoints with articles focusing on a national outlook producing nine results, local and regional outlooks each producing four results and just one study with an international perspective. General academic studies produced nine results, followed by guidance or framework documents with seven and only two policy documents could be found. Due to the lack of genuine policy documents, articles were selected that would be of high value to policymakers when implementing humanism within their healthcare decision making. Thus, local, regional and national studies were included along with guidance or frameworks that offer detailed explanations on policy implementation.

The documents, including the key aspects of their methods and their core conclusions, are summarised in the table which follows.

Article Selection

| Author(s) | Title | Year | Publication | Premise | Methodology | Conclusion | Location | Type |
|---|---|---|---|---|---|---|---|---|
| Batteson, T. and Garber, S. | Assessing constructs underlying interprofessional competencies through the design of a new measure of interprofessional education | 2019 | Journal of Interprofessional Education & Practice | The research designed, implemented and psychometrically validated an new IPE measurement tool that assessed Values/Ethics, attitudes toward morality, altruism and humanism; Roles and Responsibilities, attitudes to diversity; Teams and Teamwork, through cooperation and citizenship | 702 first year healthcare students participated in the study. 8 programs were represented. 73 item measure questionnaire was given pre- and post 16 week IPE Foundations course over two cohort years. | Values & Ethics accounted for 25.9% of the overall variance and showed significant differences in the Roles and Responsibilities domain and the Values and Ethics domain | USA | Local Study |
| Canales, C. et al | Humanism training in anaesthesiology residency: a framework to help move the field forward | 2020 | British Journal of Anaesthesia | Paper in response to two of the issues highlighted with a previous study. Physicians' attitudes change as they progress through a programme, and that the impact of the training may well expand beyond the trainees who experienced it and be representative of the culture of the department. | N/A | No educational curriculum, regardless of how well it is designed, is likely to be successful if there is no 'buy-in' from stakeholders, which in this case represent residents, faculty, and leadership of the department. Not enough emphasis has been placed on humanism in anaesthesiology, and we look forward to continued work by various groups internationally in this area. | UK | Local Guidance/ Framework |
| Kunneman, M. et al | Humanistic communication in the evaluation of shared decision making: A systematic review | 2018 | Patient Education and Counselling | To assess the extent to which evaluations of shared decision making (SDM) assess the extent and quality of humanistic communication (i.e., respect, compassion, empathy). | Systematically searched Web of Science and Scopus for prospective studies published between 2012 and February 2018 that evaluated SDM in actual | Of the 154 eligible studies, 14 (9%) included statements regarding humanistic communication. Assessments of the quality of SDM focus narrowly on SDM technique and rarely assess humanistic | USA | Local Study |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | clinical decisions using validated SDM measures. | aspects of patient-clinician communication. | | |
| Canales, C. et al | Humanistic medicine in anaesthesiology: development and assessment of a curriculum in humanism for postgraduate anaesthesiology trainees | 2019 | British Journal of Anaesthesia | As humanism is not integrated as part of formal postgraduate anaesthesiology education curricula, our goal was to design, introduce, and evaluate a comprehensive humanism curriculum into anaesthesiology training. | Subject-matter experts developed and delivered the humanism curriculum. The effectiveness of the programme was evaluated using pre- and post-curriculum assessments in first-year postgraduate trainee doctors (residents). | Residents reported high satisfaction scores. Pre-/post-Jefferson Scale of Patient Perceptions of Physician Empathy showed an increase in empathy ratings with a median improvement of 12 points. Implementation of a humanism curriculum during postgraduate anaesthesiology training was well accepted, and can result in increased physician empathy and professionalism. | USA | Local Study |
| Gilligan, M. et al | Views of institutional leaders on maintaining humanism in today's practice | 2019 | Patient Education and Counselling | To explore leadership perspectives on how to maintain high quality efficient care that is also person-centered and humanistic. | The authors interviewed and collected narrative transcripts from a convenience sample of 32 institutional healthcare leaders at seven U.S. medical schools. The institutional leaders were asked to identify factors that either promoted or inhibited humanistic practice. | Institutional leaders assisted clinicians in dealing with stressful practices in beneficial ways but fell short of envisaging systems approaches that improve practice organization to encourage humanistic care. To preserve humanistic care requires system changes as well as programs to enhance skills and foster humanistic values and attitudes. | USA | Regional Study |
| Rider, E. et al | The International Charter for Human Values in Healthcare: An interprofessional global collaboration to enhance values | 2014 | Patient Education and Counselling | The human dimensions of healthcare are fundamental to compassionate, ethical, and safe relationship-centered care. The objectives of this paper are to describe the development of the | We describe development of the Charter using combined qualitative research methods and the international, interprofessional | We chronicle the development and dissemination of the International Charter for Human Values in Healthcare. The Charter identifies and promotes core values | Inter-national | Inter-national study |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | and communication in healthcare | | | International Charter for Human Values in Healthcare, articulate the role of skilled communication in enacting these values, and provide examples showing translation of the Charter's values into action. | collaboration of institutions and individuals worldwide. | clinicians and educators can demonstrate through skilled communication and use to advance humanistic educational programs and practice. | | |
| Ruff, K. and Mackenzie. E. | The Role of Mindfulness in Healthcare Reform: A Policy Paper | 2009 | Explore | The US healthcare system is unsustainable both in terms of its financial and human costs. However, despite a nearly unanimous call for reform, there remains a lack of consensus about what form the changes should take, and different stakeholders have put forth a variety of approaches. | N/A (Editorial) | Promotes 'mind-body medicine' which focuses on the relationships among the mind, body, brain, and behaviour, and produces interventions that use these connections to achieve and maintain health. This is exploration in policy terms for the USA. | USA | National framework/ guidance |
| Gregerson, M. | A role for clinical psychology in health care and policy concerning the physical environment | 1995 | Journal of Clinical Psychology in Medical Settings | Some persons adversely react to specific environments, while others are impervious or actually thrive. Medical attention often overlooks such sensitivities to the physical environment. A theoretical/ clinical approach called the Synchronous Systems Model, which defines and uses individual differences in people and in settings, could serve medical health care and policy. | N/A (Theoretical paper) | The Synchronous Systems Model provides theory, supportive data, and clinical assessment devices to strengthen clinical psychology's role in medical settings. | USA | National framework/ guidance |
| Lévesque, M. et al | Ideological roadblocks to humanizing dentistry, an evaluative case study of a continuing education course on | 2015 | International Journal for Equity in Health | Front line providers of care are frequently lacking in knowledge on and sensitivity to social and structural determinants of underprivileged patients' | McGill University, in partnership with Université de Montréal, Québec dental regulatory authorities, and the Québec anti-poverty coalition, co- | Humanizing care and developing oral health practitioners' capacity to respond to social determinants of health, are challenged by significant | Canada | Regional study |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | social determinants of health | | | health. Developing and evaluating approaches to raising health professional awareness and capacity to respond to social determinants is a crucial step in addressing this issue. | developed a continuing education (CE) intervention that aims to transfer knowledge and improve the practices of oral health professionals with people living on welfare. Qualitative case study conducted among members of a dental team who participated in this innovation CE course over one month | ideological roadblocks. These require multi-level and multi-sectorial action if gains in social equity in oral health are to be made. | | |
| Rider, E. et al | Healthcare at the Crossroads: The Need to Shape an Organizational Culture of Humanistic Teaching and Practice | 2018 | Journal of General Internal Medicine | Changes in the organization of medical practice have impeded humanistic practice and resulted in widespread physician burnout and dissatisfaction. The purpose of this study is to identify organizational factors that promote or inhibit humanistic practice of medicine by faculty physicians | 68 written survey responses from January 1, 2015, through December 31, 2016, faculty from eight US medical schools were asked to write reflectively on two open-ended questions regarding institutional-level motivators and impediments to humanistic practice and teaching within their organizations. | While healthcare has evolved rapidly, efforts to counteract the negative effects of changes in organizational and practice environments have largely focused on cultivating humanistic attributes in individuals. | USA | Regional study |
| Quintero, G. | Medical education and the healthcare system - why does the curriculum need to be reformed? | 2014 | BMC Medicine | Medical education has been the subject of ongoing debate since the early 1900s. The core of the discussion is about the importance of scientific knowledge on biological understanding at the expense of its social and humanistic characteristics. | N/A | A new curriculum has been developed that addresses a comprehensive instruction of the biological, psychological, social, and cultural (historical) aspects of medicine, with opportunities for students to acquire leadership, teamwork, and communication skills in order to introduce improvements | Colombia | National guidance/ framework |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | into the healthcare systems where they work. | | |
| Loxterkamp, D. | Humanism in the time of metrics | 2013 | BMJ | Doctors' increasing focus on biomarkers and measures of performance has shifted our attention away from what may be most important for our patients | N/A (comment piece) | General practitioners must allow patients to learn, invest, and lead in their own recovery, and in the renewable health resource that is community. | USA | National guidance/ framework |
| Grant, J. | An investigation of culturally competent<br>terminology in healthcare policy finds<br>ambiguity and lack of definition | 2013 | Australia and New Zealand Journal of Public Health | This research explored how the concept of cultural competence was represented and expressed through health policies that were intended to improve the quality and efficacy of healthcare provided to families from culturally marginalised communities, particularly women and children with refugee backgrounds. | A critical document analysis was conducted of policies that inform healthcare for families from culturally marginalised communities in two local government areas in South Australia. | Cultural competence within health services has been identified as an important factor that can improve the health outcomes for families from marginalised communities. However, inconsistency in definitions, understanding and implementation of cultural competence in health practice makes it difficult to implement care using these frameworks. | Australia | Regional study |
| Anderson, J. et al | Narratives of "dissonance" and "repositioning" through the lens of critical humanism: exploring the influences on immigrants' and refugees' health and well-being. | 2010 | Advances in Nursing Science | The focus of this article is on narratives of "starting over," and the embedded processes, conceptualized as "dissonance"--between what people had expected to find in Canada and their actual experiences, and "repositioning"--how they subsequently restructured their lives and redefined their identities. | N/A | This narrative analysis is one way of illuminating the complex ways in which social support networks influence dissonance and repositioning, and subsequently influence health and well-being. | Canada | National study |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Filho, S. et al | The National Humanization Policy as a policy produced within the healthcare work process | 2008 | Interface - Comunicação, Saúde, Educação | This paper aims to conduct an analytical exercise detailing how the National Humanization Policy is undertaken regarding the role of institutional support, based on different mechanisms, directives and principles. | The text is divided into three parts: the first provides reflections concerning the concepts of humanness and humanism on which the analyses are based; the second seeks to expand the debate regarding the inseparability of healthcare and management and the means of providing institutional support; while the third discusses the inseparability between the production of services and the production of subjects and furthers the discussion on these three parts so they unfold in other planes of analysis. | The National Humanization Policy, through its devices, seems to be a strategy that has been constituted as a strong ally, when applying the principle of the expansion and affirmation of a healthcare system that works. | Brazil | National policy |
| Levin, R. | Humanism increasingly important in a changing health care landscape | 2017 | AAMC Website | As the academic medicine community faces new demands, maintaining a human connection with our patients is more crucial than ever. | N/A (opinion piece) | As educators and clinicians, it is up to us ensure that our future doctors and other health care providers are prepared to provide compassionate care and to guide them in approaching this challenging journey with empathy. It is more crucial than ever. | USA | National guidance/ framework |
| UK Government | The Equality Act 2010 | 2010 | UK.GOV website | Act of parliament outlining new UK law. | N/A | The Equality Act 2010 came into effect from 1 October 2010. It, for the first time, gave the UK a single Act of Parliament, requiring | UK | National policy |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | equal treatment in access to employment as well as private and public services, regardless of age, disability, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief, sex and sexual orientation. | | |
| The Royal College of Psychiatrists | Person-centred care: implications for training in psychiatry | 2018 | RCP Website | This report reviews the case for strengthening the focus on the person in clinical practice and giving person-centred approaches a central position in the practice and training of psychiatrists. | N/A | In setting out a case for reinforcing and prioritising person-centred care, this report does not suggest a new or different approach to that already supported by the guiding values of our profession. Rather, it offers guidance to bridging the gap between values and experience, principles and practice, and intention and achievement. | UK | National guidance/ framework |

## Part II: Policy Interviews

### Interview Methodology

The value of including interviews in this policy review is that they introduce an interpretivist approach to the research. Britten (1995 p. 251) states that "semi-structured interviews are conducted on the basis of a loose structure consisting of open ended questions that define the area to be explored, at least initially, and from which the interviewer or interviewee may diverge in order to pursue an idea in more detail". Miles & Gilbert (2005) also point out that using semi structured interviews offers a valuable way of finding out 'why' rather than 'how many' or 'how much'. Thus, including semi-structured interviews in the research design adds an additional layer of understanding (Gubrium & Holstein, 2002). In light of this, by including interviews the Policy Review not only reveals what kind of policies are documented in relation to humanism in healthcare but it also presents insights from those directly working in policymaking settings.

The interviews included civil servants, government advisors, and politicians. Interview questions were designed to explore the status of humanism in the healthcare system contexts of interviewees and what interviewees perceived to be the key reforms necessary for humanism to assume a more central position in the education of health professionals. Participants were selected for interview due to having wide-ranging policy experience in the field of IPE and were considered highly likely to be able to reflect on the project's themes. A total of five in-depth interviews were conducted with policymakers from Portugal, the UK, the Netherlands, and Poland. Within the confines of the project's resources, a decision needed to be made between conducting fewer, in-depth interviews or a larger number of shorter, structured interviews. The decision to conduct the former type of interview was made due to in-depth interviews being more suited to providing a new dimension to the insights gained from the policy review's document analysis.

### Interview Analysis

Interviews with policymakers provided important insights to further build on the conclusions of the desk-based research. The interviews revealed significant diversity across European health policy settings regarding the degree to which humanism is considered a policy priority. The following quotations illustrate the existence of highly contrasting policy landscapes:

> "there is neither room nor willingness to involve humanism in education and work among policymakers" ***Policymaker, Poland***

> "I'm not sure that there are that many barriers to the policy angle on [promoting humanism] […] I think that there increasingly is a really strong focus on certainly the patient and actually increasingly carer experience and not just the patient or the service user themselves, but also their families". ***Policymaker, UK***

However, despite representing diverse policy landscapes, the policy interviewees discussed a number of common themes relating to two broad issues: (i) the barriers that prevent healthcare systems from reflecting the principles of humanism, and (ii) possible reforms which hold potential to enable more humanistic approaches in healthcare systems. These will be discussed in detail below.

*Barriers to humanism*

Policy interviewees identified a diverse set of barriers which currently prevent the delivery of healthcare from reflecting principles of humanism. The most challenging barrier was considered to be related to the overarching **governance models of healthcare systems**. Interviewees argued that the current financial models of healthcare systems are fundamentally incompatible with a humanistic approach.

> "I think that the curriculum and training are victims of the way that health systems have evolved over the last century. Focusing more on procedures and technology and forgetting the fundamental basics that we

> are dealing with humans. The fact is that we have created a model that incentivizes disease and which looks at procedures as the main outcome of health systems. When we look at surgeries or hospital visits as the main outcome, we're not concerned about what is important for the patients or patient-reported experience" ***Policymaker, Portugal***

> "The only real interests in Polish healthcare are procedures and finances." ***Policymaker, Poland***

> "the health system [in the UK] is not necessarily the best-funded system, and there comes a point where because you're putting so much pressure on the people that work within it, if you literally don't have time to do the job that you're doing, then you have to in some ways be closed off to the care that you would like to be delivering because you literally just have to do what's in front of you." ***Policymaker, UK***

These quotations all describe how the system-wide governance models, their financing, and their criteria for assessing health system performance currently pose major challenges to a humanistic approach to healthcare delivery.

Moreover, it was argued that beyond the financing models of healthcare systems that the very principles on which they are based can be problematic for a humanistic approach. A Dutch policy actor described this in the following manner:

> "If you look at most western health care systems, in the past 20 years there has been introduced a perspective on mankind which is rather rationalistic: people need information to make choices and they will do that as rationally as possible. So, everything can be well described in a contract and when you're not getting the service you want or you were promised you go to a lawyer. That is a very rationalist approach in which there is not so much space for dialogue, respect, the things to share together. So, I think a more fundamental issue here is: what perspective do you have on humans, on people, on systems?" ***Policymaker, The Netherlands***

This quotation further underlines that there are large-scale system-level barriers which prevent humanism from being a central principle of many healthcare systems. A rationalistic approach to patients and the systems that treat them leads to healthcare being practiced in a manner that side-lines principles of dialogue, respect, and the significance of relationships.

Barriers to humanism were also identified in relation to the **design and delivery of health workforce education**. The key issues identified by policy actors included the lack of perspectives from social and behavioural sciences informing the curricula of health professionals, the difficulty of the typical university model (such as standard lecture formats) for being truly self-reflective, and the teaching hours made available to educators only allowing them to focus on strictly scientific material at the expense of considering patient experiences and interactions. Teaching time restrictions and the technical emphasis placed on the curricula of health professionals' education reflects an approach which is incompatible with encouraging learners to cultivate a humanistic approach to their professional practice. As one policy actor commented,

> "how do you become aware of your own biases in approaching that job, and coming at it as a holistic person? […] Humanism isn't a tick-box exercise. I think it's hard work. It's harder work than writing a curriculum with a set of technical factors." ***Policymaker, UK***

The challenge of meaningfully engaging with humanism in the delivery of health workforce education is exacerbated by how it is an area which demands a very different approach when compared to the traditional teaching approach within health sciences.

Furthermore, the **lack of interprofessional collaboration** in healthcare settings was identified as a barrier to humanism. The reason for this was described as "when there is no dialogue between all the [different] actors, the patient is left behind" (policymaker, The Netherlands). Thus, the weaknesses in

interprofessional collaboration often place a limit on the extent to which a patient can receive treatment in a manner that involves dialogue, respect, and understanding them as a unique individual.

A final barrier that policy interviewees argued was important to understanding the lack of humanism in healthcare settings related to what they **perceived to be a lack of evidence on the importance of humanistic approaches**. One policy actor argued that, "we lack extensive comparative studies in this area" (policymaker, Poland) and that this lack of evidence-base can lead to difficulties in convincing policymakers and education evaluators of the value of investing time and resources related to humanism in curricula.

*Proposed reforms for enabling humanism*

As well as identifying a range of barriers which prevent humanism becoming a more central principle of healthcare systems, policy interviewees also proposed a number of reforms for overcoming these barriers. The first type of reform is also the most challenging as it involves the **radical re-thinking of current healthcare system governance** in a manner which moves away from the overly rationalistic, technical, and output-oriented model that currently dominates most systems.

> "we have to transform radically the way we think and organize and finance our healthcare." ***Policymaker, Portugal***

> "we are living in a moment of time especially now also with COVID-19 in which you see that the behaviour of people is a big part of the answer to the systems in which we live together, in which we serve people, health care services etc. So, I think this is a moment in time in which we see that our systems are at the end of what they can do and that there is a need for a new perspective on citizens, on students, and on patients" ***Policymaker, The Netherlands***

Policy actors acknowledged that system-level reforms are hugely challenging, however they emphasised that they are vital to achieve in order for health systems to serve patients in a more respectful, equitable, and appropriate manner.

All policy interviewees suggested that key areas of **training systems and curricula** were in need of reform. These reforms include training which puts the patient at the centre of curricula and pedagogical approaches, for example by "giving patients an active voice during the training process" (Policymaker, Portugal). These reforms also included teaching professionals to be self-reflective about their own work and constantly ask themselves practical questions such as, "Do I look at the computer or do I look at the patient?" (Policymaker, The Netherlands) so that they are able to self-assess whether they are putting humanistic principles into practice. A further suggestion was for curricula and training to be designed by looking for connections between medical and social-behavioural sciences as a way of making it clearer how humanism is at the core of delivering healthcare.

In relation to reforming training systems and curricula, two types of actor were identified as key to enabling reforms to take place. The first group of actors are those occupying **positions of university leadership**, such as the deans of medical schools and directors of universities. The second group of actors relates to the **educators** themselves. A theme that emerged in a number of interviews related to the disconnect between educators and the actual practice of healthcare, arguing that it is common for educators to either have minimal experience of being in a healthcare setting or have spent a significant period away from the field. This was perceived as problematic due to educators being largely disconnected from patient perspectives, leading some interviewees to suggest that this disconnect needs to be addressed. For example, one interviewee recommended "developing programmes entrusted to those who, in addition to their professional competence, will have at least five years of professional experience in direct work with patients" (Policymaker, Poland).

## Conclusion

The policy review identified a number of resources which can support policymakers implement humanistic practices within their healthcare systems. The review found that many of the papers based on empirical studies focused on the local level, which could be due to how humanism needs to be tailored to specific contexts and also how humanism is often identified through examining personal interactions, rather than being identified as a national policy. However, the review did identify a number of national frameworks and guidelines which focused on the incorporation of humanism into practice in a country-wide manner.

Interviews with policymakers supplemented the review findings by highlighting the factors which have prevented humanism from being a core part of healthcare systems and practice, as well as proposing key necessary reforms. The insights from the policy interviews provide important insights into understanding the complex, multi-level, contextual factors that need to be considered when seeking to promote a greater degree of humanism in the education and training of health professionals. In this way, the interview material should be considered alongside the more general frameworks for implementing humanism principles in healthcare systems.

When examining the document review and interview analysis together with IO2 and IO3, it is clear that there is a lack of humanism in IPE teaching tools and general curricula for educating the health workforce. There remains a pressing need for systemic policy change at the level of healthcare systems and universities to incorporate humanism into the practices of health professionals across the EU. These reforms will require the participation and buy-in from policymakers, university leaders, educators, health professionals, and patients themselves in order for a mutual understanding to be fostered between patients and health professionals.

In the next stage of the StoryAidEU project, the consortium will use the insights from this review to tailor IO4 and IO5 in order to increase the likelihood that the training materials produced by the project will be implemented effectively across EU states.

## References


Alberani V. Pietrangeli P. & Mazza A. (1990), The use of grey literature in health sciences: a preliminary survey, Bulletin of the Medical Library Association, 78:4, 358-363

Abu-Rish, E. (2012), Current trends in interprofessional education of health sciences students: A literature review, Journal of Interprofessional Care, 1–8

Francois, J. (2019), How storytelling can help close the nursing student attainment gap, Nursing Standard. Online via: https://rcni.com/nursing-standard/students/nursing-studies/how-storytelling-can-help-close-nursing-student-attainment-gap-153711 (Last Accessed 06/11/2019 at 12:12)

Gilbert, J. Yan, J. Hoffman, S. (2010), A WHO Report: Framework for Action on Interprofessional Education and Collaborative Practice, Journal of Allied Health, 39:3

Haigh, C. & Hardy, P. (2011), Tell me a story - a conceptual exploration of storytelling in healthcare education, Nurse Education Today, 31:4 408-411

Hardy, P. (2007) An investigation into the application of the Patient Voices digital stories in healthcare education: quality of learning, policy impact and practice-based value, Belfast: University of Ulster

Moore, K. (2013), Exposing Hidden Relations: Storytelling, Pedagogy, and the Study of Policy, Journal of Technical Writing and Communication, 43:1 63-78

Scott, S.D. Brett-MacLean, P. Archibald, M. & Hartling, L. (2013), Protocol for a systematic review of the use of narrative storytelling and visual-arts-based approaches as knowledge translation tools in healthcare, Systematic Reviews 2:19

Sueiras, P. Romano-Betech, V. Vergil Salgado, A. de Hoyos, A. Quintana-Vargas, S. Ruddick, W. (2017), Today´s medical self and the other: Challenges and evolving solutions for enhanced humanization and quality of care, PLoS ONE, 12:7

## Appendix A – Academic & Grey Literature Search

| Search Area | Search Term | Found | Used |
|---|---|---|---|
| **Elsevier – ScienceDirect** | Humanism | 5,357 | 7 |
| | Humanism Policy | 2,223 | |
| | Humanism Healthcare Policy | 232 | |
| | Interprofessional Education | 8,602 | 5 |
| | Interprofessional Education Policy | 4,122 | |
| | Interprofessional Education Health Policy | 4,031 | |
| | Story telling | 36,536 | 5 |
| | Story telling policy | 13,959 | |
| | Story telling healthcare policy | 1,457 | |
| **Springer/ICM** | Humanism | 1070 | 4 |
| | Humanism Policy | 413 | |
| | Humanism Healthcare Policy | 162 | |
| | Interprofessional Education | 26,000 | 6 |
| | Interprofessional Education Policy | 13,000 | |
| | Interprofessional Education Health Policy | 13,000 | |
| | Story telling | 20,000 | 8 |
| | Story telling policy | 7,724 | |
| | Story telling healthcare policy | 3,000 | |
| **Web of Knowledge** | Humanism | 16 620 | 0 |
| | Humanism Policy | 177 | |
| | Humanism Healthcare Policy | 2 | |
| | Interprofessional Education | 5595 | 3 |
| | Interprofessional Education Policy | 363 | |
| | Interprofessional Education Health Policy | 295 | |
| | Story telling | 10 660 | 0 |
| | Story telling policy | 289 | |
| | Story telling healthcare policy | 12 | |
| **Open Grey** | Humanism | 142 | 0 |
| | Humanism Policy | 1 | |
| | Humanism Healthcare Policy | 0 | |
| | Interprofessional Education | 62 | 0 |
| | Interprofessional Education Policy | 7 | |

| | | | |
|---|---|---|---|
| | Interprofessional Education Health Policy | 5 | |
| | Story telling | 94 | 0 |
| | Story telling policy | 6 | |
| | Story telling healthcare policy | 1 | |
| **Google Scholar** | Humanism | N/A (500,000+) | 4 |
| | Humanism Policy | | |
| | Humanism Healthcare Policy | | |
| | Interprofessional Education | | 3 |
| | Interprofessional Education Policy | | |
| | Interprofessional Education Health Policy | | |
| | Story telling | | 5 |
| | Story telling policy | | |
| | Story telling healthcare policy | | |
| **Google Search** | Humanism | N/A (500,000+) | 3 |
| | Humanism Policy | | |
| | Humanism Healthcare Policy | | |
| | Interprofessional Education | | 8 |
| | Interprofessional Education Policy | | |
| | Interprofessional Education Health Policy | | |
| | Story telling | | 2 |
| | Story telling policy | | |
| | Story telling healthcare policy | | |
| **WHO** | Humanism | N/A (Unknown) | 0 |
| | Interprofessional Education | | 4 |
| | Storytelling | | 2 |
| **European Commission** | Humanism | | 0 |
| | Interprofessional Education | | 1 |
| | Storytelling | | 0 |
| **OECD** | Humanism | | 0 |
| | Interprofessional Education | | 1 |
| | Storytelling | | 0 |