

# The Path to Professionalism: Cultivating Humanistic Values and Attitudes in Residency Training

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## ABSTRACT

Though few question the importance of incorporating professionalism and humanism in the training of physicians, traditional residency programs have given little direct attention to the processes by which professional and humanistic values, attitudes, and behaviors are cultivated. The authors discuss the underlying philosophy of their primary care internal medicine residency program, in which the development of professionalism and humanism is an explicit educational goal. They also describe the specific components of the program designed to create a learner-centered environment that supports the acquisition

of professional values; these components include a communication-skills training program, challenging-case conferences, home visits with patients, a resident support group, and a mentoring program. The successful ten-year history of the program shows how a residency program can enable its trainees to develop not only the requisite excellent diagnostic and technical tools and skills but also the humane and professional attributes of the fully competent physician.

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### Hippocratic Oath

May I escape  
the shame, inadequacy, self-judgement and self-doubt  
my teachers have taught me.

May I trust  
that my love is as needed as my knowledge.

May I remember  
in me, the limitations of every man.

May I be open  
to know my darkness and true to what light I have.

May I be used  
as a blessing and a friend to life.

RACHEL REMEN, MD  
Wounded Healers

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In addition to developing superb diagnostic and technical skills, a core task for postgraduate medical education is teaching physicians how to provide humane and professional care to patients. Recognizing this, the American Board of Internal Medicine (ABIM) now requires programs to foster the development of professionalism in residency training. According to the ABIM, professionalism "comprises those attitudes and behaviors that sustain the interests of the patient above one's own self-interest. Professionalism entails altruism, accountability, commitment to excellence, duty and commitment to service, honor and respect for others."<sup>1</sup> In addition, the ABIM now requires residency programs to evaluate trainees' humanistic behaviors, including the qualities of integrity, respect, and compassion.

Though the terms professionalism and humanism each carry their own particular definitions and attributes, we consider both of these qualities to be inextricably woven into the practice and art of medicine, and therefore consider both in this article. We believe that the process of socialization and the various ways trainees learn and internalize professional and humanistic values, attitudes, and behaviors by observing and working with other professionals are critically important in training physicians.

In this article, we explore some of the components of residency training that can establish the development of professionalism and humanism as an explicit educational goal, and describe the programs and policies of our internal medicine residency program.

### BACKGROUND

Traditional training programs have commonly reinforced such values as the primacy of objective data over subjective experience, reluctance to acknowledge uncertainty, promotion of self-reliance at the expense of collaboration, and unrealistic expectations of control.<sup>2,3</sup>

While traditional approaches may not preclude residents' development of humanistic and professional values, the lack of explicit attention to this aspect of training often results in these values' being neglected or subtly devalued. Such a learning environment often takes shape without awareness or forethought, yet it can exert a powerful formative influence on trainees. Burack et al. observed that residents' uncaring, hostile, or disrespectful behaviors toward patients were for the most part ignored by teaching attendings.<sup>4</sup> When the attendings did respond to such behaviors, they gave feedback in a joking manner, through abstract discussion, or through objectifying or medicalizing interpersonal issues. The authors concluded that feedback about professional or humanistic values may go unnoticed, or be misinterpreted or devalued by already stressed learners. In addition, many programs continue such dehumanizing policies as extremely long work hours and traditional hierarchical work environments in which junior members are openly humiliated or shown disrespect.<sup>5</sup> At the postgraduate level, a recent broad sampling of second-year residents revealed both a high incidence of perceived mistreatment and that positive learning experiences and lack of mistreatment enhanced satisfaction during internship.<sup>6</sup>

Understanding the climate and culture of medical training is important not only in terms of meeting manpower needs, but more broadly in terms of the character and outlook of those persons who are its products. What are called the "education community" and "learning climate"—the context or learning environment of education and training—strongly influence learners' development of appropriate values, attitudes, and skills.<sup>7</sup> Of what values, attitudes, and behaviors are we speaking?

Beyond the universally accepted characteristics of honesty, integrity, altruism, honor, and duty, physicians must ac-

quire other attributes if they are to be effective, caring, and satisfied professionals in a progressively more complicated health care system with its competing demands on time and resources, advancing technology, and increasing challenges to the physician-patient relationship. The other attributes include a commitment to self-care and self-awareness, enthusiasm for learning, a commitment to lifelong and self-directed learning, a willingness to work collaboratively with patients and colleagues, and an interest in and respect for the subjective experiences of others.

Using principles of self-determination theory<sup>8</sup> and relationship-centered care,<sup>9</sup> over the past eight years we have con-

structed a learning environment explicitly designed to cultivate these attitudes and values. (Williams and Deci have applied self-determination theory to medical education and shown important outcomes for learners.<sup>10</sup>) This theory assumes that individuals (in this context, learners) have three basic psychological needs: the need for *autonomy*, the need for *competence*, and the need for *relatedness*. *Autonomy* means having the freedom to take initiative in and feeling volitional in one's behavior; *competence* means feeling effective and capable of achieving desired out-

comes; and *relatedness* means feeling respect and caring for others and feeling respected and cared for by them.

In a study of second-year medical students in interviewing courses, students who perceived their teachers to be more supportive of their autonomy (or learner-centered) acquired more humanistic (or psychosocial) values, felt more competent at interviewing, attended class because they valued the material more, and were more interested in course content than were those students who felt controlled by their teachers. Furthermore, six months later, the students who learned more autonomously were perceived by observers to be more patient centered in counseling simulated patients about lifestyle change. One can conclude that students who had their psychological needs for learning met were in turn more supportive of their patients' psychological needs. Thus, a theoretical basis exists for the curricular elements and processes used in our program and described below.

In our primary care internal medicine program, explicit attention is paid to core humanistic and professional skills and the fashion by which they are acquired. The curriculum and learning environment we developed is based not only on our belief in the inherent value of a humanistic approach, but also on the premise that trainees, when treated with respect, caring, and acknowledgment of their individual needs and strengths, will in turn communicate and treat their pa-

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tients in a respectful, caring manner. Other likely outcomes are improved physician and patient satisfaction.

### THE PROGRAM

Highland Hospital's internal medicine residency program has established and fostered several programs, policies, and principles in a conscious effort to promote professional and humanistic qualities. Below, we describe these components of our program, and provide excerpts from various forms of feedback and evaluation we have received from graduates of the program and review bodies.

#### Orientation Program

The residency program begins with a two-and-a-half-day orientation. Trainees are given a tour of the hospital, a seminar on policies and procedures, an opportunity to meet senior residents, who describe their experiences, and an introduction to the philosophy and mechanics of the program by the program director.

One full day of the orientation program is designed specifically to introduce trainees to the program's values and its emphasis on personal and professional development. From the very first moments, it reinforces the program's commitment to attending to subjective experience, personal awareness, collaboration, and support. Residents begin by interviewing each other in pairs for five minutes, then introducing each other to the rest of the group. They are then invited to draw on large sheets of paper pictures depicting their personal situations—what it is like for them as they begin their training, and what they bring to the residency program. The pictures may depict family members, outside interests, travel, or other aspects of their lives. As they take turns describing their pictures to the group, each new resident begins a process of self-disclosure, validation, peer support, and the explicit articulation of appreciation of each other's strengths that continues throughout the program. This is a particularly useful exercise for our program, which has a mix of international and U.S. medical graduates. It allows trainees to make a transition from where they have been to their futures as interns, residents, and, eventually, practicing physicians.

The residents next participate in a problem-solving exercise that focuses on decision making in a non-medical scenario. The exercise is structured such that each trainee attempts to solve the problem individually. Following their individual attempts, the trainees then discuss the same problem in groups of three or four, which allows them to observe

and reflect on how they participate in a group. At the conclusion of the exercise, both the individual and the group decision-making processes are judged against a "gold standard." In 95% of the cases, small-group decision making is far more efficient and effective than individual decision making, a fact that is discussed in terms of the power and effectiveness of resident teams.

The final component of the orientation program is a modified resident-support-group session. The rationale for this session is to provide trainees with an early opportunity to realize the power of sharing experiences in a safe setting. Residents often find this experience surprising and moving. This activity and the themes introduced in the orientation continue throughout the rest of the three-year program.<sup>11</sup>

Typical of the evaluation by trainees of the orientation program is the following: "I found the exercises, both planned and unplanned, that allowed us to learn more about

each other to be exceptional. The planned exercises included talking with and then introducing another person, and drawing a picture of what we are bringing to the residency and presenting it to the group. The unplanned discussion that I believe really brought people closer together occurred during the support group session around the loss of a parent during medical school. Not only was

this quite helpful for the individuals involved, but it also brought us together as a group by sharing a powerful, tragic experience and learning that no one of us is alone."

Another trainee's comments included the following observations: "The format for this orientation is exceptional in that it very quickly takes a group of people from all over the world and both unites us and initiates friendships. It also establishes a great atmosphere to begin what will be a very challenging year."

#### Communication-skills Training Program

An important part of the three-year curriculum is the communication-skills training program. Residents are videotaped in clinical patient interactions three to four times a year. Each tape is reviewed either individually or in a small-group setting that includes a faculty member who has specific training in interpersonal communication. Each year of training has a different focus. In the first year, trainees are encouraged to work on "survival skills;" these include such basic interviewing skills as the ability to elicit as patient's full spectrum of concerns, to ask for patient attribution (that is, the patient's own ideas about the cause or significance of his or her illness), and to organize the flow and content of the interview. In the second year, trainees focus on various

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forms of negotiation—agenda setting, negotiating treatment options, monitoring for adherence, etc. In the third year, the focus is on counseling skills. Here, the trainees work on such issues as grief and loss, alcohol and drug counseling, and patient education; they also develop skills needed to work with patients who are victims of abuse, suffer with somatization, or have borderline personality disorder. In small groups, such as those as occur during the one-to-two-month ambulatory blocks, residents can confront their fears, biases, and knowledge deficits in a supervised, supportive environment.

The video review process is learner centered.<sup>12</sup> Learner and reviewer routinely discuss the learner's goals for reviewing the tape. The learner is invited to stop the tape at points that he or she feels require specific commentary or discussion. The faculty-reviewer models a partnership-based approach, helping the learner to explore his or her own experiences and articulate his or her needs. The reviewer often will explicitly demonstrate and comment upon the parallels between the teacher-learner interaction and the doctor-patient interaction, e.g., careful listening, eliciting the other's perspectives, negotiating, establishing a partnership, conveying empathy, and providing support. For each review, a record is kept of learning goals set and issues discussed. Each resident has a folder that contains all the review information. Faculty are encouraged to review the resident's folder prior to each review to maintain continuity across sessions. In addition, the faculty of the behavioral medicine team meet monthly to troubleshoot and improve their reviewing skills. A copy of the video review form is included as an Appendix.

Smith et al. have demonstrated that intensive training in interviewing can positively affect residents' attitudes and behaviors.<sup>13</sup> All residents participate in the videotape program, and it is consistently rated a singular strength of the curriculum. Likewise, reviews of the program by outside bodies, including the Residency Review Committee and the ABIM, have identified the videotaping program as an important and positive element of the curriculum.

### Morning Report

Senior residents meet four mornings per week to discuss the previous day's admissions. The session is precepted by a faculty member and the chief resident. Housestaff and the program director work together to choose faculty participants in order to balance the director's accountability for quality control with the residents' need to have preceptors they believe are committed to a safe, supportive learning environment. The preceptor begins the conference by asking the present-

ing resident why he or she chose the case for discussion; this immediately focuses morning report on the learner's needs and demonstrates the value of becoming clear about defining learning expectations for each case. (A prospective study of residents' reasons for case selection in morning report revealed that diagnostic uncertainty was the major factor, accounting for 65% of cases selected.<sup>14</sup>) Residents become

increasingly more explicit about the questions they want answered, and learn to trust and depend on their peers for assistance in finding solutions to difficult problems. The department chief prohibits intimidation and humiliation. As a result, residents witness role modeling of the core attitudes of respect and interest in the experiences of others and of the communication and relationship skills that foster partnership.

After the presentation, residents are encouraged to share what they have learned and to freely acknowledge what they do not know. Faculty role model these behaviors by honestly admitting their own knowledge limitations. As a result, the group can set the acquisition of needed information as a goal. A medical search engine (Ovid), a differential diagnosis program, and a text library are available in the conference room. Residents are encouraged to search for the answers to their questions in real time. This promotes self-directed and lifelong learning skills. Our experience has been that the honest, open recognition of gaps in knowledge has led to an increase in residents' pursuit of knowledge and more determined study. One supportive piece of data is the program's ABIM pass rate, which increased substantially between 1993 and 1998 (see Figure 1).

Through this popular, practical, and resident-centered conference, residents learn the power of honesty, the value of integrity, the importance of promoting partnership, the freedom and relief of not being expected to know everything, and the excitement of learning how to find answers to important practical questions.

### Challenging-case Conference

The challenging-case conference is another activity in which honesty, compassion, respect, and professional/personal growth are explicitly fostered.<sup>15</sup> This monthly exercise allows residents to seek each other's help and support with such issues as patients' psychosocial problems that complicate clinical care, the dynamics of the ward team, and problematic relationships with patients' families or with patients themselves. For example, in one session a resident presented the case of a young woman who was frequently admitted with problems related to sickle-cell anemia. As is the custom

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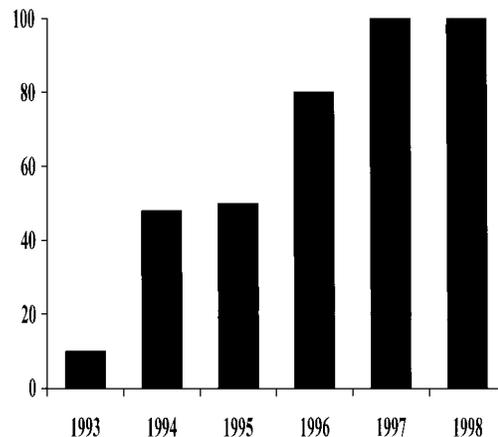
for this conference, other members of the group were invited to share their own experiences in caring for similar patients. The resident expressed a great deal of frustration in treating and communicating with this patient around issues of narcotic analgesia. What followed was the sharing of similar frustrating experiences that both surprised the presenting resident and enabled him to acknowledge how isolated he had felt, thinking that it was his problem alone. After the group's discussion of shared experiences, the resident and the rest of the group were able to explore their biases and assumptions about drug-seeking behavior and its impact on patient care.

With the support and facilitation of the faculty member and resident colleagues, the presenting resident was then encouraged to explore the patient's perspective by "becoming her" in a role play. Another resident who played the role of the physician conveyed his understanding of his fellow resident's frustration during the post-interview discussion. This display of empathy was explicitly noted and discussed by the group. The presenting resident immediately grasped the importance of empathy and noted its powerful effect on him. At the end of the conference, the presenting resident thanked the group for its help and support and said that he was actually eager to try being more empathetic during his patient's next visit.

The importance of seeking help and support within a network of collegial relationships is a socialization process that encourages honest assessment and disclosure of such "negative" feelings as anger and frustration in a safe, supportive learning environment. Asking for help in this context is treated as a strength and is positively reinforced. In addition to role play and discussion, the group travels to the bedside, when practical, to address issues directly with patients and/or families, demonstrating the utility of this approach in real-life situations.

### Home Visit

Each intern is accompanied by a member of the behavioral medicine faculty on a home visit to a patient selected by the intern. The goals of the visit are articulated by the intern and focus on the life context of a patient's illness. The objectives are to better understand the patient's home/social setting, his or her illness experience, and/or the resources available to the patient. A simple example of a trainee's improved understanding of the patient's experience of illness is that of an intern who accompanied his patient up three flights of stairs to her apartment and observed her develop an episode of dyspnea. On discussing her troubles with her, he became aware that he had failed to identify several barriers that prevented the patient from following his advice about making lifestyle changes. In discussing the case with the faculty preceptor, the intern stated that he had learned



**Figure 1.** Pass rates on American Board of Internal Medicine licensing examination for first-time test takers from the Highland Hospital internal medicine residency program, Rochester, New York, 1993–1998.

an important lesson about asking his patients more detailed questions about their home environments as a way of assessing barriers to compliance. The intern was pleased by his "self-discovery" and stated that he was motivated to look for any literature he could read on the generalizability of lessons learned from a single home visit.

### PGY1 to PGY2 Transition Workshop

A workshop is held at the start of the PGY2 year to help residents in their transition from interns to second-year residents. In a full-day session, the residents work on skills and attitudes associated with the second year of training. Typically, "imposter" syndromes, feelings of inadequacy, and poorly developed organizational and time-management skills are identified and explored. Teaching skills for working with medical students and interns are also modeled with a particular focus on learner-centered methods. Perhaps most important, residents are given time as a group to explore their fears of not knowing enough, harming a patient, or daring to step forward to lead a team. In a format similar to the one used in the orientation program, several cycles of skill building (action) and reflection are used to create a safe and collaborative learning environment.<sup>16</sup> In evaluating the experience, one resident commented that this workshop was "excellent, instilled more confidence . . . more courage [in] learning how to work together in a better way, without creating tension or fear. . . ."

### Resident-support Group

A resident-support-group meeting is offered to all residents on a drop-in basis every two weeks. Lunch is provided and

residents have an open-ended opportunity to discuss their values, personal philosophies, and experiences of doctoring as well as their joys, struggles, family concerns, and career-planning issues. On average, 90% of the residents attend each support group meeting. Behavioral medicine faculty facilitate these group sessions and maintain ground rules that include respecting confidentiality, speaking for oneself, and saying as much or as little as one wants.

At one support-group meeting, a second-year resident described an incident in which he had made a procedural mistake that might have contributed to a patient's death. The resident tearfully described the following 72 hours as "a living hell" in which he had not slept or eaten and during which he had contemplated leaving the residency program and medicine altogether. His fellow residents responded with respect and empathy. Many of them shared their own experiences of and reactions to their own mistakes. At the conclusion of the session, the faculty facilitator asked the resident if there was anything he wanted or needed from the group. His response was, "I could really use a hug." The 18 participants in the room spontaneously rose, formed a circle, and hugged the resident and one another for perhaps two minutes. When contacted by the faculty facilitator 48 hours later, the resident reported never having felt so cared for in his adult life. He went on to report that after the support-group meeting, he had gone home and fallen into a deep sleep that lasted for 14 hours. He said he awoke feeling a sense of calm and peace he had been unable to obtain since the incident happened. On several occasions during the rest of the year, the resident made reference to the relief he had felt at being able to share his experience with his peers and the positive effect their support had had on him. During the very first resident-support group of the next academic year, this particular resident chose to tell, unsolicited, the story of his mistake and the other residents' support. He ended the story with an admonition to the new intern class, "that it's okay to make mistakes . . . it's the only way you really learn. It's also safe to talk about them here [in the support group]. I did and it really helped me a lot."

Obviously the resident in question had had a positive experience in sharing his mistake openly and honestly. By exposing his own vulnerability, he was able to obtain the empathy and support he needed to begin to work through his feelings in a healthy way. Perhaps most gratifying, the resident was willing to "lead by example" when it came time to socialize new trainees to the nature and function of the sup-

port group. In this manner, the values of honesty, humility, accountability, respect for the subjective experiences of others, collegial support, and self-disclosure<sup>17-19</sup> were communicated from one generation of trainees to the next. In evaluating the entire residency program, one resident summarized his experience in the support group as "great bonding time with fellow residents [that] allows release of stresses/angst."

### Resident Retreat

In the spring of each year, all the residents are relieved of their responsibilities to attend a full-day retreat. In brainstorming discussion groups during this retreat, residents are invited to identify concerns and creatively grapple with such issues as curriculum reform, scheduling, and recruitment in the context of programmatic improvement. Initially, residents tended to identify systems issues over which they had little or no control. In more recent retreats, however, they have focused much more specifically on issues within the program and have set up ongoing committees and task forces to work toward satisfactory solutions. The support for autonomy in the program has created an environment in which residents feel able to identify and then solve their prob-

lems, rather than simply to complain to the program director and wait for a solution. As an example, in 1995, the hospital requested a 10% across-the-board budget cut; this meant that the moonlighting budget needed to be reduced. A group of residents took the data, identified duplicative coverage hours, and created a proposal for eliminating duplicative coverage so that the patients would be appropriately cared for and the hourly rate preserved. The group felt a satisfactory plan had been created that represented their perspective well.

### Mentor Program

In the first six months of the internship, each trainee is assigned an adviser whose job it is to help orient and guide his or her initial experiences in the program. After six months the trainee selects a faculty mentor who agrees to be available over three years of training. Advisers may become mentors, but not necessarily. The mentor spends time with the trainee and becomes invested in his or her professional and personal growth.<sup>20,21</sup> Residents make use of the mentor relationship to varying degrees, at a minimum meeting once a quarter to review incoming block evaluations and discuss

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elective and scheduling choices. The pair is further encouraged to schedule regular meetings to explore the resident's training experience, personal and professional goals, and career decisions. Mentors are encouraged to use learner-centered methods in their interactions by eliciting the learner's goals, exploring what the learner believes to be his or her strengths and weaknesses, and discussing these within the context of program evaluations, feedback, and testing performance. Mentors help trainees establish realistic, focused goals, and identify resources, time frames, and methods by which to accomplish these goals. Once a month a departmental faculty meeting is devoted to reviewing residents' progress, and each mentor is responsible for presenting the results of the various evaluations and assessments contained within his or her resident's file. Additional comments and discussion are solicited from the faculty at large and the mentor makes note of any corrective actions or commendations suggested by the faculty.

Many of our trainees have commented on the value of the mentor program. For some, the existence of a mentor becomes a critical step in their making the most of the training process. In addition, the mentor program teaches residents to both expect and give support as a part of lifelong learning. One trainee graduated from the program with such positive feelings that he named his newborn child after his mentor. Another resident commented that he "felt protected by my mentor during difficult times."

#### **Praise/Concern Cards**

To promote continuous improvement and encourage effective behavior, the residency program partnered with the ABIM to use "praise and concern" cards. (At the suggestion of one of our faculty members, the ABIM changed the name from "warning" to "concern.") These cards are available to faculty, chief residents, residents, nurses, and administrators to offer immediate, transactional feedback. Concern cards encourage colleagues to point out perceived weaknesses, and allow residents to receive feedback, which, if given in a non-judgmental way, can enhance their motivation to develop corrective plans and master their challenges in medicine. Perhaps even more important, praise cards offer the typically all-too-infrequently given praise that supports a learner's sense of competence. The premise that all learners need encouragement is supported by self-determination theory, which holds that one of learners' three important psychological needs is the need to know that one can be effective in one's behavior and actions.

Perhaps the lack of praise in training explains the striking lack of praise in both administration and clinical practice settings. For example, opportunities to praise patients are infrequently taken by clinicians in medical encounters.<sup>22</sup> In our program, residents are helped to identify opportunities for praise during their video reviews of patient encounters. As a result, residents learn to expect both negative *and* positive feedback in a context that normalizes feedback and permits praise. Recent analysis of this component of the program revealed that praise cards now outnumber concern cards.<sup>23</sup>

#### **Learner-centered Methods**

Underlying all these activities is a relationship-centered approach, in which the individual needs, levels of skill, goals, self-assessment, and ongoing evaluation of the trainees are considered as part of an ongoing educational partnership.<sup>9</sup>

The program encourages self-directed learning. Residents are coached to take responsibility for identifying their own educational needs and for creating, executing, and evaluating plans for meeting them. This is accomplished not only through the mentor-protégé meetings and relationship, but also as much as possible in various clinical and learning settings. Faculty are encouraged to elicit residents' learning

agendas, usually taking the form of both short-term and long-term goals. This can occur on attending rounds, on a particular elective block, in the ambulatory practice, or on a research or teaching project.

#### **Faculty Development**

Our program offers several forms of faculty development. For example, junior faculty with research interests can obtain mentoring from more senior department members with research expertise. Challenging-case conferences are also offered to aid faculty in working through their own challenging cases as well as in providing support for residents who are struggling with cases. In behavioral medicine, several faculty development programs are in operation. One focuses on the process of doing video review. Faculty who participate in this program are videotaped with their own patients and given feedback on their clinical performances. At a more advanced stage the same faculty "graduate" to recording themselves reviewing resident tapes. On a rotating basis faculty members present tapes of themselves conducting resident reviews, and the faculty development group provides con-

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structive feedback. The stepwise progression from getting feedback on one's own clinical performance to getting feedback on one's work with residents allows faculty to move through the full range of experiences necessary to develop expertise in delivering effective feedback and associated skills.

### Relationship-centered Administration

As important as the specific learning activities are, the institutional work environment and "buy in" at all levels of the organization to support collaboration are critical to the program's success. Person-centered care thrives in a relationship-centered administrative environment.<sup>9,24,25</sup> If as clinicians and teachers we are expected to listen to, empathize with, and reflect with our patients and learners, we need to work in healthy environments where honesty, respect, collaboration, and accountability are seen as core values and are practiced institutionally. In other words, a consistent culture in which the same values and behaviors are woven throughout the program and at all institutional levels can more effectively nurture humanism and professionalism in its trainees. The Highland Department of Medicine has a mission statement that defines its commitment to these goals, this environment, and the learning process. It includes the statement "we will be guided by core values of respect, intellectual rigor, compassion, and honesty." (See boxed Mission Statement.)

#### MISSION STATEMENT

### HIGHLAND HOSPITAL DEPARTMENT OF MEDICINE

*Rochester, New York*

The fundamental mission of our Department is to provide high-quality, personalized care that is responsive to community needs to prepare future practitioners to do likewise. In support of this mission, we will sponsor an outstanding residency program; maintain active, fiscally sound clinical programs; conduct medical research; and join with the hospital and medical community to create a more effective and comprehensive health care system.

To help ourselves achieve and continually renew our excellence as clinicians and educators, we will create a supportive, collaborative, and enjoyable work environment that fosters growth, creativity, and fulfillment in our personal and professional lives. We will be guided in our work by core values of respect, intellectual rigor, compassion, and honesty.

An example of the success in communicating this approach is the following excerpt from a patient's letter praising a resident.

It is my opinion that Dr. \_\_\_\_\_ is a very thorough and skilled physician. His meticulous and detailed approach to getting me well was noteworthy. As an untrained non-medical person, I can only attest to what I believe, but he instilled both confidence and a very satisfactory level of comfort in my care. What is more important to me than his technical expertise, however, was his empathy for me; his taking whatever time was necessary to explain or answer questions, engage in simple conversation, or make me feel as comfortable as possible through his actions such as a handshake or reassuring touch letting me know he cares, his sense of humor and his just being a kind person who made the effort to put me before his own needs.

The hospital administration has actively sought to parallel a relationship-centered process and create a community. Decision making is shared with faculty and residents; residents have collaborated to redesign the recruitment process, integrate work and learning spaces on the medical floors, develop a PGY2 night-float system, and negotiate an approach to re-designing their moonlighting system.

### CONCLUSION

There is good reason to believe that the socialization process in residency training is reflected in subsequent practice behavior. All too often, lack of explicit attention to the values of humanism and professionalism creates learning environments that are antithetical to good medical care. The ways in which trainees are treated and the values their teachers and institutions exhibit powerfully influence the manner in which residents treat patients, themselves, and others.<sup>21</sup>

Christakis and Feudtner eloquently describe the dilemmas and risks of current inpatient training scenarios in which trainees have few opportunities to develop meaningful and sustaining relationships. The risks go beyond what intrinsic values are inadvertently modeled and promoted; the "ethical and emotional lives of patients and care providers" suffer.<sup>26</sup> Through specific programs and policies, including communication-skills training, regularly held sessions for discussion of troubling or problematic relationships/encounters, a support group to process the experiences of doctoring and their personal implications, home visits to broaden a provider's understanding of the patient as person, mentoring that, among other purposes, models respectful, invested relationships, and the other elements described above that incorporate a learner- and relationship-centered philosophy and practice, we believe we have succeeded in redefining the education community and culture of medical training at our institution. The challenge for the future is translating and extending this cultural shift to conventional learning envi-

ronments, so that programs such as ours are not the exception but the norm.

As educators and role models, we must closely examine and integrate the methods for delivering both the content and the conduct of educational programs designed to promote values of professionalism and humanism. We owe it to our trainees, our patients, and ourselves.

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APPENDIX

*Video Review Form*

Resident's Name: \_\_\_\_\_ Level of Training: PGY \_\_\_\_ Date of Review: \_\_\_\_\_ Reviewer: \_\_\_\_\_  
 Date of Recording: \_\_\_\_\_

**VIDEO REVIEW PREPARATION**

1. Resident's learning goals/priorities:
  
2. Summary of day's visit and previous encounters (continuity of relationship). Include patient's pertinent medical and psychiatric history.

Visit: N \_\_\_\_\_ R \_\_\_\_\_

3. Family and social history:

**VIDEO REVIEW**

(Note the following during the video review: (1) if tape is stopped by resident, reviewer, or group; (2) issue/event/theme when stopped; (3) tape counter number when stopped.)

<u>Counter #</u>	<u>Issue/Event/Theme</u>	<u>Who Stopped Tape</u>
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Strengths or areas that still need further review (include follow-up plan):

Resident's "take-away" ideas: