



humanities at the heart of health care

Program Evaluation, Literature and Medicine Program 2007

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Executive Summary

The Literature and Medicine Program is a health facilities-based, scholar-led humanities reading and discussion program for professionals and staff in the field that benefits both them and their patients. This report details an evaluation survey of 338 individuals who participated in the Program during 2007. Earlier surveys of participants were conducted in 2005 and 2006. Results from the three surveys correspond closely, indicating that the program has had a consistent and positive impact on participants over the 3 year period. Evaluation outcomes significantly reflect the basic Program goals for participating individuals: increased empathy for patients, greater cultural awareness, improved interpersonal relations, better communication and more job satisfaction. The summary of results from the 2007 evaluation survey indicates:

The Program is well-administered. Respondents indicate a high level of satisfaction with activities such as structure, content and the role of facilitators. On-site, process analysis of the program also indicates an effective organizational design and delivery system.

The Program has the ability to recruit new individuals as well as retaining previous participants who contribute to a peer learning environment. Findings on the reasons for participation suggest an important value of the Program: it has the power to address both professional and personal aspects of a person's life. The majority of the participants are middle-aged, mid-career or later and female. These data suggest the Program may want to broaden its pool of participants through a review of strategies to target younger, less experienced and male participants.

The Program had a positive effect on those aspects of participant attitudes measured through standardized scales (empathy, cultural awareness, interpersonal relations, communication, job satisfaction). With the exception of one area (communication), a majority of participants indicated their involvement produced a "medium to large influence" on their professional and/or personal life.

The open-ended comments on the workplace environment cover a wide range of personal and professional themes which serve to indicate the broad impact that the Program can have on its participants. It was able to produce considerable reflection on how actual events in professional life were influenced by the readings and discussion.

In reflecting on these outcomes, it is noteworthy the impact that the Program has had on empathy toward patients and other caregivers. This dimension encompasses elements of personal and professional growth that is not easily taught through training and development workshops. The Program has made a significant contribution, adding to professional development in this area. Further, measurable gains were made in the area of cultural awareness. Issues related to diversity in the workplace have proven to be difficult organizational challenges, not just in the medical, but all fields. The approach used by the Program should be seriously examined by health organizations as a way to increase understanding and communication in diverse employment settings.

In looking to the future, the Program should continue its approach to medical humanism as reflected in its discussions, reading lists and staffing through liaisons and facilitators. The survey suggests no major changes in this regard. However, the Program should examine its recruitment efforts. Despite a large number of participants (545) there is a disproportionate number of older, senior, and female participants. It is difficult in a seminar series, such as this one, to be representative of such a diverse field as health care. Further, it is very decentralized in its recruitment activities. Each of the 54 participating sites is responsible for its own recruitment. But, at the same time, the ultimate impact of the Program will partially depend upon its ability to recruit a cross-section of professionals and staff. A strategy to achieve this end would be to work with participating organizations to broaden recruitment into the Program.

Overview of the Program

This report summarizes the results from a program evaluation survey administered to participants in the Literature and Medicine Program for the year, 2007. The Program is coordinated by the Maine Humanities Council in partnership with humanities councils in other program states. The purpose of the evaluation is to assess the consequences of participant involvement in the Program.

The Program, as described on its web site, (http://www.mainehumanities.org/programs/litandmed/lm_program.html) consists of the following elements:

Created by the Maine Humanities Council, Literature & Medicine: Humanities at the Heart of Health Care® is a national award-winning, hospital-based, scholar-led humanities reading and discussion program for health care professionals that benefits both them and their patients. The Maine Hospital Association has cited it as a patient-quality initiative.

The program encourages participants to connect the worlds of science and lived experience, giving them the opportunity to reflect on their professional roles and relationships through plays, short stories, poetry, fiction and personal narratives in a setting where they can share their reflections with colleagues. It has a significant effect on the way participants understand their work, and their relationships with patients and with each other. It is also an innovative and cost-effective way to improve patient care.

The Program is representative of the emerging field of medical humanism. It represents a broad perspective on health care as a system with many different actors in various roles and locations and responsibilities, both formal and informal. The backgrounds of participants fit the goal of the Literature and Medicine Program: drawing professionals and staff from throughout the health profession. A basic premise of the Program is that the experience of patients should be viewed from a holistic perspective, that health is a function of more than medicine and treatment. It encompasses all the factors that make-up the healing experience for patients. While nurses and physicians may have the most substantive day-to-day-contact with patients, how patients respond to care includes all the elements of the healthcare system and interpersonal factors as well. Conversations with housecleaning staff, for example, may represent the most frequent contact a hospital patient has with anyone on a daily basis. This necessary kind of interaction can be an important part of the healing process (see Cassell, 1985, Crellin, 2005).

The evaluation approach is based on a logic model format developed by the Kellogg Foundation (2001). It involves the specification of goals, resource inputs, program activities, outputs and outcomes. This report primarily focuses on the outcomes of the Program at an individual-level (professional and staff) although data are provided on the assessment of program administration. See Figure 1 for an outline of the logic model.

The report includes an analysis of the survey findings, which involves both open and close-ended questions. Additionally, background data on the respondents are summarized.

The main focus of the report is the extent to which participants evidenced personal and professional growth in terms of five major goals of the Literature and Medicine Program:

- Increased empathy for patients
- Greater cultural awareness
- Improved interpersonal relations
- Better communication
- More job satisfaction

Survey Design

The survey was sent to 545 participants enrolled in the Program during 2007. Administration of the survey was through an Internet provider (<http://www.insitefulsurveys.com/default.aspx>). Email addresses of all participants were collected and the surveys were sent to those addresses. After three rounds of email follow-ups, 338 respondents returned surveys for a response rate of 62 percent. This figure is considered acceptable for internet surveys. The conventional level of acceptable response is approximately 50 percent (Coffman, 2004).

Participants from 54 different sites were sent the survey. At least one respondent from 48 sites (89%) returned a survey. Most of respondents (62%) are from the Northeast where the Program originated: Maine (24%), Vermont (15%), Massachusetts (11%), Connecticut (2%), and New Hampshire(10%). Participants from these following states also returned surveys: Illinois (2%), Florida (2%), Hawaii (5%), Maryland (7%), Nebraska (4%), New Jersey (11%), South Carolina (4%), and Arizona (2%).

Focus groups were also conducted at four Program sites. Where appropriate, data from these groups will be presented in conjunction with the survey findings. These statements can serve to elaborate and build on interview data, often providing possible explanations for survey results (see Morgan, 1997).

Program Participation

Sixty-four percent of the participants were new to the Program in 2007, providing evidence it can recruit new participants. At the same time, it has been effective in engaging individuals on a repeated basis since the remaining 36 percent have been involved for 2 or more years. Given the experience of these individuals, they can provide an important peer learning environment in the seminars. Research shows that the knowledge of peers in a classroom has a positive effect on student achievement (Hanushek, 2003), suggesting the value that participants with multiple years of experience could have for the Program.

The appeal of the Program is evident in the specific reasons cited for enrollment. Table 1 summarizes the data. The question was open-ended and responses were grouped into 7 categories. They can be broadly divided into professional versus personal reasons for choosing to participate. Three categories focus on personal factors. The latter reflect an individual orientation toward the Program and its potential benefit. The categories include: value of literature, personal interest and intellectual stimulation. Four categories are professional in

focus: improved care giving, collegial interaction, learning about issues in medicine, and professional growth and development.

The most-cited reasons for participation are personal, 48 percent. Professional factors also are stated frequently, 44 percent. Consequently, the Program has the power to address both professional and personal aspects of a individual's life—the link between these two being a critical element of its mission.

The value of literature is the main reason for participating (25 percent). In focus groups held with participants, many said the greatest value of the Program was connecting their love of literature to health care. In this context, the Program potentially broadens what an individual reads and the ways in which it affects his or her life. The second, most frequent reason was interaction with colleagues (23 percent). At the focus group sessions, many said it was the only opportunity to meet colleagues outside the traditional confines of their roles.

The presence of personal and professional reasons for engaging in the Program reflects a basic supposition of medical humanities. Many themes addressed in this body of literature (and the arts as well) encompass both dimensions: the nature of the human condition, responsibilities to others, empathy, self reflection and the social milieu of behavior (Crellin, J. K., 2005).

Background of the Participants

The vast majority of the participants are middle-aged. Just 19 percent are 40 years or less in age. Given this age distribution, most are mid-career or later in their field. Seventy-six percent indicate they have been in the healthcare field for more 10 years or more. The vast majority of participants are female, 79 percent. These indicators of recruitment suggest the Program should attempt to broaden its pool of participants. Strategies should be reviewed that allow for targeted efforts to recruit younger, less experienced and male participants.

The challenge in recruiting younger participants into the Program parallels a problem facing the medical field in general. The issue of an aging workforce has been raised in a variety of medical profession publications in the healthcare field (AHA Strategic Policy Planning Committee, 2001). Also, the difference in the number of women versus men (a ratio of more than 3 to 1) participating in the Program should be considered. Gender disparities in the medical profession have long been evident in a variety of areas, from nursing to clinical practice (American Medical Association, 1998). An important program question for the future is why such a difference exists across gender groupings and how it can be remedied.

Participants are a relatively well-educated group. Sixty-six percent have a graduate academic degree. In terms of professional degrees, nurses comprise the largest group. Twenty-nine percent have either an RN or BSRN.

Positions presently held by the participants represent a diverse set of activities within the health field. The largest number holds administrative positions, 25 percent. Examples include program directors, medical librarians and referral specialists. The next largest category is nurses, 19 percent. Physicians comprise 13 percent of the respondents.

Program Administration

Program operations were assessed in a variety of ways. As the logic model in Figure 1 shows, a variety of methods are used to assess this evaluative area: a checklist on whether basic administrative functions are performed, semi-structured interviews with program staff (including liaisons and facilitators), field observation of activities such as the discussions. Questions on the participant survey also focus on this dimension.

The ratings, discussions and observation all indicate that the program is well-designed and implemented. The Program has sufficient fiscal resources to support a wide network of sites: 54 across 13 states. It has an active communication within this network through newsletters, list-serves and a web site as well as one-to-one conversations. An effective process exists to select facilitators and organizational liaisons for each of the Program sites. It holds national conferences on the Literature and Medicine Program and summer workshops for its partners (councils, facilitators and liaisons). The actual discussions elicit broad and energetic involvement among the participants.

Survey questions on program administration also are asked. The results are similarly positive. Eight questions focus on the program and its operations. At least 70 percent of the respondents rate the administration as positive across each of the eight questions:

Time of day	(81%)
Session length	(81%)
Meeting room	(71%)
Session format	(77%)
Size of the group	(77%)
Facilitator knowledge of the content	(90%)
Stimulation of discussion by the facilitator	(85%)
Facilitator moderation of the discussion	(85%)

Based on this process analysis of program administration, it has a sound organizational design and is effective in delivering its basic services.

Individual Outcome Scores

The main purpose of the survey is to collect data on the effects of the Literature and Medicine Program on the attitudes and behavior of its participants. A variety of literature was reviewed to identify potential measurement scales, particularly within the context of the medical field. The logic model was devised, in part, to help clarify goals of the Program, and how they relate to expected outcomes for the Program. The focus of the survey, which is central to medical humanities, is how professionals feel about themselves and understand others, dimensions critical to patient care (Crellin, J. K., 2005).

Five outcome dimensions were identified: Empathy for Patients, Cultural Awareness, Job Satisfaction, Interpersonal Relations, and Communication. A minimum of 5 variables (questions) were developed to measure each domain. Measurement was based on 4 point, Likert equal-appearing interval scale (large, medium, small or no influence).

The Program has a significant effect on all five domains (see Table 2 for a list of the variables and the scores). The percent improvement (“medium to large”) for the five dimensions

ranges between 46 percent and 75 percent. The average or mean improvement across all the five dimensions was 58 percent. For 4 of the 5 dimensions, over a majority of the respondents indicate the Program has, at least, a medium influence on their personal and professional lives. The scores for each dimension are:

*Percent of Participants Who Indicated “Medium and Large”
Influence from the Seminar*

Empathy for Patients	73%
Cultural Awareness	60%
Job Satisfaction	55%
Interpersonal Relations	51%
Communication	46%

Although there is no benchmark for satisfactory performance in terms of a Program of this type, the Literature and Medicine Program appears to have a significant influence on attitudes and behavior change across a broad range of dimensions within the health profession.

Empathy for Patients

Empathy is a concept denoting cognitive as well as affective or emotional dimensions. The cognitive domain involves the ability to understand another person's inner experiences and feelings as well as a capacity to view the outside world from another's perspective. The affective domain is the potential to enter into the experiences and feelings of another individual. In terms of patient-care situations, an empathetic perspective allows the health practitioner to understand the patient's views and experiences and an ability to communicate at this level. The work of Hojat, et. al. (2001) in this area served as the framework in developing the five variables included in this domain.

For 4 of the 5 variables that comprise the empathy scale, over 70 percent indicate the Seminar had a “medium to large influence.” The mean percent across the 5 variables is 73, 13 points higher than the next ranked category, Cultural Awareness. The only score below 70 percent is “nonverbal cues of patients (57%).” An explanation for this lower ranking is that it is difficult to convey this aspect of medical care through the written word, including the type of fiction, nonfiction and poetry readings used in the Literature and Medicine Program. More typically, training in this area relies upon the use of exercises and other forms of experiential education (see Blatner, A., 1985). However, with this exception, participants ranked empathy toward patients as the area in which the Program had its greatest influence.

The focus groups provided specific examples of what participants in the Program actually mean by empathy. Themes that emerged in discussions were: *different perspectives, more compassion, holistic behavior, deeper relationships, greater honesty, complexity of human beings, understanding sub-cultures, and transcending everyday issues with people.* The link among these themes is an increased awareness of self and others and how these dimensions relate to each other.

Cultural Awareness

The National Center for Cultural Competency at Georgetown University (<http://gucchd.georgetown.edu/nccc/pa.html>) created an instrument, Cultural Competence Health Practitioner Assessment (CCHPA) and many of its questions formed the basis of the scale used in this evaluation. The purpose of the instrument is to foster greater cultural competence among practitioners in relationship to different racial and ethnic groups. The instrument includes questions for six subscales. Of particular relevance to the Literature and Medicine evaluation was the Clinical Decision-Making subscale, which asks questions about how well knowledge of the risk factors of diverse groups are integrated into practice.

The average score for the 6 variables (“medium to large” influence) in this domain is 60 percent. It is the second ranked domain. For 5 of the 6 indicators, a majority indicate this level of influence. Hence, the data provide substantial evidence that the Program had an influence in this area.

The variables cover a broad range of topics, from the much discussed role of diverse values in medicine to nonconventional topics such as the potential role of traditional healers and their remedies. Similar to empathy, this area has been difficult to approach from a training perspective. Based on the positive findings from this evaluation, health facilities should investigate the ways in which humanistic readings on cultural diversity could be included in training and development initiatives for staff.

Job Satisfaction

The third ranked domain is satisfaction with one’s job. Fifty-five percent rate the Program’s influence as “medium to large.” This rank is a change from the previous 2005 and 2006 surveys where it was ranked last. There are several reasons why this change could occur. The background of the participants could be different, but the earlier surveys included individuals with similar characteristics. The reading material could have had a greater focus on this topic. However, the facilitators and groups at each site make the decision about the literature. Answering this question would be prohibitive since it would involve content analyzing the literature for 3 different seminar series across more than 50 sites.

Job satisfaction is a complex concept. For example, in the widely referenced work of Herzberg (1959) on motivation in the workplace, 12 factors are cited as relevant to this aspect of a worker's attitudes: organizational policies and administration, recognition, supervision, working conditions, interpersonal relations, salary, status, security, achievement, recognition, advancement and job interest. It is unlikely readings and discussions focused on many of these dimensions, but interpersonal relations are listed. It could be that changes in this dimension, along with empathy which is a factor in relating to others, prompted a reevaluation of how participants viewed their jobs.

Interpersonal Relations

Among the competencies identified by the Accreditation Council for Graduate Medical Education (2006) are interpersonal skills. The Council developed a “Humanism Scale” which encompasses a wide variety of interpersonal dimensions that relate to the medical profession: cooperation with medical colleagues and paramedical staff, physician-patient relationships, rendering comfort and empathy, involving patients in decisions and addressing their concerns

and willingness to admit errors. Several of these dimensions are included in the 8 variable scale measuring interpersonal relations.

Fifty-one percent indicate the Program has a “medium to large influence” on this domain. It is ranked fourth among the six included in the survey. However, 4 of the items do have scores greater than 50 percent, indicating a majority indicate, at least, a “medium” influence from their Program participation. Three of the four questions focus on patient interaction, again indicating the ability of the Program to impact upon how health professionals and staff interact with patients.

Communication

There is increasing emphasis within healthcare on communication as a basic medical skill. Some medical programs have curricula focusing on communication, especially how to work with a variety of stakeholders including patients, physicians, nurses, other healthcare professionals and advocates (Kurtz, 1997). Based on a review of this literature, eight variables were developed to measure the communication dimension.

Communication is the lowest ranked domain (46 percent). It is the only area where a majority did not indicate a “medium to large” influence of the Program. Only one item, “people from cultural and ethnic backgrounds different from your own,” has a majority (57 percent) indicating the influence of the Program at this level. This finding reflects others in the survey on the positive influence of the Program on individuals' responses to cultural diversity. At the same time, only 35 percent gave the same score to communication with patients of a different gender. The Program should look carefully at these results since it apparently had markedly more success addressing cultural/ethnic than gender diversity (although one question focuses on “people,” the latter “patients”). Even given the difference in question wording, the Program should explore whether a greater emphasis should be given gender diversity as topic for 2008 programming.

Program Outcomes: Open-Ended Questions

Participants were asked two open-ended questions. The first focused on what impact the Program had on work life. The second was more defined, asking the participants to provide a description of a specific event in which their participation in the Program had an impact.

Impact on the Workplace Environment

The respondents provided 227 separate statements regarding how the Program affected their work life. Hence, over two-thirds (67 percent) were able to identify at least one aspect of their professional lives impacted by their participation. The open-ended comments are broken down into 5 scales for which the individual, close-ended questions were grouped. The percentages of statements within each domain are: empathy (30%), job satisfaction (26%), interpersonal relations (22%), cultural awareness (16%) and communication (6%). This ranking correlates highly with that of the close-ended questions. The only major difference is cultural awareness. It was ranked 2nd for the close-ended questions. In contrast, the ranking was 4th in the open-ended format.

One possible reason for this discrepancy is the nature of the work environment of many respondents. While cultural awareness may be important to a person, it may not be something that he or she regularly deals with in the work setting. Hence, it is not the first thing that comes to mind when asked about the influence of the Program on actual work life. Despite this one difference, the correspondence of rankings suggests that respondents were consistent in how they assessed the influence of the Program. This consistency is a way to establish the validity of the survey's measurement of the Program's impact.

Empathy

As with the scales measuring individual outcomes, empathy is the most-cited benefit of the Program (30 percent). Thirty percent of the statements reflect this dimension. A single theme dominates the responses that fall into this category. Participation in the Program helped caregivers better understand patients as well as staff and the different perspectives they bring to the medical process. The statements reflect a clear understanding of the value of empathy in health care. Representative quotes include:

- *“The diversity of professional strata in the group gave me a connection to them in a personal way, and we were able to acknowledge this connection outside of the group setting to personally ascertain how we felt about many other healthcare issues.”*
- *“It has made me more willing to consider a patient's departure from the principles of medical practice that I believe in.”*
“I frequently need to address patient/staff conflict. I feel the program gave me some tools to do that with increased sensitivity to reasons for misunderstandings.”
- *“It has helped me better understand the duties of my co-workers, the stresses they face, and the importance of listening to the patient. The information and insight I have learned will help me provide better service to the hospital staff and patients.”*
- *“Helped me understand a little better the way a person that was not well educated might perceive thing.”*

Job Satisfaction

Twenty-six percent of the participants indicate increased job satisfaction as a result of the Program, ranked second. It ranked third in the close-ended responses. The similarities in rankings underscore the importance of this outcome of the Program. Themes which emerge from the statements are: the extent to which the Program helped in coping with job demands, understanding one's responsibilities from a non-medical perspective, increased knowledge about patient care and improved relationships with co-workers.

Examples of statements made by the participants include:

- *“I have very high expectations of myself and others regarding customer service. Sometimes this prevents me from looking at situations/interactions from others perspective. This course has really helped me step back and understand the roles/challenges/experiences of colleagues in accomplishing our mutual work.”*
- *“It didn't change how I worked, but it connected me to others at the hospital in a way that was social and deeply meaningful at the same time. I got to know doctors and nurses and how they felt about my year.”*
- *“Improved my awareness in everyday practice.”*
- *“Put more spirituality in my care-help burnout from administrative negativity.”*
- *“This program helped reconfirm my mission. We work in a very difficult medical model, and the system, litigations health care insurance, makes it difficult at times to practice the way we chose. I worry about humanistic practice and how we interact with one another on the health care team.”*

Interpersonal Relations

In terms of statements that participants make about the value of the Program, those related to interpersonal relations are third in terms of frequency (22 percent). It was ranked fourth in terms of the standardized scales. In important respects, it is difficult to separate statements about this domain from others addressed in the survey. Interpersonal relations often encompass elements of empathy as well as communication. A challenge in coding open-ended responses was to make distinctions among these areas. It cannot be assumed the various domains, although labeled as separate, can necessarily be separated from one another in coding a statement.

One key theme was evident in almost all of the statements related to interpersonal relations. The Program resulted in better relationships with colleagues in terms of work, discussion and understanding. Representative statements include:

- *“I have enjoyed discussing issues with colleagues; these topics do not commonly arise in the day to day situation.”*
- *“Enhanced and enlarged relationships with healthcare professionals with whom I may not otherwise interact very much.”*
- *“Broaden the scope of my experience interacting with such a range of individuals within our organization. There is no other such unique opportunity which is very enriching. It gives me hope for the health of the organization within the larger healthcare system.”*
a non-threatening and non-goal oriented environment. I think we all have come to appreciate each other in new ways.”
- *“Interactions with persons from all different levels of the health care institution improved, including interactions with physicians (medical and surgical), rehabilitative specialists, board members, administrators, laboratory technicians, home nursing and hospice individuals.”*

Cultural Awareness

Sixteen percent gave reasons for the value of the Program that focus upon cultural awareness, ranking fourth among the domains. It was second among the scales for the close-ended questions. The difference, as described above, may be due to the work environment of many participants. On a day-to-day basis, they may not regularly encounter issues of cultural diversity. Hence, the effect of the Program would likely be less than for an individual in a diverse workplace.

A frequent theme in the responses on cultural awareness was how the Program increased awareness of racial, ethnic, gender and other differences and how they influence healthcare practice. Below are examples of actual statements made by the respondents:

- *“It helped me to better understand the other cultures and not to be so hasty in making judgments until I had all the facts and understood more about their medicine.”*
- *“The anthropological study of Hmong family provided exposure to dramatic differences/problems of cultural perspectives. We need constant reminders of the vital influence of one's cultural dimensions.”*
- *“The conversations we had with colleagues was absolutely wonderful. I so appreciated hearing what the doctors were thinking and worrying about. The cultural issues really opened up for me and I gained more respect for diverse cultures and the ways things are seen in relationship to medicine.”*
- *“Awareness. Though my work is related to patient as potential contributor, the awareness of diversity is still key.”*
- *“More awareness of cultural beliefs in healing.”*

Communication

Six percent of the participants gave examples of a communication impact, ranking fifth among the domains. It was also a lower ranked domain for the scales, ranking last. The comparability of rankings for closed and open-ended questions indicates that communication impacts from the Program are not as evident as for other domains. However, there are substantial overlaps between it and other ones included in the survey, particularly interpersonal relations and empathy. Coding statements, according a specific dimension can be difficult, when such overlaps exist.

A primary theme in the responses was organizational. Participants often said their ability to communicate with patients, other staff members and different organizations had increased. Below are examples of this theme:

- *“The program increased awareness of difference of opinions.”*
- *“Contributes to a richer dialogue between the medical and nursing staff and the board.”*
- *“Opportunity to interact with other staff in a serious context, not directly related to immediate patient care issues. Promotes better communication and understanding with other staff.”*
- *“It has provided me with a wonderful opportunity to have conversations of substance with coworkers.”*
- *“Helped me with public speaking and understanding others who are not like me or do not share my worldview.”*

Examples of Program Impact

Respondents were asked to describe a specific event to illustrate how the Program impacted them. The purpose of this question was to get them to think about outcomes, not in a general sense, but in terms of concrete examples. This approach is close to "grounded theory," an attempt to build social science constructs by asking questions and/or observing everyday events of the subjects under study (see Glaser and Strauss, 1967). The goal was to "ground" the responses in terms of daily organizational life.

A total of 177 statements were made by the respondents. However, many were very general and did not reference a “specific event” (105 or 59 percent). However, among the 67 statements (38 percent) that did reference an actual occurrence, many were detailed and offered a “real world” view of the Program’s influence.

Given many of these statements involved multiple sentences, they often included multiple themes. The themes are defined in terms of the five domains employed in this evaluation. Of the total number of statements (67), 48 percent made reference to multiple domains. Overall, 93 different domain references appeared in the statements. All referred to some aspect of the workplace and one’s role, so all reflected some element of “job satisfaction” as defined in the close-ended items of the survey. In terms of the other four domains, the distribution of themes is: empathy (39%), interpersonal relations (25%), communication (23%) and cultural awareness (14%). Again, empathy emerged as the domain where the influence of the Program was most evident. The rank for the other items is quite different from the close-ended and other open-ended question (on how it affected work life). However, listing a specific event is not as much an assessment of the Program’s influence as whether its activities were actually reflected in an event in the health care setting. For many, such an event may not have occurred or they could

not remember one.

A number of these statements are listed below:

- *“I am a clerk. Patients walk in the front door and come to me for answers whether the question has to do with my department or not (Primary Care). Veterans come in already angry. Our group read Achilles in Vietnam. Angry veterans come in everyday and get angry with the system, etc. Actually they come in the door angry. It isn't me, its what they live with. I can better separate myself from their anger instead of taking it personally.”*
- *“Our program was covered by the Chicago Tribune. I was quoted in the article and have had a few reactions to my statements. I have been able to respond in an open manner to those who disagree with my opinion.”*
- *“I was talking to one of the doctors who attended this group over some other issue, and he demonstrated how he felt about that issue by saying that this was an illustration of being treated like a Hmong. I knew exactly what he meant, and for both of us, that comment evoked the feelings we were experiencing as we were reading The Spirit Catches You and You Fall Down.”*
- *“I've been working with a philanthropic donor who wanted to create a gift annuity for the hospital, but developed Alzheimers in the process. The discussions of aging and illness led me to involve the whole family in this and future decisions.”*
- *“I was having some difficulty interacting with a staff member from a group outside of my own team. As we got to know each other better through this program we found out that we are very much alike and came to appreciate each other in new ways. The project that we were working on went on to become very successful. We still complement each other and very much respect and appreciate each other's contributions to our organization.”*

These statements provide examples of how the participants linked the readings and discussions to their actual working life: be it personal understanding, the support of people, how individuals and groups interact and caring for others. It is difficult to capture the value of literature in program evaluation, but these statements provide a rich and detailed accounting of the Program and what it meant to participants in specific work circumstances.

Conclusion

The Literature and Medicine Program is a health facilities-based, scholar-led humanities reading and discussion program for professionals and staff in the field that benefits both them and their patients. This report details an evaluation survey of 338 individuals who participated in the Program during 2007. Earlier surveys of participants were conducted in 2005 and 2006. Results from the three surveys correspond closely, indicating that the program has had a consistent and positive impact on participants over the 3 year period. Evaluation outcomes significantly reflect the basic Program goals for participating individuals: increased empathy for patients, greater cultural awareness, improved interpersonal relations, better communication and more job satisfaction. The summary of results from the 2007 evaluation survey indicates:

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In reflecting on the outcomes, it is noteworthy what impact the Program has on the empathy of participants toward patients and other caregivers. This is a dimension of personal and professional growth that is not easily taught through training workshops. The Program has made significant contribution, adding to professional development in this area. Further, measurable gains were made in the area of cultural awareness. The general question of diversity

in the workplace has proven to be a difficult organizational problem, not just in the medical, but all fields. The approach used by the Program should be seriously examined by health organizations as a way to increase understanding and communication in diverse employment settings.

In looking to the future, the Program should continue its approach to medical humanism as reflected in its seminars, reading lists and staffing through liaisons and facilitators. The survey suggests no major changes in this regard. However, the Program should examine its recruitment efforts. Despite a large number of participants (545) there is a disproportionate number of older, senior, and female participants. It is difficult in a seminar series, such as this one, to be representative of such a diverse field as health care. Further, it is very decentralized in its recruitment activities. Each of the 54 participating sites is responsible for their own recruitment. But, at the same time, the ultimate impact of the Program will partially depend upon its ability to recruit a cross-section of professionals and staff. A strategy to achieve this end would be to work with participating organizations to broaden recruitment into the Program.

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TABLE 1 Reasons for Participation in the Literature and Medicine Program

Reasons Percent / n	
<i>PERSONAL 48% (154)</i>	
Value of Literature	25% (81)
Intellectual Stimulation	4% (13)
Personal Interest	19% (60)
<i>PROFESSIONAL 44% (141)</i>	
Collegial Interaction,	23%(74)
Learning about Issues in Medicine,	9%(29)
Improved Caregiving,	6%(20)
Professional Growth and Development	6%(18)
<i>OTHER 8% (25)</i>	
<i>TOTAL 100% (320)</i>	

TABLE 2 Individual-Participant Outcomes

<i>Variables</i>	<i>Percent who Indicate “Medium or Large Influence”</i>
<i>EMPATHY FOR PATIENTS</i>	73%
Trying to put myself in the patients place	81%
Ability to show compassion	75%
Belief in the role of empathy in health care	77%
The emotional state of patients and their families	71%
Nonverbal cues of patients	57%
<i>CULTURAL AWARENESS</i>	60%
Attention to diverse values and belief systems about health and disease	70%
Patient perceptions of the reasons for their disease	66%
Value of culturally relevant information from family members	64%
Potential significance of traditional remedies to patients	58%
Significance of factors such as race/ethnicity and gender in screening and diagnosis	50%
Potential significance to patients of traditional healers (e. g. curanderas, santeras, medicine men or women, espiritistas)	46%
<i>JOB SATISFACTION</i>	55%
Your appreciation of your colleagues and coworkers skills and contributions	67%
Appreciation of your own skills and contributions	60%
Commitment to your profession and/or work	48%
Your ability to deal with the stress of your work	45%
Your job satisfaction	44%
<i>INTERPERSONAL RELATIONS</i>	51%
Attentiveness to patient concerns	63%
Trying to put patients at ease	58%
Interacting with patients	52%
Interacting with medical staff	52%
Involving patients in decision-making	48%
Interacting with non-medical staff	45%
Interacting with paramedical staff	41%
Acknowledging mistakes to yourself and others	34%
<i>COMMUNICATION</i>	46%
People from cultural and ethnic backgrounds different from your own	57%
Children (pediatric patients)	51%
People from economic and/or educational backgrounds different from your own	50%
Other health care professionals and allied staff	50%
Persons from geographic locations (e. g. rural and urban) different from your own	44%
Adult patients	43%
Patients of another gender	35%
Families (of patients)	32%

**FIGURE 1:
EVALUATION LOGIC MODEL
*Literature & Medicine: The Humanities at Work in the Heart of Health Care -- Maine Humanities Council***

GOALS	RESOURCE INPUTS	ACTIVITIES	OUTPUT S (SERVICES)	OUTCOMES (INDIVIDUAL-LEVEL)	IMPACTS (ORGANIZATIONAL-LEVEL)
<p><u>Individual Level</u> (health care professionals e.g.: doctors, nurses, physician assistants, nurse practitioners, psychiatrists, therapists, e.g., physical, hospice workers, allied and support staff, chaplains, trustees) -Reflect on responsibilities as health care professionals -Increase satisfaction with their work -Explore the quality of professional and patient communication</p> <p><u>Organizational Level</u> (hospitals, hospice/palliative care facilities, community health care organizations) -Integrate humanities with health care -Introduce a variety of perspectives on health care -Communicate across professional roles within health care system</p>	<p>Humanities Council staff Scholars Materials (including readings; annotated bibliography; manual; website; SYNAPSE.E-newsletter; & anthology -in progress) Equipment Fiscal support Meeting sites Hospital Liaisons</p>	<p>Summer Institute -Readings -Discussion groups -Syllabus workshops -Panels & Plenary Sessions <i>Literature & Medicine</i> National Conference -Readings -Discussion groups -Speakers -Panels & Plenary Sessions Technical support from MHC staff Regional & National Meetings (for humanities council staff)</p>	<p>Readings Group discussions (scholars) Administration (hospital, liaisons, scholars, humanities councils) Scheduling and organization Group membership Meeting space Participation levels</p>	<p>Empathetic behavior Interpersonal Relations (attitudes, behavior) Interpersonal communication (e.g. careful listening) Cross cultural communication Conflict resolution Questioning assumptions Self awareness Holistic health care philosophy Critical thinking</p>	<p>Role perception (in relation to other health care professionals) Patient / caregiver relationship Holistic / patient centered care Sensitivity and acuity to patients Continuity of care Team building Staff recruitment and retention levels Peer support Professional versus patient language Burn out Self care</p>
EVALUATION QUESTION	What are the resources that are devoted to the achievement of program goals?	To what extent are the goals of the project reflected in its activities?	How are program services rated by humanities council staff, scholars, liaisons and participants?	What have the participants gained personally from the program?	How have health care practices changed due to involvement in the program?
EVALUATION METHODOLOGY	Resource audit ("checklist")	Semi-structured interviews of Council staff and participants Field observation (by evaluation staff) Documents (e.g. minutes of sessions, content of readings) Internet Survey (of participants based on open-ended survey questions)	Internet Survey (of participants based on standardized survey instrument and open-ended survey questions) Focus groups of participants	Internet Survey (of participants based on open-ended survey questions) Focus groups of participants	1) Focus Groups (of participants) 2) "Mini" Best Practice Case Studies (written by participants)
DATA COLLECTION	<p>Data collected before initiation of proposed program evaluation. Formative (process) evaluation Data collection will begin prior to the start of the program and continue to its conclusion. Summative (output) evaluation. Data collected at conclusion of the program. Summative (outcome) evaluation. Survey administered pre and post program. Summative (impact) evaluation. Data collection 3 to 5 months after the program's end</p>				