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Editorial

Regarding Faculty Development: Challenges and Methodological Resources for Bringing Humanism into Clinical Practice

Formando os Formadores: Desafios e Recursos Metodológicos para Levar o Humanismo até a Prática Clínica

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In an editorial published in this space[1], we analyzed the opportunities and threats that the recent and immense growth of MEO (Medical Education Online) has brought us due to pandemic times. The reflections of this editorial led us, through movie scenes, to the irreplaceable importance of medical education in practice, in the "*trench*", what the cinematographic perspective called "*the smell of the Sistine Chapel*". It is not enough to know everything about Michelangelo, but it is necessary to feel, to smell, being there, to incorporate the learning. Which leads us to a new reflection, now regarding the facilitator of the process, who will guide the students in this plunge into real medicine – already in the Sistine Chapel – so that they can, in fact, learn.

The smell. The mosaic. A step back. A new field of vision to recognize and give new meaning to the beauty of encounter and in health care. To smell "*the Sistine Chapel*" or any kind of real experience in practice we need to sharpen our senses: sight, smell, touch, listening, speaking. Teaching through experiencing practical situations requires opening and expanding our senses to the unknown. When it comes to medical teaching, the "*visit to the Sistine Chapel*" imposes several challenges to all subjects involved. It requires a little more, especially from the teachers – guides – who propose to develop a teaching-learning process in loco.

To face such a challenge, faculty would need to take on a double task: develop technical knowledge (clinical reasoning, diagnostic hypotheses, and therapeutic possibilities) and recognize the meaning (perceptions, meanings of each one) that the students actually experience in and through the experience. Certainly, the visit to the Sistine Chapel requires a step back that allows the professor to open to the human being, to its totality and uniqueness, to the person: it requires a humanistic perspective of medical action and of the teaching task[2].

A new need thus arises: first, for the academic professors who conduct the learning process, but also for the "*front-line*" medical professionals who provide services to patients and families in the various care settings, being the true "*guides*" of the students when in the trenches of the Sistine Chapel. A single movement is needed, from the academic source to the end, so that there is no divorce of thought or sowing of perplexity: what the student learns in the classroom must be made possible later in the assistance, in practice. And this is not what happens, quite often, in the student's routine[3]

We live in paradoxical times in these post-pandemic moments. Despite the advancement of MEO technologies, students are increasingly voracious "*to get into action*", to see patients and experience "real

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medical practice" in order to reduce the sense of "*lost time*" caused by a forced and necessary pandemic reclusion[4]. However, the lenses created from the academy, behind the sharp eyes, insist on "*looking at the disease*" and not on seeing the patient. We are inside the Sistine Chapel, but in front of the seductive beauty of technique the patient loses his contours.

The re-signification of the object of medical practice requires investment in a type of wisdom that is distinct from theoretical and technical knowledge: we also need to exercise practical wisdom (what to do when faced with a particular situation, when faced with a particular patient and a particular family). In this sense, the importance of listening and dialogue are placed as one of the main attributes of medical work.

The agreement on care plans and strategies, the shared decision with the subjects only happens in act, at the exact moment of the encounter between the subjects. The pedagogical exercise - with students at the bedside or in outpatient clinics – must necessarily go beyond the indispensable discussions about diagnoses and therapeutic conducts. We need to include the dimension of practical wisdom - true Aristotelian praxis – in the encounter between teachers, professionals, and students. How are we going to agree on our conducts, based on technical and scientific protocols, with patients and families? How to perform and teach this in the encounter that is always unique and surprising?[5,6].

For this, it is necessary to advance in the formation not only of students during medical graduation, but especially of professionals (preceptor physicians) and teachers who are daily faced with the double challenge of caring for patients (in the battlefield) and teaching new generations humanistic and communicational competences that are essential to the technical and practical success of actions. The appreciation of the mosaic and the endless possibilities of teaching-learning in practice settings needs to be accompanied by provocations that sharpen the senses and enable other reflexive openings for new experiences and dialogues.

In this sense, the Medical Humanities are an indispensable resource to take this step back, and prepare for the encounter: with the patient, and with the student. During some years of the last decade (2009-2011), the Discipline *Evaluation of New Pedagogical Resources for the Humanistic Training of Physicians* (MPT5789) was offered in the post-graduation course in sciences at FMUSP, located in the Department of Pathology. Some of the results of this faculty development course were recently published[7].

The Medical Humanities are the starting point. But it is necessary, next, to take the learning to the clinical practice. The challenge is great. I remember once, in a similar course given to medical students, where we used the cinema as a reflection resource, the students wanted to take this reflection to the practice in the emergency room. There was a certain revolution because the professors were not involved. And one of the emergency room leaders even commented that cinema is one thing, real life is another. That is, it doesn't work unless the leader is also involved in the course. This is the desirable format for Humanizing Medicine through the Medical Humanities.

The resources are many and varied, as pointed out by the bibliography already elaborated in this line of research[8]. Good intentions are not enough, but specific methodology and prepared teachers are required. The emotions that learning awakens – in students and teachers – are not only inevitable, but desirable. But it is necessary to know what to do with these emotions[9]. This is another point where projects end up bending.

And, finally, teaching Medical Humanities, involving students and professors, implies an investment of time and resources. Otherwise, any humanizing movement is not sustainable[10].

The smell of the Sistine Chapel can be appreciated when it is in the hand of a capable teacher-guide. Only then, it is possible to live this phenomenological experience of the encounter with the patient and to develop medicine as science and art. For this we need the humanities, as pointed out by Pellegrino[11], because they are the resources that provide the attitudes and competences that distinguish an educated doctor from a simple executor of techniques and procedures. This is how, in the opinion of the same author, medicine can be seen as the most scientific of the humanities, and the most human of the sciences[11].

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