I was interested to read Matthew Reisz's recent article 'Helping doctors see the whole person', which argued for an increased focus on medical humanities in UK medical education. As a health psychologist based within an interdisciplinary centre for health services studies, I work alongside academic and clinical colleagues with a passion for improving health and social care through research. An important aspect of this work is the development of evidence-based curricula for health and social care professionals. To be 'fit for purpose' these must be designed to meet the evolving health and social care needs of the population and enable practitioners to develop the skills needed to work within systems that are undergoing rapid change.

The challenges facing health and social care systems are well documented. For example, data on obesity in England indicate that around two thirds of adults, a third of 11-15 year olds and a quarter of 2-10 year olds are overweight or obese (Public Health England, 2017). Obesity increases the risk of conditions including cancer, heart disease, stroke, type 2 diabetes, depression and anxiety. The annual cost to the NHS is estimated at £6.1bn, with costs to Social Care of £325m and total costs to the economy of £27bn (Public Health England, 2017). Population aging is also associated with rising prevalence of long term conditions (LTCs), which affect around 50% of people aged 50 and 80% of those aged 65; multi-morbidity is increasingly common (Department of Health, 2012). Mental health co-morbidities represent a further challenge - around 30% of all people with a long-term physical health condition also have a mental health condition and this figure may be closer to 50% for those with two or more LTCs (Naylor et al., 2012). People with LTCs find it harder to manage their treatment regimes in the context of reduced psychological wellbeing, are less likely to take medicines as prescribed (NHS Confederation, 2012). Mental health co-morbidities in people with LTCs have been linked to poorer clinical outcomes, reduced quality of life, increased costs to the health service and increased overall morbidity (Naylor et al., 2012; NHS Confederation, 2012). At the same time, health and social care professionals are facing mounting workloads and greater levels of stress and burnout (Kinman and Teoh, 2018).

To respond effectively to these challenges, practitioners need to develop an understanding of the way people think and behave, what it means to live with chronic illness, how and why beliefs about health and illness vary and how factors such as beliefs, values and social norms influence the way people manage and cope with health problems. They need to develop new competencies, including those necessary to support health behaviour change, long-term conditions management and maintenance of psychological wellbeing (their own and others). This involves drawing on not only the medical humanities, but also the behavioural and social sciences (B&SS).

In recent years, the importance of B&SS in medical education has been increasingly emphasised. Evidence based curricula have been developed for teaching psychology (Bundy et al., 2010) and sociology (Collett et al., 2016) to medical students. However, research has also revealed barriers to integration of B&SS into medical education and highlighted the importance of commitment from both clinical faculty members and B&SS specialists (Tabatabaei et al., 2016; Litvia & Peters, 2008). Public Health England recently published a comprehensive strategy to enable public health professionals to use B&SS to improve health and wellbeing (Public Health England, 2018) – many of the underlying principles (e.g. working beyond traditional disciplinary boundaries; adopting a reflective and critical approach, informed by evidence) are also applicable to the wider health and social care workforce.

Reisz's article highlights the struggle medical students face in adopting a more reflective and critical approach to both their own practice and the needs of the patient. To do so, the individual must be willing to ask questions that do not have a single 'right' answer, to embrace the limits of their own knowledge and engage with human suffering in the raw. Drawing on a wider range of disciplines may help to equip practitioners for working in this way, providing tools they can use to formulate an understanding of problems that would otherwise appear messy and intractable, together with knowledge of evidence-based approaches for responding to emotional, behavioural and psychosocial support needs.

Helping doctors to see the whole person is important, but it is only the first step. Faced with the reality of human suffering and fragility and the multiple interacting factors influencing individual health and wellbeing, doctors also need to know how to respond. To make this possible, clinical educators and disciplinary experts will need to work together more closely.

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