INTRODUCTION

Humanistic care in the twenty-first century requires reflective maturity, global perspectives, interdisciplinary, technical information, and comfort with ambiguity. Health professionals face challenges everyday when offering their services to people. They know what they know and do not know, and have alternative methods to make clinical decisions. Health professionals also need to be reflective in the context of patients, families, and communities. It is very important that health professionals are enabled to be reflective, critical, flexible, and comfortable with humanistic care [1]. In 1992, Carper regarded the various “patterns of knowing” as “not mutually exclusive”, as “interrelated and interdependent” [2]. By focusing on the concept of humanistic care, health professionals will be able to understand the core values in their services.

From the significance of the reflective, multidimensional approach to humanistic care, we realize that the health care arena is an extremely complex and dynamic process. Therefore, there are many ways in which humanistic care can be implemented in the care of individuals, families, and communities. In addition, health professionals need humanistic care to provide their services as a multidimensional reflective experience. Self-reflection, history, legal and ethical issues, spirituality, culture, family, media, group, evidenced-based practice, economics, and health policy can all affect humanistic care, and need to be critically thought about as an important process to consider throughout humanistic care [1]. Being aware of the possibilities allows for fluidity and flexibility in thinking that the health professional needs. Health professionals touch the lives of people in every situation from birth to death, in health and illness. Care is a human response to a particular situation. To allow for diversity of ideas, health professionals write from their own experience, use their own case studies, and develop their own thoughts on the caring situation.
How do people respond to issues surrounding sickness and health? As a teacher thinking about how to teach in the 21st century, it is wise to understand the changes in approaches to education. With regard to health care education from the 20th to 21st century [3], here are some strategies: (1) the “dreaded” lecture; (2) small group learning; (3) problem-based learning; (4) case study; (5) reflecting on reflection; (6) role play—a stage of learning; (7) creative activities; (8) simulation—transforming technology into teaching; (9) experience learning exercises; (10) blended and e-learning; (11) self-directed study; and (12) applying strategies to practice.

This article will elaborate on the following issues: reflection and critical thinking; humanistic care; core values and teaching strategies in medical education; and learning of life cultivation.

**Reflection and Critical Thinking**

O’Donnell et al defined self-reflection as “an examination of one’s own thoughts and feelings, and requires maturity and a desire to know who you are” [4]. The genesis for humanistic care began when we taught education; self-reflection was used to develop a nature of knowledge needed for medical practice. Knowledge lies embedded within everyday life experiences, and how to transform daily experience to the answer we need is self-reflection. Self-reflection asks that we look at ourselves and transform our everyday life experience to knowledge that can then be applied in humanistic care [1]. As a result, those intellectual and affective activities in which individuals engage to experience will lead to new understandings and appreciations [5].

When expressing care, health professionals need to understand that the process requires looking inward at one’s own self, then outward at the world around them, and then back in again. We describe who we are, where we are from, our education, and relate how these experiences have shaped our philosophy and care for others. During the period of reflection, we can share and recognize that reflection is the process of looking back at an experience or situation and analyzing it. It is an opportunity to question our values, beliefs, and assumptions [6]. We each draw from our intra- and interperceptual experiences; however, it is better to have adequate action with self-reflection and awareness of what the self brings to the humanistic care process. Reflection can facilitate the development of encouraging inquiry and autonomy, acknowledging feelings, increasing self-awareness and understanding, and enhancing professional practice. Witmer described these steps in reflection: (1) look back; (2) elaborate and describe; (3) analyze outcomes; (4) revise approach; and (5) new trial [7].

**Critical thinking** was defined by Campbell as “open-minded reasoning; use of intellectual standards of reasoning including, clarity, depth and breadth of understanding and relevance of information to a situation, and questioning of assumptions and biases” [8]. In addition, critical thinking gives us a way to look at the world and, thus, support the work we do. According to Paul and Nosich’s theory, critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, and communication, as a guide to belief and action [9].

There are five elements to critical thinking: thought; macro-abilities; traits of the mind; affective dimensions; and intellectual standards. Further, there are six processes that can improve critical thinking ability: experiential learning; reflection; advanced questioning technique; computer assisted instruction; concept mapping; and case method. Combining nursing theoretical work with critical thinking, we can find that critical thinking is essential in this era of theory utilization because theory provides the basis for nurses’ knowledge as well as a structure to guide caring actions [10].

**Humanistic Care**

In the 21st century, health professionals are expected to provide more than medical care, going more in the direction of holistic care. Medicine can be not only a science but can also be more humanistic by assisting people to seek their own value of life and achieve self-actualization and self-healing. Maslow’s hierarchy of human needs (Figure 1) provides the profound map to understand humanistic desires.

Looking into Watson’s theory [11], humanistic caring is a fundamental belief in the internal power of the care process to produce growth and change for people. Watson believed that faith–hope can facilitate
the promotion of holistic nursing and positive health. Watson’s 10 care factors are: (1) formation of a humanistic–altruistic system of values; (2) instillation of faith–hope; (3) cultivation of sensitivity to one’s self and to others; (4) development of a helping–trust relationship; (5) promotion and acceptance of the expression of positive and negative feelings; (6) systematic use of the scientific problem-solving method for decision-making; (7) promotion of interpersonal teaching–learning; (8) provision of a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment; (9) assistance with gratification of human needs; and (10) allowance for existential–phenomenological forces. Watson defined each of these care factors and gave examples of what nurses can ask themselves critically with regard to each factor. For example, for: (1) formation of a humanistic–altruistic system of values: practice of loving-kindness and equanimity in the context of caring-consciousness. The questions you can ask yourself are: “Who is this person? Am I open to participate in his/her personal story? How am I being called to care? How ought I to behave in this situation?” For: (2) instillation of faith–hope: being authentically present and enabling and sustaining the deep belief system and subjective life world of self and the one-being-cared-for. The questions you can ask yourself are: “What does this relationship mean to this patient? What health event brought this person to the health facility? What information do I need to nurse this person? Can I imagine what this experience is like? Can I encourage this person to find faith/hope?”

Applying Watson’s perspective, when working with others during times of despair, vulnerability and the unknown, we are challenged to learn again, to reexamine our own meaning of life and death [11]. A human-to-human act of caring within a given moment becomes a basic foundation for facing our humanity, uniting us and the cosmic energy of love. Caring and compassionate acts of love beget healing for self and others [12]. For Christians, humanism means valuing life over material things, and to encourage ethics and moral values [13]. The sacrament of reconciliation is considered: in relation to God, in relation to my neighbor, in relation to myself [14]. Watson’s human care theory projects a reverence for the mysteries of life and an acknowledgment of life’s spiritual dimensions. A health care professional who is tuned in to life’s spiritual dimensions can express care and help patients do the same by taking into account patients’ spiritual needs; they have the ability to understand their own spirituality and that of the patient, family, and community. Chen addresses values, religious beliefs, and what is meant by spirituality and humanistic care in nursing [13].

**Figure 1. Maslow’s hierarchy of human needs.**
and beliefs [17]. The Taiwan Nursing Accreditation Council identified different professional core values of universities and colleges. For universities, they are: (1) critical thinking and reasoning; (2) general clinical skills; (3) basic biomedical science; (4) communication and teamwork capability; (5) caring; (6) ethics; (7) accountability; and (8) life-long learning. For colleges, they are: (1) general nursing skills; (2) basic medical sciences; (3) respecting life and caring; (4) identifying and solving problems; (5) professional conduct and teamwork capability; and (6) self-development [18].

There has been a great growth in knowledge and research with regard to education, resulting in many theories of how to learn. Some of them have been grouped under schools of thought as follows:

- **Behaviorist.** This theory presents transactional analysis theory and considers that positive and negative strokes to self-esteem have great impact on learning.
- **Cognitivist.** Here are many theorists who consider that in terms of skills acquisition, a learner moves from being a novice to being a potential expert.
- **Humanist.** Learners are people; we learn from each other and have different driving forces and life problems.
- **Reflectionist.** Focus is on what goes on inside an individual’s head, their thinking. Due regard is given to the idea that we can use this to identify learning, in a reflective way [3].

In relation to teaching styles, there are also several models:

- **Kolb’s model.** Kolb, who considered the different processes of concrete and abstract thinking, together with experimentation and observation. There are four categories of learners; a learner will have a preferred leaning towards one of the categories: diverger, converger, assimilator, accommodator.
- **Honey and Mumford’s model.** In this theory, students are categorized as activists, pragmatists, reflectors or theorists.
- **VARK model.** These models consider the cognitive processes (visual, auditory, reading/writing, kinesthetic); students will have a preference for one to enhance learning.
- **Neurolinguistic programming.** Helps provide reference to individuals who think with pictures, sound and feeling. Also, the other senses of taste, touch and smell are connected with memories; therefore, learning may be improved if these aspects are also incorporated into the teaching sessions.

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- **Robins and Greenwood.** They describe two different teaching styles—conservative and progressive.
- **Gilmartin’s model.** There are four styles. Type 1 is a didactic style, type 2 is similar to type 1 but includes experiential activities, type 3 favors student-centered facilitation, and type 4 focuses on creative approaches.
- **Grasha’s model.** This reflects the activity pursued by the person at the front of the class. There are five categories: expert, formal authority, personal model, facilitator, delegator.

### LEARNING OF LIFE CULTIVATION

Caring concern is the core of nursing. Quality medical care is patient-centered and based on safety, effectiveness, adequacy, efficiency, and equality. The incorporation of care, concern and compassion (3Cs) into nursing education is the major subject we would like to discuss [19]. The 3Cs are the mission of the School of Nursing, Catholic Fu-Jen University in Taiwan. In research into the 3Cs applied in nursing education, Shiau demonstrated that the relevant concept and strategies embracing the 3Cs of nursing education can develop into the learning of life cultivation through which are included three elements: growing experience; life’s meaning and value; and professional services (Figure 2) [20].

![Figure 2. Learning of life cultivation.](image-url)
Shiau et al reported on the phenomena of offering and receiving 3C experiences of life, based on emphasizing the cultivation of life education in nursing education. Their findings demonstrated that utilization of the 3Cs to offer and receive experiences of bitter events can transform the bitterness into a learning mechanism of love and wisdom. Their results provide important references for the continued development of the fundamental theory and strategies of life education in nursing, and the enhancement of in-depth self understanding and service to others [21]. In another report, Shiau et al studied one teacher and 11 students on a “Leadership and Management” course. They participated in weekly discussions of the learning experience associated with the clinical practicum. Content analysis revealed four main problems: “individual characteristics of patients and families and their stress adaptation on bio-psycho-spirits”; “humanity-centered procedures and equipment”; “suffering related to nursing working context”; and “nurse growth to be a whole person”. The following problem resolutions were found: “offering care in respecting the individual characteristics of patients and their families, and stressing care in stress adaptation of bio-psycho-spirits”; “formulating and planning humanity-centered nursing procedures and equipment”; “cultivating an understanding and supportive nursing administration culture”; and “constructing a developing program of knowledge, attitude and behavior for self and professional development” [22].

A 3Cs Learning Group was developed to promote nursing leaders’ adoption of the concepts and competencies of the 3Cs in nursing administration in order to more firmly root nursing care in care for the human being [23]. The findings demonstrated the effectiveness of the mentor’s facilitation concepts and skills, and the dynamic operation of the group process (Figure 3). The results can provide information and suggest techniques to assist nursing leaders in 3Cs learning groups to promote self growth and encourage nursing staff to enhance service advocacy and quality [24].

The results of this series of research studies with the incorporation of 3Cs will develop a humanitarian perspective, focused on patients, nurses, and the working environment perspective, which will more closely meet the core values of caring concern and medical quality.

Figure 3. Dynamic operation of the group process.

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