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A Few Good Doctors:

An Examination of Humanistic Outliers in Medical Education

A dissertation submitted in partial satisfaction of the requirements for the degree

Doctor of Philosophy in Education

by

Michael Soh

2017

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2017

ABSTRACT OF THE DISSERTATION

A Few Good Doctors:

An Examination of Humanistic Outliers in Medical Education

by

Michael Soh

Doctor of Philosophy in Education

University of California, Los Angeles, 2017

Professor Mitchell J. Chang, Chair

Medical education literature has indicated that, on average, the humanistic orientation of medical school students declines from matriculation to graduation. This humanistic orientation, or humanism, commonly is referred to as attitudes and behaviors that are “sensitive to the values and the cultural and ethnic backgrounds of others” and characterize “a respectful and compassionate relationship between physicians, as well as all other members of the healthcare team, and their patients.” Although a stronger humanistic orientation can lead to better and more positive patient outcomes, the deterioration of humanistic behaviors and attitudes such as integrity, compassion, empathy, and professionalism can largely be traced back to clerkship rotation experiences during the third year of medical school. Because clerkship rotations take place outside the “traditional” classroom at the bedside of real-life patients, medical students rely on the actions and conduct of their clinical instructors to help inform their own patient care

principles. In other words, clinical faculty who teach in clerkships play a pivotal role in shaping the humanistic orientations of medical students.

This study examines how highly humanistic clinical faculty guide, teach, and advance their humanism amongst their students, colleagues, and specialty. These highly humanistic physicians were selected from specialties representing opposite ends of the humanism spectrum, e.g. surgery, internal medicine, and pediatrics. Using Bandura's social learning theory and Spreitzer and Sonenshein's positive deviance framework, this study employed observational fieldwork and semi-structured interviews to explore the teaching practices of fifteen Teaching Humanism Award (THA) winners within the UCLA Health System. Over the course of nine months, this qualitative data drew from the knowledge, attitudes, and behaviors of clinical faculty members who had been recognized for their exemplary humanistic teaching practices.

Findings point to the critical impact that role models had on the development and expression of the humanistic orientation of THA faculty. In addition to role modeling, THA faculty pointed to the relationship between clinical expertise, confidence, and comfort within their specialty as primary guides for their humanistic orientations. Observational fieldwork revealed five typologies of THA faculty with regards to teaching humanism – storytellers, active listeners, sensors, communicators, and guardians. Though humanism was readily apparent amongst trainee interactions, advancing humanism within the specialty and the hospital seemed to incur challenges – both philosophically and institutionally. As such, this study concludes with several recommendations revolving around improving the expression, protection, and adaption of one's humanistic orientation to different audiences and context. Implications for medical education speak to future research into the relationship between humanism and leadership and the longitudinal impact of THA faculty.

This dissertation of Michael Soh is approved.

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2017

To the three strongest role models in my life:

Mom, Jennifer, and Barbara

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My dissertation journey has pushed me to look beyond my preconceived notions of what it meant to be a teacher, practitioner, and leader. Within education, the power of role modeling cannot be overstated. Whether it be in medicine or higher education, the actions and behaviors of those in power and influence, implicit or not, have a profound effect on their surroundings. Students, trainees, learners – however you want to classify them – all look to instructors, faculty, and experts in their discipline for knowledge, guidance, and inspiration. It was through my interviews and observational fieldwork that I came to truly understand and experience what it meant to be a *positive* role model – someone who talks the talk **and** walks the walk. Positive role modeling is not an 8-5pm job or something only demonstrated at the bedside. It is not, nor should it be, turned on and off at your convenience. It is a reflection of one's capacity for integrity, humility, empathy, and patience. In essence, it is your humanity.

First, and foremost, I want to thank the participants in this study. I owe my sincerest gratitude to the Teaching Humanism Award winners that took the time to speak with me and share their perspectives. This manuscript only captures a snapshot of the incredible work they do – both on and off the hospital floor. I walked away from each interview and observation with a deeper respect for the art of medicine and a stronger commitment to continuing this important work.

Second, as someone who has eaten more than his share of food in this world, I want to thank the handful of chefs that I have looked to for inspiration, creativity, and drive. Meals, from domestic to international and mom and pop shops to 3-star Michelins, with my wife have not only helped me take my mind off academic responsibilities but also provided a glimpse into some of the highest levels of artistry, technique, and finesse that I've ever witnessed and tasted

(see Jeremy Fox's work). Seeing this passion, both in the kitchen and on the plate, re-energized me and drove me to dig deeper into my work. One of the unwritten tenets of kitchen life is putting your head down and grinding until the job gets done – and done well. A lot of this requires accountability, persistence, determination, organization, and a willingness to keep pushing when there seems to be nothing left to give. Though I can't say I am the exemplar for these domains, I learned the importance of these qualities while working as a line cook under **Chris Kidder**. I want to thank Chef for teaching me that life is all about the details, simplicity is the ultimate sophistication, and more often than not, the most fulfilling yet most salient work is unglamorous and accomplished behind-the-scenes.

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엄마, this is for you.

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Vermillion, M., Soh, M., Doyle, L.H. (2016, November). *#Feedback: Using PhotoVoice as a Tool for Program Evaluation in Order to See the Full Picture*. Poster to be presented at the Association for American Medical Colleges Annual Meeting, Seattle, WA.

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Walker, V., Soh, M., Tran, M., Isabel-Jones, J., Gordon, L. (2015, June). *Moving Beyond Political Correctness: Empowering Faculty to Create a Diverse and Inclusive Workforce*. Paper presented at the Association of American Medical Colleges Group on Diversity and Inclusion and Group on Faculty Affairs Annual Conference, San Juan, PR.

Kang, M., Soh, M., Wilkerson, L. (2014, October). *Academic hospitalist attitudes toward teaching humanism: a workshop evaluation and needs assessment*. Poster presented at the Symposium on the Science of Learning in Medical Education, Los Angeles, CA.

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Soh, M., Vermillion, M., Doyle, L.H., Uijtdehaage, S. (2013, April). *The Impact of a Structured Reading Intervention in a Summer Medical/Dental Education Program*. Paper presented at the American Educational Research Association Annual Conference, San Francisco, CA.

Soh, M., Wimmers, P. (2012, October). *Student Use of Formative Assessment Tools and the Effect on their Performance*. Poster presented at the Symposium on the Science of Learning in Medical Education, Los Angeles, CA.

Eagan, K., Garibay, J., Soh, M., Hurtado, S., Chang, M. (2012, June). *'Gunning' for the Win! How Competitive Classroom Environments and Student Experiences Predict Pre-Meds' Commitment to Health Research and Practice*. Paper presented at the Association for Institutional Research Annual Conference, New Orleans, LA.

Chapter 1: Introduction

Problem Statement

“...I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug...I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick...”(Lasagna, 1964)

Every year in late spring, approximately 17,000 medical students across the United States recite these words as part of the Hippocratic Oath before their faculty, families, and friends. After completing four years of medical school, these students transition into residency programs where they diagnose, treat, and interact with patients on a daily basis. However, medical education literature has indicated that, on average, the humanistic orientation of medical school students declines from matriculation to graduation (Maheux & Beland, 1986; H. M. Shapiro, 1993; Wolf, et al., 1989; Zeldow & Daugherty, 1987). This humanistic orientation, or humanism, commonly is referred to as attitudes and behaviors that are “sensitive to the values and the cultural and ethnic backgrounds of others” and characterize “a respectful and compassionate relationship between physicians, as well as all other members of the healthcare team, and their patients. (The Arnold P. Gold Foundation, 2013)” Although a stronger humanistic orientation can lead to better and more positive patient outcomes (Kim, et al., 2004; Street, et al., 2009), the deterioration of humanistic behaviors and attitudes such as integrity, compassion, empathy, and professionalism can largely be traced back to clerkship rotation experiences during the third year of medical school (Daugherty, et al., 1998; Hojat, et al., 2009; Wiggleton, et al., 2010).

These rotations not only expose medical students to numerous specialties within a hospital, but they also provide their first hands-on experiences with patient care under the supervision of clinical instructors. Because clerkship rotations take place outside the “traditional” classroom at the bedside of real-life patients, medical students rely on the actions and conduct of their clinical instructors to help inform their own patient care principles. As such, clinical instructors during clerkships play a pivotal role in shaping the humanistic orientations of medical students. In fact, recent literature has revealed that clinical instructors within the clerkship experience are associated with numerous factors that contribute to the decline in humanism, namely mistreatment, burnout, negative role-modeling practices, and the hidden curriculum in medical school (C.M. Brazeau, et al., 2010; Daugherty, et al., 1998; Hojat, et al., 2009). More troubling is that even when clinical instructors observed non-humanistic behavior during rotations, they rarely addressed or responded in an explicit or constructive manner (Burack, et al., 1999).

This is particularly concerning when one considers the cyclical nature of teaching and learning in medical school. As medical students graduate and move into residency programs, they become entrusted with more responsibilities, most notably the teaching of the next generation of medical practitioners. If these residents, on average, possess weaker humanistic orientations than when they first matriculated, then it is likely that their teaching practices reflect this devaluation and become inculcated by ensuing medical cohorts. In other words, humanistic training of medical students during clerkships can not only maintain and strengthen their sense of humanism, but also dictate how humanistic they will be as future clinical instructors. Moreover, continued trainings and interventions centered on enhancing humanistic practices for current

clinical instructors are as important in promoting an environment conducive to developing a medical student's humanistic orientation (Burack, et al., 1999).

That being said, though the teaching practices of clinical faculty clearly shape how humanistic medical students or clinical instructors will be, it is unclear how this pedagogy is developed and implemented by clinical instructors who have stronger humanistic orientations and thus, teach humanism more effectively than their counterparts. Specifically, medical educators have not addressed how, in specialties that exhibit lower levels of humanism, these clinical faculty members foster, evolve, and advance their teaching practices.

Purpose and Research Questions

Thus, the central purpose of this study was to examine how highly humanistic physicians express their humanism amongst their students and colleagues and how they navigate their hospital environments and cultures. This study addressed the following research questions:

1. What guides the humanistic orientation of physicians who display a high degree of humanism?
2. How do these physicians impart humanistic practices to their trainees?
3. How do these physicians advance humanistic practices or orientation within specialties?

Significance of Problem

Questions continue to cloud the realm of humanism in healthcare and hinder its dissemination and value across all medical specialties. Despite noted benefits for patient outcomes, including lower levels of distress, more accurate diagnosis and prognosis, as well as increased open communication lines with physicians (H. Beckman & Frankel, 1984; Colliver, Willis, Robbs, Cohen, & Swartz, 1998; Kim, et al., 2004), physicians and medical educators

alike seem to still wrestle with how and why humanism should exist in medicine. Why is it important? How does it contribute to a patient's medical outlook? And most importantly, what does it actually look like on the wards? Because humanism can manifest itself through simple and nuanced to explicit and expected actions, these questions are best understood through the experiences of actual patients. The following anecdote underscores the importance of talking to patients, empathizing with their unfamiliarity with disease, and treating them with compassion.

In December, [Bridget] O'Malley found herself suffering from severe back pain and went to see an osteopath. He did blood tests, which were ominous; an ultrasound revealed tumors in her liver. "I decided I should be in a teaching hospital, so I got a referral to an oncologist at Northwestern. He was abusive, abrasive, arrogant--he never gave me a diagnosis I could accept. I wanted to know if it made sense to have chemotherapy, or if I should just go home, get my affairs in order, and get ready to die. He just wouldn't play straight with me: all he would tell me was 'You have small-cell cancer.' Well, I don't know small-cell cancer from big-cell cancer or middle-sized-cell cancer. He wouldn't give me any answers about my chances. And meanwhile I was getting sicker and sicker, in more and more pain."

O'Malley began chemotherapy ("Very expensive, very effective"), and saw the doctor exactly once during her week in the hospital. "No one ever gave me explanations of what I was taking, why I was taking it, what it would do. It cost me \$936 a day for a room that was filthy, with no working shower. I was left in my own excreta for hours--I was even taken to tests in that condition! I was on

morphine, but even with morphine you remember that. It was like I was put there to die." (B. Miller, 1992)

Though the patient ultimately survived, much to the surprise of the physician, this experience serves to emphasize elements of the physician-patient interaction, no matter how insignificant, that could have positively bent the trajectory of this encounter. What if the physician had sat down next to Bridget O'Malley and described to her what small-cell cancer was? What if the physician had visited Bridget O'Malley more frequently to ensure that her accommodations were, at the very least, humane? Another anecdote highlights how sometimes the basic expectation that a physician accurately and accordingly diagnose and treat a medical condition can be too much.

In 1986, Pat Orzechowski had an accident on her back porch. It seemed like a small enough thing--a deck chair collapsed under her--but her back hurt. She called her doctor, who diagnosed a fractured coccyx, though he never took X-rays. The doctor told her the coccyx needed to be removed.

"I trusted this guy," says Orzechowski. "He'd operated on me once before, when he removed a tumor from my back. Well, I'd been admitted to the hospital for my surgery, when the anesthesiologist came in, and he took a look at my back. 'Who butchered you?' he asked. I told him about the tumor, and that it had been as big as your thumb. "If it was that small, why did he cut you all the way across your back?" he asked.

"The next thing I knew, the hospital administrator came in--at night--and asked me questions. It turned out that the procedure--removing the coccyx--was no

longer approved. The next day an orthopedic surgeon looked at my back. It turned out that I did have a fractured coccyx, but it had healed. The cause of my pain was a herniated disc.

"My [original] doctor actually asked me, did I want to transfer to another hospital where they'd still let him remove my coccyx? I told him no."

A chiropractor who knew the doctor told Orzechowski, "Oh, yeah, he probably had to make a car payment." Orzechowski claims, "He was scheduling people for surgeries they didn't need. He was operating just to make money."

Was her earlier tumor surgery necessary? "That's something I'll never know. I still have the herniated disc, I'm still not healed, I still go to therapy twice a week. The doctor I have now says if we'd known in time, we could have treated it and maybe corrected it. But where the tumor was taken out is where the disc herniated. There's too much scar tissue to operate. I should have sued the asshole. I don't know why I didn't.

"Now I get three opinions before I do anything. I spend at least four months of the year in bed. I'm considered disabled because of this problem. I'm not dependable, because I don't know from day to day if I'll be there. It's pretty much wrecked my life." (B. Miller, 1992)

This patient's experience is particularly noteworthy because it encapsulates how an array of humanistic attitudes and behaviors could have led to a better quality of life for Pat Orzechowski. What if the physician for Pat Orzechowski had been motivated more by the desire

to heal patients than making money? What if the physician had the integrity to acknowledge his earlier mistake and “righted the ship”, so to speak? One thing is certain though – Pat Orzechowski could have avoided spending four months of the year in bed and identifying as a disabled person. Humanism in healthcare is a vital component in achieving higher quality patient outcomes and its value and need is beginning to take shape in different ways across the medical landscape. In fact, because non-humanistic patient care has become so frequent, the recent implementation of the Affordable Care Act has stipulated that patient satisfaction scores be calculated into Medicare reimbursements for physicians and hospitals. Also, beginning in 2015, the Medical College Admission Test (MCAT) included questions revolving around human behavior and psychology in an attempt to evaluate prospective medical students’ understanding of people and society. Additionally, more and more hospitals and health networks are utilizing patient satisfaction scores when deciding on physician compensation decisions.

Yet, teaching medical trainees how to deliver humanistic patient care can be challenging. While an argument could be made that empathy and similar attributes are intrinsic, Mohammadreza Hojat, one of the leading scholars on clinical empathy, states that “empathy is a cognitive attribute, not a personality trait. (Boodman, 2015)” But in a fast paced hospital environment where speed and accuracy are emphasized, teaching humanism has taken a backseat to teaching science in medical education on the road to defining the expertise and competence of the modern physician. Whereas scientific medicine can be taught by boiling down a patient’s symptoms into a checklist, humanism, as shown by the earlier stories, unfolds in many different ways on the wards. Thus, sound, intentional pedagogies incorporating the versatility and multiplicity of humanistic patient care is vital. Considering the circularity of who teaches and learns within medical education, the perpetuation of the pedagogies revolving around these

humanistic practices is critical for both medical students and clinical instructors. If humanistic patient care is taught and reinforced during clerkships by clerkship instructors, then medical students are likely to propagate these same attitudes and behaviors when they become responsible for teaching on the wards. However, one of the most powerful methods of imparting these humanistic behaviors and attitudes – role modeling (N. P. Kenny, Mann, & MacLeod, 2003; Weissmann, Branch, Gracey, Haidet, & Frankel, 2006) – relies, first and foremost, on the existence of role models.

This presents an interesting dilemma for specialties that tend to attract less humanistic physicians, as Coutts-van Dijk et al. and Newton et al. (1997; 2000) suggest. If medical trainees with highly humanistic orientations are perpetually entering specialties that already attract highly humanistic physicians, do low humanistic specialties even have role models? If so, how do these role models, or highly humanistic physicians, perceive and experience humanism within a specialty that struggles to promote it? How have their teaching practices within the context of humanism changed since entering their specialty? Additionally, how are they advancing their notions of humanistic patient care, in spite of their setting? This study aims to examine these issues, and on a broader level, provide insights into how the best practices and strategies of highly humanistic physicians in low as well as highly humanistic specialties can be scaled up for medical institutions and practitioners across the country.

Scope of Study

This study was informed by literature highlighting the history and evolution of humanism in healthcare, factors that contribute to its decline throughout medical education, and the prevailing pedagogies used to teach it. I focused on studies that examined humanism in its many dimensions including empathy and professionalism. These studies tend to utilize a mixed

methods approach to their analyses similar to the approach I plan to use for this study. As such, much of the literature reviewed for this study helped shape its methodology, data collection, and interpretation of findings.

This study was guided by two conceptual frameworks that helped structure my research questions and semi-structured interview protocol: Bandura's social learning theory (1977) and Spreitzer and Sonenshein's positive deviance (2003). Bandura's social learning theory highlights the apprenticeship-like structure of medical education and the acculturation process that occurs for medical students. Culture plays an important role in this study and presents possible interpretations for Research Question 1 and 2. Spreitzer and Sonenshein's framework of positive deviance emphasizes the honorable and intentional behaviors of highly humanistic physicians that depart from the norms and values of that particular specialty. As such, examination of each physician's role in their specialty and their efforts to advance humanism helped answer Research Question 3.

Observational fieldwork and a series of semi-structured interviews were used to answer the three research questions. Multiple data sources were utilized throughout the data collection, allowing for triangulation, confirmation of any salient findings related to how and why certain phenomena occur, and improvement in the reliability of the study (Miles & Huberman, 1994; Yin, 2009). This study essentially unfolded via two methodological processes: 1) literature review of humanism scholarship to identify 'higher' and 'lower' humanistic specialties, and 2) observations and interviews with Teaching Humanism Award winners.

Significance of Study

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) implemented six general competencies that need to be imparted during residency or fellowship

training in all medical specialties (Accreditation Council for Graduate Medical Education, 1999). One of these six competencies is professionalism, an important part of a humanistic orientation. The same year that professionalism was listed as an ACGME general competency, the Medical Professionalism Project was launched by the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine. The result was a professionalism charter that was subsequently adopted by many major professional physician organizations (American Board of Internal Medicine Foundation, American College of Physicians, American Society of Internal Medicine Foundation, & European Federation of Internal Medicine, 2002). This push was also echoed by several other prominent medical specialty boards and organizations and demonstrated the importance of training more humanistic physicians, regardless of specialty (Accreditation Council for Graduate Medical Education, 2011, 2013; American Board of Pediatrics, 2013; The Arnold P. Gold Foundation, 2013).

Despite this push across all medical specialties for humanism and professionalism, the research on how these behaviors and attitudes are developed and taught has been lopsided. Based on the ensuing literature review, a significant majority of studies were conducted in specialties labeled as more humanistic, or patient-centered specialties. According to Coutts-van Dijk et al. and Newton et al. (1997; 2000), these patient-centered specialties benefit from an abundance of humanistic medical practitioners and yet, the current state of research on humanism continues to serve those working in said specialties. Undoubtedly, each specialty has its own infrastructure, rituals, values, and norms. Thus, the perception and value of humanism likely differs, particularly in disciplines that tend to exhibit lower levels of humanism, or non-patient-centered specialties. Within this specific context, non-patient-centered specialties have been minimally

explored. Additionally, because teaching and learning in medicine are ensconced in an apprenticeship-like philosophy, the role of clerkship instructors deserves further study. Especially given that non-patient-centered specialties tend to attract less humanistic medical students and residents (Coutts-van Dijk, et al., 1997; Newton, et al., 2000), the existence of role-model-like clerkship instructors may be few and far between. Thus, examination of the role and influence of these teachers is critical.

This study contributes to the medical education literature by providing medical institutions and practitioners with tools for advancing humanism in non-patient-centered specialties. Given the dearth of research on humanism within these specialties, its impact on patient outcomes, and its continued decline, this study can build a foundation for future work in other disciplines and fields that do not house clerkship rotations and focus on more specialized training of residents. This study also contributes theoretical nuances to the study of humanism in healthcare by examining the roles of both the culture of the specialty and the individuals themselves. Though situated learning and legitimate peripheral participation revolve around apprenticeships, the transfer of idiosyncratic behaviors and attitudes requires a different lens provided by social learning theory. Rather than observe the typical transmission of explicit skills and knowledge that embody apprenticeships, this study utilizes social learning theory as a means of magnifying the subtle or sometimes “invisible” humanistic traits and qualities imparted by medical trainers. Particularly within a culture that may not value such transmission, participants in this study also opine on the challenges they encountered and how they resolved them. Additionally, I uncover whether the positive deviance of selected physicians leads to tangible positive outcomes. This may expand the scope of positive deviance to include more than honorable intentions and provide a stronger framework for the identification of positive deviants.

Thus, I highlight any cultural or organizational shifts that participants observed as a result of their humanism work.

Chapter 2: Review of the Literature

This study examines how humanism is taught and advanced within both low and high humanistic specialties through the lenses of highly humanistic physicians. In this chapter, I first present an overview of humanism in healthcare, how humanism is defined in this study, its impact on patient care outcomes, and the evolution of its perception within medical education. Based on these definitions and perceptions, I then describe how and why the development and growth of humanistic attitudes and behaviors in medical education are often hindered by numerous factors such as the ‘hidden curriculum’, burnout, mistreatment, and clerkship rotations. I then elaborate on scholarship that describes how these factors influence the decline of empathy and professionalism throughout medical school. This provides the context for a discussion on the pivotal role that apprenticeship plays in teaching and learning in medicine, or what many refer to as the “see one, do one, teach one” paradigm. Embedded within this apprenticeship-based structure is one of the more ubiquitous pedagogical methods used in the wards – role modeling – and I detail how role modeling can shape humanistic qualities desired in a physician. Afterwards, I touch on research centered on various pedagogical methods utilized by medical educators to teach humanism.

Following the review of scholarship pertaining to humanism in healthcare, I then present an overview of the conceptual frameworks guiding this study. I pay close attention to the role of cultural values and norms within a community of practice, or specialty, and its impact on the iterative cycle of teaching and learning, as it relates to situated learning and legitimate peripheral participation. Additionally, I also hone in on the intention-oriented nature of positive deviance and how positive deviants, or “outliers”, strive to disseminate, maintain, and sustain their uncommon behaviors, attitudes, knowledge, and strategies. The chapter concludes with a

summative assessment of the literature review and the conceptual frameworks and the respective existing gap in research that this study fills.

Humanism in Healthcare

The current role and value of humanism in healthcare has been shaped by a number of factors including the dominance of science in medical education and a shift in how medical ethics have been viewed and integrated in training and practice. Additionally, because of these influences, the goals of medicine have become less clear, particularly for those practicing it. Kenny, Mann, and MacLeod (2003) argue that without clearly defining and understanding the goals of medicine, it is difficult to develop humanistic qualities and characteristics desired in a physician and needed to facilitate medical practice. While some insist that the goals lie within the patient-physician encounter, others believe that physicians are “gatekeepers for society-approved access to science and technology. (N. P. Kenny, et al., 2003, p. 1205)” This tension between a patient-centered approach to medicine and the growth of science and technology in medicine continues to intensify and raises questions about what is expected and desired of physicians. In other words, what should good physicians do? And how should new physicians or medical students be trained to take on the desired qualities of a good physician? Before going into detail about the evolution of the role and value of humanism in healthcare, it is important to clearly state how humanism is defined and operationalized within this study.

Defining Humanism in Healthcare

In the world of medical education, humanism has been used in several different ways. It has been referred to as empathy, compassion, professionalism, and altruism, among many other things. Regardless of how humanism is labeled, the qualities that embody a humanistic healthcare professional inevitably enhance patient-physician interactions. That being said, for the

purpose of this study, humanism is defined using a model put forth by the Arnold P. Gold Foundation, one of the leaders in advancing humanistic medical care and building caring, trusting, and collaborative relationships with patients. This model was developed in the late 1990s by a committee of medical educators and residency program directors who desired streamlined yet comprehensive criteria for selection into the Gold Humanism Honor Society (GHHS). The purpose of this society is to recognize individuals who are exemplars of humanistic patient care and who can serve as role models, mentors, and leaders in medicine. Funded by a series of grants from the Robert Wood Johnson Foundation, deans, medical educators, and experts in assessment convened to create a model representing humanistic values and behaviors desired within medical students, residents, fellows, and physician teachers. Though the model used by the GHHS is much more extensive, the attributes defined below capture the essence of the interpersonal skills and attitudes necessary for the highest level of patient care.

According to the GHHS model, humanism in healthcare is characterized by “a respectful and compassionate relationship between physicians, as well as all other members of the healthcare team, and their patients.” Additionally, humanism “reflects attitudes and behaviors that are sensitive to the values and the cultural and ethnic backgrounds of others. (The Arnold P. Gold Foundation, 2013)” Going even further, the foundation lays out seven attributes that define a humanistic healthcare professional: integrity, excellence, compassion, altruism, respect, empathy, and service. These attributes are further detailed in the following figure (Figure 2.1). These seven attributes help shape the analysis of survey results, the study design, and interview protocol while also informing how I interpret and analyze results for my first research question.

Table 2.1. Attributes of a humanistic healthcare professional. (The Arnold P. Gold Foundation, 2013)

Attribute	Explanation
Integrity	the congruence between expressed values and behaviors
Excellence	clinical expertise
Compassion	the awareness and acknowledgement of the suffering of another and the desire to relieve it
Altruism	the capacity to put the needs and interests of another before your own
Respect	the regard for the autonomy and values of another person
Empathy	the ability to put oneself in another's situation, e.g., physician as patient
Service	the sharing of one's talent, time and resources with those in need; giving beyond what is required

Humanism and Patient Care Outcomes

Since 1999, the Accreditation Council for Graduate Medical Education, along with several other certification and specialty boards, have required medical trainees to learn and demonstrate attitudes and behaviors consistent with humanistic care (Accreditation Council for Graduate Medical Education, 1999). These mandates were a result of scholarship indicating a strong link between humanistic physicians and more satisfied patients who achieve better health outcomes (Evans, Stanley, Mestrovic, & Rose, 1991; Hauck, Zyzanski, Alemagno, & Medalie, 1990; Safran et al., 1998; Smith, Lyles, Mettler, & et al., 1995). Additionally, evidence is mounting that patients desire and expect humanistic care from their doctors (Krupat et al., 2000). Physicians and scholars alike have argued that humanism is a pivotal skill required for

medical practice (Branch, Kern Jr., Haidet, & et al., 2001; Tosteson, 1979).

Starting from the beginning of a patient-physician encounter, medical practitioners have several opportunities to set the foundation for improved patient outcomes. For example, indicators such as empathetic verbal communication and understanding nonverbal cues, as well as time spent with a patient, can increase patient satisfaction and compliance, reduce patient distress, and improve self-efficacy in diverse clinical settings (H. Beckman & Frankel, 1984; Kim, et al., 2004; Levinson, Gorawa-Bhat, & Lamb, 2000; Nightingale & Yarnold, 1991; Squier, 1990; White, Levinson, & Roter, 1994). In some cases, these empathetic qualities can lead to lower rates of malpractice litigation (Levinson, Roter, Mullooly, Dull, & Frankel, 1997). Once empathetic relationships have been forged between the patient and physician, studies have shown that diagnosis and prognosis become much more accurate (Colliver, et al., 1998; Coulehan et al., 2001; Greenberg, Watson, Elliot, & Bohart, 2001; Larson & Yao, 2005). This may be a result of an increase in the physician's understanding of patients' perspectives, which therein leads to improvements in patients' perceptions of being helped, patients' perceptions of a support network, and patients' empowerment (Eisenthal, Emery, Lazare, & Udin, 1979; Street, et al., 2009). Specifically, studies have shown that, as a result of an empathetic, humanistic physician, patients will reveal more about their medical concerns (H. B. Beckman & Frankel, 2003; Coulehan, et al., 2001). This allows physicians to gather more detailed information about patients' symptoms, history, and individual needs (D. A. Matthews, Suchman, & Branch, 1993; Stepien & Baernstein, 2006; Suchman, Markakis, Beckman, & Frankel, 1997).

Even outside the realm of the initial patient encounter, studies have shed light on how humanistic care can lead to better health outcomes, regardless of specialty or type of care. A study of patients who suffered from the common cold revealed those who gave their clinician a

perfect empathy score reported that their colds were less severe and lasted fewer days than patients who gave their physicians a less-than-perfect empathy score (Rakel et al., 2011). Another study conducted with cancer patients in Germany found that physician empathy was positively correlated with improved quality of life and lower levels of depression (Neumann et al., 2007). From a more clinical perspective, researchers found that, for patients with diabetes, having a physician with higher empathy scores can lead to a significantly lower rate of acute metabolic complications (Del Canale et al., 2012). In a separate study on diabetic patients, researchers noted that patients of physicians with higher empathy scores were more likely to control levels of hemoglobin A1c and LDL-C – both important for managing diabetes (Hojat et al., 2011). Finally, in what is likely the most telling example of how humanism can improve a patient’s clinical outlook, McKay et al. (2006) found that for psychiatrists treating patients with depression, those who created a bond with the patient but used a placebo had better results in treating depression than those who used an active drug but did not form a bond.

Evolution of Humanism within Medical Education

Despite these positive patient outcomes, humanism in healthcare continues to evolve and shift in response to societal and environmental forces. Although the Arnold P. Gold Foundation makes it abundantly clear that the seven attributes in Table 2.1 are expected in a humanistic healthcare professional, no mention is made of particular specialties and practices or whether humanism should be defined differently in fields as diverse as palliative care, orthopedics, community health, or cardiac surgery. Questions still remain as to how these common values and attitudes can, and should be, incorporated into different specialties and how these attributes connect back to the goals of medical practice. In other words, within this defined context of

humanism, how should physicians in different specialties be trained to take on these humanistic attributes and how can these attributes help shape the goals of medical practice?

In order to begin to tackle these questions, one must examine the evolution of humanism through its relationship with science and technology and its roots in medical ethics. The increasing dominance of science and technology in medical education can be attributed to the Flexner Report of 1910, which transformed the processes of medical education in the United States by embracing scientific knowledge and its advancement as the defining philosophy of the modern physician. Science-based university education followed by internships replaced proprietary schools and unregulated apprenticeships. In essence, physicians began to “lose their authenticity as trusted healers” and the trust and respect extended to the medical profession began to erode (Duffy, 2011, p. 274; Rothman, 2000). As a result, the development of humanistic qualities and characteristics took a backseat to scientific innovation and research. Cognitive traits became the prevailing ideal for medical practitioners and the capacity to do science became the standard for medical school acceptance. As Kenny et al. so clearly stated, “moral authority became rooted in scientific competence. (2003, p. 1205)” Constant breakthroughs in science also helped reinforce the power of the scientific good and soon enough, for the betterment of the patient, mastering scientific medicine became the benchmark for those in pursuit of a medical career (Jonsen, 2000).

Despite the notion that the science of medicine has essentially dismissed the “active witnessing of patients” (Duffy, 2011, p. 275), there are still specialties operating in highly specialized and highly technical medical environments that are re-envisioning how healthcare professionals prioritize and operationalize humanistic attitudes and behaviors. In a sub-specialty as fragile as heart transplantation, Raia and Deng (2014) highlight the instrumental role that the

healthcare professional plays in guiding a patient from a state of *selva oscura* (unrecognizable to us) to *selva antica* (familiar to us). According to Raia and Deng, after heart transplantation, a person does not “see her/himself as a whole person but as one with a body which has become an instrument that has failed to do its job, with replaceable broken-down part(s). (2014, p. 136)” As such, in accordance with Raia and Deng’s RelationalAct model, the healthcare professional begins to help the patient become more familiar with their transformed existence and as a result, helps translate highly technical medical interventions embedded within natural bodily functions into something recognizable, accessible, and applicable to the patient’s life. This sense of compassion, excellence, and service showcase humanistic behaviors and attitudes in arguably the highest levels of medical practice. Although medical students do not rotate through these types of specialties and are not privy to such role modeling, the work of Raia and Deng provide some insight into how interpretations of humanism can differ from specialty to sub-specialty.

As the medical landscape has shifted, so have the traditions of medical ethics and subsequently, the goals of medical practice. According to Pellegrino and Thomasma (1993), traditional medical ethics focused on the character of the physician. Hence, good medicine depended on the personality of the physician and put the patient’s best interests in the hands of the knowledge, skill, and character of the physician. However, as hospitals became more modernized and science and technology played a larger role in medical decision making, medical ethics shifted from individual practitioners to professional consensus. That is, rather than rely on the character and integrity of each physician to ensure ethical practice, professional etiquette and decorum became the “moral authority of practice. (N. P. Kenny, et al., 2003, p. 1205)” As a result, medical educators began rejecting character formation as a goal for medical students and trainees. Instead, the knowledge and skills required for ethical decision making took priority and

a formal medical ethics education was incorporated into medical education in order to train a more clinically competent physician (Fox, Arnold, & Brody, 1995). Ethics education focused more on ethical dilemmas and provided medical students with the skills necessary to obtain consent or deliver bad news, rather than cultivate behaviors and attitudes rooted in professional character. This pedagogical shift did not take into account what is now known about how the character of medical students is developed and the impact processes like clerkship rotations, rounds, peer interactions, the informal and formal curriculum, and role models can have on humanistic attributes (Babbott, Levey, Weaver, & Killian, 1991; F. W. Hafferty & Franks, 1994; McMurray, Schwartz, Genero, & Linzer, 1993).

Declining Humanistic Behaviors and Attitudes

Contrary to earlier beliefs that the character of medical students had essentially been formed by the time of admission into medical school (N. P. Kenny, et al., 2003), medical education research has revealed that various experiences in medical education can profoundly impact the humanistic orientation of medical students. In fact, on average, medical school graduates possess lower levels of humanism than when they first enter medical school (Maheux & Beland, 1986; H. M. Shapiro, 1993; Wolf, et al., 1989; Zeldow & Daugherty, 1987). Their humanistic orientations, no matter how strong at the start of medical school, continue to decline into residency programs and can be largely traced back to clinical or clerkship rotation experiences during the third year of medical school (Burack, et al., 1999; Daugherty, et al., 1998; Hojat, et al., 2009; Wiggleton, et al., 2010). The following elaborates on three specific factors that shape the clerkship rotation experiences of medical students – the hidden curriculum, burnout, and mistreatment – and how the clerkship experience, in turn, informs medical students' development of humanistic behaviors and attitudes.

Hidden Curriculum

The hidden curriculum refers to the values, norms, and attitudes often transmitted unconsciously or unintentionally through the educational structures, practices, and cultures of a particular institution (F. Hafferty, Gaufberg, & O'Donnell, 2015). Throughout one's medical education, Hafferty et al. (2015) argue that four types of curricula are experienced by medical trainees: the formal curriculum, the informal curriculum, the hidden curriculum, and the null curriculum. These four types contribute to the clinical competence, humanistic orientation, and personality of every physician either via implicit or explicit means. Some elements of each curriculum are deeply embedded into the notion of "how things are typically done" and taken for granted while others are visible and obvious.

The formal curriculum includes everything that is found in textbooks, lecture presentation slides, and the course syllabi. This typically accounts for all the biological, physiological, and chemical information that medical students study for throughout medical school. Additionally, the formal curriculum includes the number of hours a medical student spends on clinical experiences and any other requirements put forth by their medical institution. Essentially, the formal curriculum is what the Liaison Committee on Medical Education (LCME), the accrediting body for all U.S. medical institutions, uses to maintain and standardize medical education. As a result, what trainees were actually learning and internalizing or the competence of medical school graduates were overlooked in order to collect measurable metrics like course content and instructional time.

As such, Hafferty et al (2015) state that the impact of informal curricula, null curricula, and hidden curricula was not given as much attention. The informal curriculum, or unintentional and unscripted teaching and learning, refers to interactions that typically happen outside of a

formally identified learning environment. There is no syllabus for these teaching and learning moments and they tend to take place on an ad hoc basis. For example, an informal curriculum is often presented in casual settings like a lounge, cafeteria, or elevator. The null curriculum constitutes what is taught through omission. Hence, things that are not explicitly mentioned in the formal curriculum or depicted on the wards are then labeled as unimportant by medical students. And finally, the hidden curriculum refers to lessons, specifically in relation to cultural norms and values, which are ingrained in an educational institution's practices and structure. These moments are not explicitly taught and can be passed on without the trainer or trainee's full acknowledgement.

It is important to note that all of these types of teaching moments may or may not be consistent with what medical students learn via their formal curriculum. In particular, the hidden curriculum is most troubling due to its embedment into the very values and norms that drive an organization and is invisible to trainees and trainers. Especially if the hidden curriculum runs contrary to the formal curriculum or what medical students expect from their medical education, the hidden curriculum can adversely impact the development and aspirations of medical students. Therefore, it is critical to understand how a particular specialty's structure and culture operate, especially within the context of humanism, before analyzing how practitioners function.

Burnout

As suggested above, empathy and similar humanistic attributes decline as medical students complete their medical education and training. Interestingly enough, as humanism erodes for medical trainees, the likelihood of burnout tends to increase (Bellini & Shea, 2005; Dyrbye, Massie, Eacker, & et al., 2010; Ghetti, Chang, & Gosman, 2009; Hojat, et al., 2009; Wallace, Lemaire, & Ghali, 2009). Medical educators have shown that an increasing prevalence

of burnout is associated with an accompanying increase in cynicism, a decline in empathy, and a deterioration of humanistic attitudes (Dyrbye, Thomas, & Shanafelt, 2006; Hojat, et al., 2009; Thomas, 2004). According to Maslach and Leiter (1997, p. 186), burnout begins when “energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness.” The literature on burnout states that the three classic symptoms of burnout are: 1) loss of enthusiasm for work, or emotional exhaustion, 2) reduced empathy and increased cynicism, or de-personalization, and 3) a decreased sense that one’s work is meaningful, which can lead to inefficacy, or demeaned personal accomplishment (Maslach, Jackson, & Leiter, 1996).

Studies on burnout in medical education have found that between 25-60% of medical trainees experience burnout across an array of medical specialties (Hyman et al., 2011; Shanafelt et al., 2009). Recently, a 2012 study of over 7,000 U.S. physicians noted that 47% had experienced burnout, much higher than the general population (Shanafelt et al., 2012). In fact, a study conducted by Dyrbye et al. (2006) found that medical students, when compared to the general population, experienced a greater degree of depression and anxiety as they progressed through their medical training. Burnout also contributes to lower physician retention and has been associated with suboptimal care, medical errors, and patient non-compliance (Leiter, Frank, & Matheson, 2009; Wallace, et al., 2009). Additionally, emotional exhaustion, de-personalization, and self-inefficacy can contribute to lower staff morale, higher staff turnover, and an overall decrease in the cohesiveness of a healthcare system (Yamey & Wilkes, 2001). These findings are also corroborated by scientific analysis of the neurological relationship between empathy and burnout. Using functional magnetic resonance imaging, Tei et al. (2014) found that higher burnout scores were predictive of reduced empathy-related brain activity.

For medical students as well as residents, burnout could be a result of demanding work hours, inadequate resources, or the pressures of a training system that prioritizes perfectionism, delayed gratification, and denial of personal vulnerability (N. Miller & McGowen, 2000; Spickard, Gabbe, & Christensen, 2002; Wallace, et al., 2009). Particularly in clinical settings where weakness and self-care can be stigmatized, burnout can easily overwhelm any sense of control medical trainees may have and lead to emotional exhaustion, cynicism, and de-personalization (Maslach, Schaufeli, & Leiter, 2001; N. Miller & McGowen, 2000; Spickard, et al., 2002; Wallace, et al., 2009). As such, in order to minimize the frequency of burnout and its negative effect on the quality of patient care and professionalism (C.M. Brazeau, et al., 2010), we must examine how burnout might manifest itself in physician-student interactions. Particularly in intense patient-centered environments, cynicism, emotional depletion, loss of motivation and commitment, and decreased professional competence can lead to another critical force shaping the clerkship experiences of medical students – mistreatment.

Mistreatment

In the late 1980s, through the personal accounts of several medical students, medical educators and the public as a whole were introduced to the feelings of rejection, humiliation, dehumanization, and alienation that medical students experienced during their medical education (Klass, 1987; LeBaron, 1981; Reilly, 1987). Later analysis of their experiences revealed that all had struggled to learn medicine while also maintaining a humanistic and compassionate perspective on their work (Conrad, 1988). Conrad also found that these students were especially concerned that their behaviors and attitudes would resemble those who had mistreated them. Intertwined within these mistreatment experiences was the power dynamic between the trainee

and trainer that prevented these students from speaking up about the offensive interactions and subsequently forced the students to continue their participation.

Follow up studies on the prevalence of these types of negative teacher-learner interactions revealed that perceived mistreatment during medical school was pervasive and widespread (Sheehan, Sheehan, White, Leibowitz, & Baldwin, 1990; Silver & Glicker, 1990). Not only did students feel that they became more cynical during their medical education as a result of this dehumanization and alienation (Wolf, et al., 1989), students also indicated that instructors frequently provided negative feedback about their choice of career in medicine (D. J. Baldwin, Daugherty, Eckenfels, & Leksas, 1988). This likely produces feelings of self-doubt and confusion amongst medical students and raises questions as to whether humanism has a place in medicine (Reuler & Nardone, 1994). These findings are particularly concerning considering that mistreatment can have an indelible effect on medical students and unfavorably impact future doctor-patient relationships (Sheehan, et al., 1990; Silver & Glicker, 1990). In addition, these instances of “traumatic de-idealization” as a result of humiliation and rejection can lead to weakened self-esteem and a disregard for clinical instructors and the medical profession as a whole (Kay, 1990). Unfortunately, since that time, studies continue to show that mistreatment still occurs, particularly in clerkship rotations, and that the behaviors, attitudes, and demeanor of clinical faculty, residents, and nurses toward medical students are often abusive and unprofessional (D. Baldwin, Daugherty, & Eckenfels, 1991; Fried, Vermillion, Parker, & Uijtdehaage, 2012; Sheehan, et al., 1990). In fact, the most recent report from the Association of American Medical Colleges’ (AAMC) Medical School Graduation Questionnaires revealed that, at the end of their fourth year, nearly one in five U.S. medical students had experienced some kind of mistreatment (Association of American Medical Colleges, 2014).

This type of mistreatment opened the eyes of medical educators and physicians alike and in 1999, led to the LCME establishing a standard on medical student mistreatment that required all medical schools to define their standards of conduct in the teacher-learner relationship. The LCME also required all schools to create structures and processes that would enable trainers and trainees to report, handle, and prevent mistreatment. Now, as a result, medical schools must have these mechanisms in place in order to achieve or maintain their accreditation. However, beyond these safeguards and continued reports of mistreatment, a larger issue persists within medical education as a result. This issue is examined in depth by Baldwin et al. in his study of mistreatment across ten U.S. medical schools. Baldwin et al. (1991, p. 144) argues that it would be “difficult to see a ‘kinder and gentler’ physician emerging from an environment in which students perceive themselves as having been mistreated or humiliated.” Going even further, Baldwin et al. (1991) asserts that mistreatment may perpetuate a cyclical nature that will adversely impact medical students down the line. In other words, medical students who experience mistreatment now will inevitably become residents in the future and their development and identity as physicians will embody non-humanistic interactions and lessons that they may utilize when assuming positions of authority over future students and patients.

Clerkship Rotations

The medical education literature indicates that the hidden curriculum, burnout, and mistreatment all play a significant role in the clinical clerkship rotation experiences of medical students. These rotations provide the first opportunities for medical students to receive hands-on clinical training on the wards and their experiences are typically delivered in a demanding environment that highlights the implicit nature of teaching and learning and frequent interaction with good and bad role models. Given this, it is apparent that clinical clerkships are an important

determinant of medical students' learning and development of humanistic attributes. Medical students who interact with good instructors score higher on clerkship examinations, board certification exams (Step 2), and even perform better overall during their clerkship rotations (Griffith, Georgesen, & Wilson, 2000a; Roop & Pangaro, 2001; Stern, Williams, Gill, & et al., 2000). In fact, Griffith et al. found that good instructors who serve as role models can positively influence their students' career choices (Griffith, Georgesen, & Wilson, 2000b). However, because a multitude of factors have to line up in order to result in a positive clinical training experience, clerkship rotations can easily stray and compound the negative effects of mistreatment, burnout, and the hidden curriculum.

For example, a study involving a survey of medical students found that negative clerkship experiences was one of the strongest factors in turning students away from pursuing internal medicine (Babbott, et al., 1991; McMurray, et al., 1993). Findings from recent surveys also revealed that less than half of Canadian medical students and residents thought that their instructors displayed humanistic characteristics, that 23% of U.S. medical residents thought they have become less humanistic during their medical training, and that nearly 61% acknowledged becoming more cynical as a result of their medical education (Beaudoin et al., 1998; Collier, McCue, Markus, & Smith, 2002). Several scholars chose to examine the clerkship experiences and its relationship with humanistic qualities within the context of a student's four years in medical school. Newton et al. (2008) found that empathy significantly decreased during the third year of medical school, or when clinical clerkship experiences begin for medical students in the U.S. Hojat et al. (2009) in a similar study found no statistically significant change in the first two years of medical school but noted a significant decline in empathy at the end of the third year up till graduation. Finally, Chen et al. (2007) found statistically significant differences in empathy

scores when comparing medical cohorts as they moved from the end of their second year of medical school to the end of their third year.

The latter three studies and their subsequent findings were especially compelling given its clerkship rotation setting and were considered to help inform how I shaped my dissertation study. The clerkship rotation setting is unique in that it provides the first clinical encounters for medical trainees. As a result, many factors come into play when analyzing the context of humanistic development on the wards. For example, Newton et al. (2008, p. 244) focus their study on vicarious empathy, or what is commonly referred to as “an individual’s vicarious emotional response to perceived emotional experiences of others.” However, the authors explicitly note a separate dimension of empathy – imaginative empathy, or “an individual’s ability to imaginatively take the role of another so as to understand and accurately predict that person’s thoughts, feelings, and actions” – that is not included for analysis (Newton, et al., 2008, p. 244). According to Davis (1983), imaginative empathy refers to “cognitive” empathy and indicates a learned ability to empathize. This is important to note because, in essence, Newton and colleagues measured for intrinsic levels of empathy rather than empathic behaviors and attitudes that may have been learned during medical school.

Additionally, although Newton et al. as well as Chen et al. (2007; 2008) found decreasing empathic levels amongst medical students, they do not expand on their analyses to account for possible factors that contribute to this decline. In other words, no emphasis is placed on the role of clinical instructors during the clerkship rotations. Each study utilized a different instrument to measure empathy and both instruments did not delve into external variables such as instructor, specialty, or hospital site. Though there is some allusion to various types of specialties, the authors fail to recognize who comprises these types of specialties and their subsequent impact on

clinical training during the third year of medical school. When taken into context with recent literature that has found that some specialties tend to attract medical students with lower levels of empathy and humanism than others (Coutts-van Dijk, et al., 1997; Newton, et al., 2000), this missing methodological piece could have provided much needed texture to their findings by identifying and explaining how clinical instructors shape medical students' humanistic orientations.

Finally, in Hojat et al. (2009), the authors identify and label two types of specialties: people-oriented specialties such as family medicine, internal medicine, and pediatrics, and technology-oriented specialties such as anesthesiology, pathology, radiology, and surgery. In their analyses, they found that students intending to pursue technology-oriented specialties had lower empathy scores at the beginning of medical school and also lost more empathy during medical school than those in people-oriented specialties. As such, Hojat and colleagues suggest that there are "at-risk" medical students who are more vulnerable to losing their sense of empathy. This serves to further underline the need to include low humanistic specialties, or specialties that tend to attract these "at-risk" students, in this dissertation study.

This erosion of humanistic attitudes and behaviors is troubling given its role in bettering patient care. Clinical training environments continue to change and there is no indication that this deterioration will stop. Medical trainees have limited time and resources, particularly in specialties with rigorous demands, to develop any sort of clinical competency, let alone humanistic qualities that may enhance teamwork, leadership, communication, or management, (Stockwell, Pollack, & Turenne, 2005). The pressures of medical training combined with changes in the healthcare system may only lead to "a false idea that empathy is outside the realm of evidence-based medicine and, thus, has no importance in the education of physicians-in-

training or in the practice of medicine. (Hojat, et al., 2009, p. 1188)” In addition, scholars continue to argue that medical education promotes clinical neutrality as well as emotional detachment and distance rather than the actual art of patient care (Coulehan & Williams, 2001; Farber, Novack, & O’Brien, 1997). These subversive elements of medical education implicitly endorse a genre of patient care that avoids any sort of interpersonal engagement. Combined with burnout, the hidden curriculum, mistreatment, and the varying humanistic orientations of clinical instructors, scholars contend that traits such as compassion and empathy will continue to decline amongst medical trainees (Frank, Carrera, Stratton, Bickel, & Nora, 2006; Killgore et al., 2008; S. M. Wright, Kern, Kolodner, Howard, & Brancati, 1998).

“See One, Do One, Teach One”

Clerkship rotations constitute a combination of curriculum, pedagogy, and patient and physician interaction that rely heavily on the classic apprenticeship model of “learning by doing,” or what many refer to as the “see one, do one, teach one” model. That being said, one can clearly see how the hidden curriculum, burnout, and mistreatment play a role in the clerkship experiences of medical students. The time that medical students spend during their clerkship rotations can not only shape their humanistic orientation but ultimately, the specialty they decide to pursue after graduating (Abbott, 1983; Hojat, et al., 2009). As such, the following section delves deeper into the intricacies of the “see one, do one, teach one” teaching model, describe some of its challenges, and elaborate on a specific pedagogical method that has been used to teach humanism.

Within medical education, teaching procedural skills involves both a cognitive conceptualization of the procedure and the manual, or “hands on” skills, necessary to perform it. Initially, simple procedures are discussed, demonstrated, and performed and then as trainees

become more experienced, more complex and complicated procedures are added. In essence, the guiding principle behind the “see one, do one, teach one” paradigm is that experience facilitates learning and promotes autonomy. As a result, the learner, or the medical student, is completely dependent on the teacher’s, or clerkship instructor’s, knowledge base and technical mastery.

In the first phase of this paradigm – “see one”, simple observations will not provide enough foundation for expertise in a particular medical procedure. According to Birnbaumer (2011, p. 391), “activated demonstration” is required by the instructor to properly perform a medical procedure and give a detailed explanation of each step. Also referred to as a “talk through and walk through” by some scholars, the instructor should verbally break down each step while demonstrating each step. This ensures that the instructor is being intentional about sharing and teaching the procedure with the learner.

In the second phase – “do one”, the learners have an opportunity to perform a medical procedure. It is done in the presence of the instructor and prior to, the learner must verbally walk-through each of the steps in the procedure. Before using an instrument, the learners must understand the appropriate indications, contraindications, complications, and documentation needed for its use. This cognitive component is either completed during the “see one” phase or in the classroom. While performing the actual procedure, the learner talks through each step. The instructors immediately correct any errors and sometimes guide the learner through each of the motions necessary to perform a particular medical procedure.

In the last phase of “teach one”, the learner is charged with teaching a particular procedure or skill to others while being observed by the teacher. Prior to this step, the teacher must ensure that the learner firmly understands the cognitive and manual elements of the procedure. However, it is important to note that teaching a particular procedure or skill to others

does not equate to mastery of the procedure. Repetition and supervised practice for each procedure and skill is needed to ensure proficiency and subsequent mastery. This is especially important for medical students or interns who recently acquired a particular skillset or learned a new procedure.

Although it may seem like this model takes place in a short amount of time in a clerkship rotation for the instructor and learning, it can also describe the broad processes of who teaches medicine and how it is taught over the course of one's medical education. For example, medical students are often the observers in the wards and do not have an extended amount of time to perform or repeat hands-on procedures. So, one can argue that medical students embody the "see one" phase of this paradigm. After graduation, medical students move into residency programs where they are now expected to perform and repeat procedures on a daily basis with live patients. Therefore, one can argue that residents embody the "do one" phase of this paradigm. And finally, as residents move up through their residency program and gain more experience, they are now expected to not only perform and repeat procedures, but also teach them to rotating medical students. This phase is particularly important because this is when clinical instructors transfer what they have learned and experienced to their trainees. In other words, the teaching practices utilized in the "teach one" phase reflect the humanistic orientations of the clinical instructors, whether it be positive or negative. As such, one can argue that senior residents and those that work beyond this capacity embody the "teach one" phase of this paradigm.

Throughout all three phases of this model, it is evident that this traditional paradigm lacks the structure, guidance, and standardization needed to ensure that trainees are competent to practice medicine. For example, although medical residents are assigned an arbitrary number of procedures to perform under supervision during their training (American Board of Internal

Medicine), it is concerning that many residents reported a lack of comfort in the performance of invasive bedside procedures (Huang et al., 2006). To make matters worse, a recent survey conducted by the American College of Physicians revealed that the number of procedures performed by general internists upon completion of their training actually declined (Wigton & Alguire, 2007). Medical trainees are not given enough time and guidance to develop sufficient proficiency with medical procedures and skills and even after entering the workforce as healthcare professionals, they are still unable to practice and develop the proficiency needed to perform procedures independently and safely.

Rodriguez et al. (2009) further elaborate on lacking structure and guidance within the “see one, do one, teach one” model by identifying the following deficiencies: 1) the high-risk and stress environment, i.e. the hospital, in which medical students are taught, 2) the lack of rigorous evaluation, readjustment, and correction of problems necessary to standardize the “see one, do one, teach one” model, 3) the lack of practice time given to medical students as they pass through clerkship rotations, and 4) the ambiguity surrounding how to teach humanistic qualities needed to successfully navigate team interactions, crisis management, and conflict resolutions. Furthermore, Baldwin et al. (1998) found that a significant proportion of mistakes made by trainees were a result of insufficient knowledge or inexperience. Besides these deficiencies, other factors tied to the “learning by doing” framework that lead to medical mistakes include inadequate supervision, ineffective communication and teamwork, and a lack of standardized protocols across instructors and specialty sites (McQuillan, Pilkington, & Allan, 1998; Pronovost, Thompson, & Holzmueller, 2006). Mason and Strike (2003) also found that between 28-42% of trainees felt inadequately prepared to safely perform a medical procedure independently for the first time. Another study revealed that 45% of internal medicine residents

reported making at least one mistake that, in 31% of cases, were fatal (Wu, Folkman, & McPhee, 1991). In yet another study, Cox et al. (2003) found that 44% of residents, at the end of their residencies, still expressed concern about their limited knowledge when managing their patients.

It is safe to conclude that the “see one, do one, teach one” paradigm within medical education is flawed. Undoubtedly, within the context of teaching humanistic behaviors and attitudes, the pedagogical issues within the apprenticeship-like structure of medical education are magnified. Teaching qualities such as empathy, compassion, and respect is not as clear cut as teaching how to take vitals or suturing. In the hands of a clerkship instructor who is unable to successfully master the “see one, do one, teach one” paradigm, errors, miscues, and failures will likely be propagated. Considering this challenge and the prominence of this teaching model in medical schools and hospitals, it is necessary to detail one of the more common and effective methods used to teach humanism within the “see one, do one, teach one” framework: role modeling.

Role Modeling

A role model is defined as a “person whose behavior in a particular role is imitated by others” (Merriam-Webster Online Dictionary, 2014) and taken within the context of medical education where teaching and learning is entrenched within the “see one, do one, teach one” model, role models can have a powerful effect on medical students and residents. Role modeling has been noted as the most common and effective method of teaching ethics, values, leadership skills, and the human dimensions of care (Branch, Kroenke, & Levinson, 1997; Kopelman, 1999; Reuler & Nardone, 1994; J. Shapiro, 2002; Taylor, Taylor, & Stoller, 2008; S. Wright, 1996; S. Wright, Wong, & Newill, 1997; S. M. Wright, et al., 1998). Role models have also been found to influence the career choices of medical students (Ambrozy et al., 1997; Hunt, Badgett,

Woodling, & Pugh, 1995; Mutha, Takayama, & O'Neil, 1997; S. Wright, et al., 1997). Despite its reliance on excellent clinical teachers, medical education scholars agree that role modeling is an integral component of medical education and that the personal qualities, teaching skills, and clinical competence found in role models should be imparted to their learners (C. Matthews, 2000; Paukert & Richards, 2000; Shuval & Adler, 1980; S. Wright, 1996; S. Wright, et al., 1997; S. M. Wright, et al., 1998).

For the purposes of this study, it is critical to understand how role modeling takes place in the medical wards and how humanistic attitudes and behaviors are taught in clinical settings. In order to do this, a recent study by Weissmann et al. (2006) was utilized to shed light on the intricacies of role modeling. Their study focused on a single specialty – internal medicine – and observed clinical faculty as they interacted with their patients and medical students. Their observations revealed five compelling findings, among many others. First, the clinical faculty imparted professional values exclusively by role modeling them. Each role model had a different style and the authors noted that each clinical instructor had learned their role modeling skills on their own, likely from their own role models. Second (and inter-related with the first), role models assumed that learners would identify, learn, and emulate their humanistic behaviors and attitudes without added comment or direction. Interestingly enough, some clinical instructors stated that they intentionally withheld statements of humanistic learning goals at the risk of sounding too “preachy. (Weissmann, et al., 2006, p. 665)”

Third, clinical instructors were very aware of their status as role models. As such, they placed high value and priority in their responsibility as role models and in transferring humanistic qualities to their students and trainees. Fourth, role models utilized an array of nonverbal cues when interacting with their patients. For example, teachers asked for permission

to sit on the side of the bed at eye level with the patient or arranged chairs for medical students and trainees in a patient's room. In some cases, clinical instructors held patients' hands or incorporated some form of brief, appropriate touching. And fifth, the authors noted that role models incorporated different communication styles when speaking with trainees and patients. Specifically, the instructor's tone of voice and pace of speech changed when speaking with a student or patient. This established a sense of comfort between the instructor and the learner or patient and clearly indicated that the physician was "not coming on too strong. (Weissmann, et al., 2006, p. 662)"

This study by Weissmann and colleagues provided unique insight into the process of role modeling humanistic behaviors and attitudes. However, the study contained several methodological limitations that prevented it from being more generalizable, especially for low humanistic specialties. First, data collection took place within the department of internal medicine. Medical education literature has consistently acknowledged that internal medicine lies within the category of "patient-centered", "patient-oriented", or "people-oriented" specialties (Chen, et al., 2007; Hojat, et al., 2009; Newton, et al., 2000). In essence, Weissmann and colleagues studied the process of role modeling humanistic qualities in an environment where humanism was valued, sought after, and in abundance. For specialties that did not benefit from the recruitment of highly humanistic medical trainees (Coutts-van Dijk, et al., 1997), the process of role modeling is likely different and may unfold in various ways. Also, the observations of participating faculty were limited to routine teaching rounds. This sheds light on only one dimension of the role modeling process – the physician-patient interaction. Role modeling, however, can also occur in the absence of the patient, particularly in pre-rounds meetings amongst physicians, trainees, nurses, and other medical practitioners as well as didactic sessions.

In the absence of the patient, role modeling can occur via patient charts when medical trainees are exposed to the written documentations of clinical instructors. How clinical instructors convey information and refer to their patients on paper, especially in a medium that patients are not privy to, can speak volumes on their humanistic orientation.

Shuval and Adler (1980) took a closer look at the interaction of role modeling between medical students and their instructors and found that students generally pick and choose traits from several models. As a result, a student's set of humanistic values are a combination of several attributes and qualities from a variety of role models. Shuval and Adler (1980) also noted three basic patterns utilized by medical students to screen and process what they observe from their instructors: active identification, or the emulation of the role model, active rejection, and inactive orientation, or the reinforcement of preexisting values. Among these three patterns, Shuval and Adler found that medical students most frequently used active identification in their interactions with clinical instructors. Using this process of active identification, Wright et al. (1997) found that students relied on very specific attributes in order to identify excellent role models to emulate. Rather than look at research expertise, specialty area, or title, medical students emphasized clinical skills, personality, and teaching ability. Ironically, those who are chosen to serve as attending residents, or the supervisorial instructor in hospital wards and prospective role models, are selected based on their status as researchers and academics.

Regardless, role modeling remains unstandardized across specialties and as a result, repeated negative experiences or demonstration of undesirable behaviors and attitudes continues to adversely affect medical students' development of professionalism and humanism. This type of negative role modeling has been shown to breed unprofessional behavior and can even lead to ethical erosion during clinical training (F. W. Hafferty, 1998; Haidet, Dains, Paterniti, & et al.,

2002; Hundert, Hafferty, & Christakis, 1996; Stern, 1998). This conflicts with the explicitly stated humanistic attitudes and behaviors that many scholars, physicians, and patients desire and even need across all medical practices. Given that medical students study professionalism, medical ethic, and doctoring in the first two years of their curriculum, negative role modeling during clerkship rotations can subvert internalized lessons and values and promote a culture of negative attitudes and non-humanistic behavior (F. W. Hafferty, 1998; Hundert, et al., 1996).

Within the scope of this study, role modeling constituted the primary method of teaching and learning on the wards for medical students. However, given that this study also took place in low humanistic specialties, the number of role model-like clinical instructors available for medical trainees was lower than other specialties. Additionally, the range of how role modeling is perceived and experienced was wide and diverse. Therefore, the extent and depth of each clinical instructor's role modeling was important to observe and document. For instance, are these clinical instructors more intentional about their actions given their specialty's culture? Are there specific practices that they engage in to specifically teach humanism? Also, do they exhibit their humanistic behaviors and attitudes differentially when interacting with students, colleagues, supervisors, or patients? The literature on role modeling helped inform how each selected clinical instructor was interviewed, observed, and analyzed, and provided a lens through which the findings for how humanism was taught, is presented.

It is apparent that role models are instrumental in how medical students become socialized into the realm of medicine. Ranging from proficiently demonstrating medical procedures to empathizing with the needs and wants of a patient, clinical instructors are responsible for determining how medical students handle and manage their transition from first-year medical student to practicing physician. Role model clinical instructors have a unique

opportunity to remedy the scientific dominance in medicine and the hidden curriculum by imparting desirable, humanistic traits to their students (Reuler & Nardone, 1994). These role models and their accompanying characteristics constitute what Kenny et al. (2003, p. 1204) refer to as the “moral ecology” of the medical school environment.

Emerging Practices for Developing Humanism

In order to construct the right “moral ecology”, a number of factors must line up the right way so that medical students, residents, and physicians understand and teach the value and role of humanism in healthcare. Although role modeling has been identified as one of the more common and effective methods of teaching humanism, it is not perfect and can also lead to the delivery of negative, or undesirable, traits. In turn, medical educators have proposed and developed several pedagogical, organizational, and structural interventions to help teach humanism, in the absence of or in conjunction with role modeling.

Role modeling has often been identified as mentoring, but scholars and practitioners have delineated the two as separate processes. For example, a role model teaches primarily by example and shapes learning by promoting observation and inspiring humanistic conduct. A role model is much less intentional and informal about their impact and at times may be completely unaware they are providing instruction. On the other hand, mentoring is much more deliberate and explicit. Mentors and their mentees spend more time together and mentoring relationships are typically formed between senior, more experienced members and younger, inexperienced members. Mentoring can include role modeling and can also provide the same influence offered by observational learning and watching leaders in action (Taylor, Taylor, & Stoller, 2009).

More patient-centered methods used by medical institutions are reflection exercises and narratives. At times, reflective exercises can be used by medical students after role modeling to

encourage feedback and processing. However, reflective exercises are employed by clinical instructors to provide cognitive and emotional self-awareness of one's beliefs, attitudes, and values (Mann, Gordon, & MacLeod, 2009). Self-reflection can stimulate discourse, transform perspectives, internalize humanistic values, explore one's own assumptions and biases, and most importantly, help physician's actualize the values that the medical profession embraces (F. W. Hafferty, 2006; Leach, 2004). Narratives utilize patients' stories and experiences in order to integrate their perspectives into physician training. Patient narratives can not only help physicians adopt a more patient-centered approach to delivering medical care (Branch, et al., 2001; Charon, 2001; Wear, 2002), but can also lead to positive changes in medical student empathy (DasGupta & Charon, 2004). Some narrative interventions are comprised of longitudinal interactions with patients, reflective exercises, and small group discussions to further foster humanism in medicine (Kumagai, 2008).

In a similar vein, medical institutions have also formed faculty development programs aimed at reinforcing humanistic attributes. Branch et al. (2014) noted that a supportive group process embedded within a faculty development program for clinical faculty encouraged reflection and provided an environment where feedback on humanistic qualities and skills could be safely processed. By engaging in this process, the study by Branch et al. (2014) found that participants in the developmental program were rated as better examples of humanistic qualities by learners than non-participants. The authors of this study go on to state that the positive outcomes of the faculty development program were not a result of a single role model-like individual but rather the organizational and educational structure of the program.

Some institutions have taken a more formal curricular approach to teaching humanism. Shapiro et al. (2004) found that an eight hour literature and medicine elective led to a significant

increase in empathy among first-year medical students. In a later study, Shapiro et al. (2007) also found that, after completing a multi-dimensional humanities elective, empathy levels were preserved among third- and fourth-year medical students. This elective may serve as a buffer to the decline in empathy that scholars have noted beginning in the third year. In yet another separate study, Shapiro et al. (2006) noted that a “doctoring” course aimed at increasing empathy and compassion toward patients led to important self-reflection that revealed common biases and assumptions. These shared reflections and class discussions helped medical students process and cope with their behaviors and attitudes. Finally, Stevens, Wilkerson, and Uijtdehaage (2014) argue that continuity sites during clerkship rotations provided students with a stronger ability to more effectively participate in patient care. They also found that because continuity sites allowed medical students to follow patients over a longer period of time, their knowledge of the patient, the healthcare system, and its effects on patient outcomes increased. Similar to narratives, these longitudinal encounters through entire illness episodes can only serve to help medical students process the experiences and perspectives of the patient.

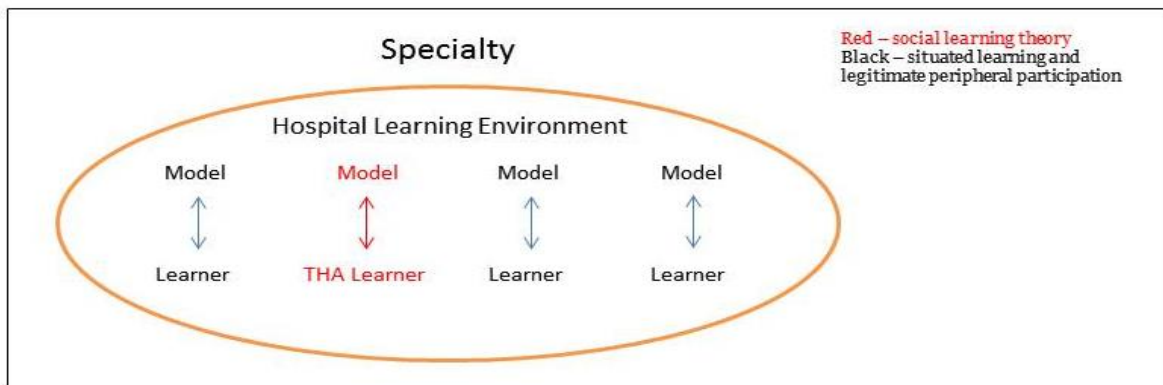
Benbassat and Baomal (2004) sum up the ethos behind these emerging practices by proposing two teaching approaches that can promote empathy during clerkship rotations as well as medical education as a whole. First, Benbassat and Baomal stress the importance of reinforcing the humanistic skills taught during the preclinical years of one’s curriculum. They argue that this would eliminate any established clinical habits seen on the wards. And second, Benbassat and Baomal recommend that a major portion of clinical clerkship rotations relocate to primary care clinics, home care, and hospice facilities. Ideally, this would provide students with an opportunity to observe physicians who conduct patient-centered interviews, draw concerns

and sources of distress from their patients, and postpone the write-up of patient history until after the interview (F. W. Hafferty, 1998).

Conceptual Frameworks

Based on the literature, it is evident that the people who come in contact with trainees shape how their humanism is valued, taught, and advanced within healthcare. As such, this study primarily relied on two conceptual frameworks that take this into account. This framework – social learning theory – focuses on the people that enter in and out of the lives of medical trainees and how their interactions contributed to how physicians inform their humanism, and how they teach it. Significant emphasis was placed on the relationship between role models and the learners, or study participants. This concept primarily guided Research Questions 1 and 2. The second framework – positive deviance – focused on the physicians as individuals and how they perceived their role as an “outlier” in their specialty within the context of humanism. This framework was also used to interpret how they maintained their humanistic orientation in spite of their specialty’s climate and culture. This concept primarily guided Research Question 3.

Figure 2.2. Social learning theory vs. situated learning and legitimate peripheral participation



Social Learning Theory

As previously mentioned, teaching and learning in medical schools in the wards has largely been predicated on the paradigm of “see one, do one, teach one”. This apprenticeship-like nature of physician training provides the basis for any and all transmission of knowledge, behaviors, and attitudes, from teacher to learner in a clinical setting. Given this unstructured “learning by doing” model, the culture and environment in which medicine is taught and practiced play a pivotal role in imparting humanistic qualities and attributes. Embedded within this culture is the role that people play in imparting such qualities and attributes. Social learning theory (Bandura & Walters, 1977) provides a necessary framing for how role models, mentors, and those surrounding the Teaching Humanism Award winner influence their learning and development as physicians and caregivers. In essence, Teaching Humanism Award winners buck the trend of their specialty’s culture and climate. They are recognized for humanistic behaviors that are not the norm for their field. As such, given the prevalence of implicit learning and role modeling in medicine, social learning theory may explain how and why these clinical faculty members develop and display their humanism differently.

In contrast, Lave and Wenger’s theory of situated learning and legitimate peripheral participation (1991) – a prevalent framework commonly used to describe the medical training environment – describes how learning takes place in the same context in which it is applied, i.e., the hospital, and how apprentices slowly become experienced members of a particular community of practice by taking on peripheral, or simple and low-risk, tasks that enable them to learn the principles of the community. Similar to clinical clerkships, third-year medical students as well as medical residents serve as apprentices in a particular community of practice, or a clinical specialty, and take on peripheral tasks as assigned by their instructors and supervisors.

As time goes on, Lave and Wenger suggest that apprentices take on more tasks that are more central to the functioning of the community - mirroring the transition of medical school students into residency programs and subsequent teaching roles. Taken in its entirety, Lave and Wenger's theories of situated learning and legitimate peripheral participation within communities of practice outline the very same paradigm dictated in clerkships by allowing individuals to learn by socialization, visualization, and imitation.

However, Lave and Wenger's approach does not seem to explain for these Teaching Humanism Award faculty members. Based on their recognition as humanistic teachers and practitioners, they have clearly 'gone against the grain' and defied the acculturation that typically takes place for incoming trainees into a given specialty. In fact, THA winners not only maintain their humanistic orientation in spite of their specialty's given culture, but they may strengthen it as well. Embedded within this framework is the role of culture and the acculturation of medical students as they progress through their medical education. Medical schools are, in essence, cultural entities and moral communities closely involved in constructing ideas and definitions of what "good" and "bad" medicine is (F. W. Hafferty, 1998). Within this context, as medical students move closer and deeper to the core values of a given specialty, they accept and become desensitized to their surroundings. They assimilate and what was initially something they thought required attention and change now becomes something acceptable and given. This process can happen in an invisible and almost unconscious manner. Similar to apprenticeships, daily routines unfold in predictable ways and the values associated with such routines can be taken for granted. More often than not, these values essentially go unnoticed. This can be perceived as a challenge, especially when detailed examination and inquiry is necessary to unpack how any and all teaching and learning is achieved.

Given this, the existence and influence of role models on THA faculty members serves to underline the importance of social learning theory. For all we know, their presence may be the keystone to THA winners preserving their sense of humanism, developing their humanistic orientation, and confidently and effectively teaching and practicing it amongst their trainees and peers. For whatever reasons, the selected participants for this study “buck the trend” in their specialty and do not adhere to the tendencies illustrated by Lave and Wenger’s framework. On the other hand, social learning theory dictates that this “bucking” may be a result of an alignment of values between the role model and trainee. In other words, the trainees observe a behavior that reflects an intrinsic value set; they integrate said behavior and replicate it in their practice. Perhaps this is the reason why THA winners become who they are. They simply possess the humanistic qualities prior to their training and seeing their role models model the behavior only confirms their orientation. Or, perhaps the humanistic behaviors and attitudes of THA winners were taught differently by these role models, or the role models created a buffer for their trainees to practice and learn humanistically? Whether moral enculturation occurred for these “outliers” or not, the values, attitudes, and character of the selected highly humanistic physicians set them apart from their colleagues. As a result, their place in the specialty is spotlighted and perhaps, become magnified. The ensuing conceptual framework delves into those actions.

Positive Deviance

Based on Spreitzer and Sonenshein’s work (2003, p. 832), positive deviance is defined as “intentional behaviors that depart from the norms of a referent group in honorable ways”. In turn, these intentional behaviors can be deemed beneficial and subsequently adopted by an entire community (Marsh, Schroeder, Dearden, Sternin, & Sternin, 2004). Although traditional definitions of deviance refer to intentional behaviors that depart from organizational norms that

threaten the well-being of an organization (Bennett & Robinson, 2000), Spreitzer and Sonenshein contribute to the expansion of the theoretical understanding of deviance to include positive behaviors. Positively deviant behavior has been shown to influence the very individuals and organizations that participate and benefit from such behaviors (Quinn, 1996; Quinn & Quinn, 2002). Although the parameters of defining positive deviance are varied, Spreitzer and Sonenshein (2003) contend that a normative approach to positive deviance is most appropriate. Rather than rely on a statistical view that defines positive deviants as individuals found on the far right side of a normal distribution, positive deviants simply depart from normative expectations in an honorable way.

For example, positive deviance has been used extensively in the realm of public health. In a study on malnutrition in Vietnamese rural villages conducted by Sternin and Choo (2000), the authors examined the behaviors of very poor families who had managed to avoid malnutrition and keep their children healthy. In their observations, they noted unconventional best practices that were helping young children stay healthy. Sternin and Choo noted that these practices did not require additional outside resources or more money but simply a change in behavior that emulated these poor families, or positive deviants. These practices were then institutionalized via a larger scale program that targeted more families in and around the rural areas. This example of positive deviance highlights the power that one person, or a group of people, can have on their community if their practices are appropriately distilled and scaled up for larger use. And, for the purpose of this study, the unique skills, strategies, habits, or mechanisms that selected clinical instructors possess for humanistic development and advancement were documented to then help change the behavior and values of their specialty.

It is important, however, to note several implications related to the use of positive deviance that lends itself to this study's design as well as its intentions. First, as suggested above, positive deviance is an evaluative term that is based off of normative expectations (Goode, 1991). That is, clerkship instructors labeled as positive deviants conduct themselves in a manner that should or should not occur based on what is normally and collectively expected within a particular specialty. These collective expectations are also referred to as the organizational norms, or shared understandings of work values and behaviors amongst individuals in an organization (Elangovan & Shapiro, 1998). Second, positive deviance is always viewed in relation to a referent group that exhibits typical behaviors that are normally expected (Clinard & Meier, 2001). Third, when positive deviance is observed or noted by others within a group, that behavior is commended or recognized. Finally, and most importantly, positive deviance highlights honorable, intentional behavior, independent of their outcomes. Although some clerkship instructors may exhibit humanistic teaching practices and advance their ideas amongst their colleagues, within the context of positive deviance, the outcome, or impact, of their intentional behavior is evaluated separate from the behavior itself.

Given this concept of positive deviance and its implications, one can argue that social learning theory and positive deviance all stem from elements of organizational culture. Whereas in Bandura's framework, organizational culture may influence the interpretation of teaching and learning, positive deviance is calibrated by the normative expectations of organizational culture. For the purposes of this study, social learning theory takes the approach of interpersonal teaching and learning to answer Research Questions 1A and 1B. In other words, this conceptual framework examines humanism in healthcare transmitted from individual to individual, i.e. role model to learner. On the other hand, positive deviance takes a top-down approach to answer

Research Questions 1A and 1C. That is, this particular framework was used to examine humanism in healthcare going from exemplar individuals (“top”) down to their colleagues in their specialty.

Research Gap

Based on the literature and the proposed conceptual frameworks, this study aims to fill a gap in the medical education research regarding how humanism is guided, taught, and advanced by highly humanistic physicians in both low and high humanistic specialties. To date, the literature on teaching and advancing humanism is largely focused on patient-centered specialties. Hence, specialties such as internal medicine and pediatrics tend to house studies on humanism. This may be due to easier recruitment of study participants or minimal pushback in implementing a study that may run contrary to what is valued in a given specialty. These specialties, though, already benefit from a prevailing culture of humanism and an influx of highly humanistic physicians. As Coutts-van Dijk et al. and Newton et al. (1997; 2000) found in their studies, patient-centered specialties tend to attract medical trainees with a stronger humanistic orientation. However, highly humanistic physicians enter, operate, and even thrive in non-patient-centered specialties. Though they are likely one of very few, these “outliers” commit to their specialty despite a seemingly adversarial culture.

This study answered three research questions and in so doing, attempted to identify what common characteristics these “outliers” shared, whether their humanistic orientations are guided differently from others, how their teaching styles have changed, if at all, since entering their specialty, and what they are doing to advance humanism amongst their colleagues. Given the calls and mandates for humanism and professionalism from national and global medical and specialty bodies (ABIM Foundation, ACP-ASIM Foundation, & European Federation of Internal

Medicine, 2002; Brownell & Cote, 2001; Institute of Medicine, 2004; D. T. Kenny, 1995; Liaison Committee on Medical Education, 2003; Swing, 2007), the goal for this study was to pinpoint best practices, values, processes, ideas, and lessons that can be scaled up for medical institutions that experience challenges with promoting humanism within their lower humanistic specialties.

Chapter 3: Methodology

In this chapter, I outline the methodology that I utilized for this study on humanistic clerkship instructors in high and low humanistic specialties. First, I provide a summary of the purpose and the research questions guiding this study. Second, I describe my research design and limitations to data collection and interpretation. Third, I detail the recruitment of the sample and data collection methods, including descriptives of the study sample. Lastly, I conclude with my positionality as a researcher and a recap of the methodology for this study.

Purpose and Research Questions

The central purpose of this study was to examine how humanistic physicians in both ‘high’ and ‘low’ humanistic specialties operationalize their humanism amongst their students and colleagues and how humanism informs and influences their roles and responsibilities in the context of their hospital environment and culture. By focusing on these humanistic specialties, this study contributes a unique perspective to the ongoing discussion on how humanism can be taught, delivered, and cultivated in disciplines that exhibit more and less patient-centered behaviors and attitudes. Specifically, this research examines the experiences of ‘outlier’ physicians, or those who differ from the norms of a particular specialty culture, by asking the following research questions:

1. What guides the humanistic orientation of physicians who display a high degree of humanism?
2. How do these physicians impart humanistic practices to their trainees?
3. How do these physicians advance humanistic practices or orientation within specialties?

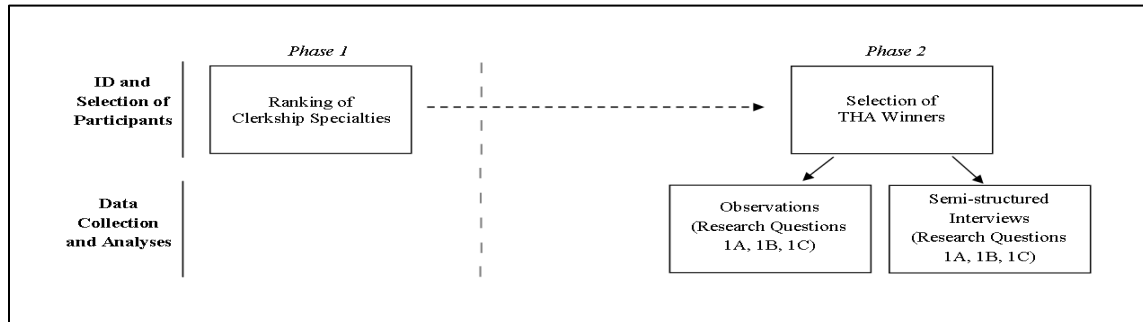
Of key importance to this study, particularly during fieldwork data collection, was adjusting to the context and pace of a teaching hospital. From an educational standpoint, close proximity to illness and death on a near-daily basis and consistent exposure to anxious, sad, or angry patients provided a unique backdrop for teaching observations. However, for those actually learning in this environment, observations provoked questions and thoughts about how one might comprehend the vast knowledge needed to perform at a high clinical level in such a physically and emotionally demanding environment. It is no surprise that medical education research has not only documented a drop in humanism during medical school but also an increased prevalence of burnout and stress amongst trainees (C. M. Brazeau, R. Schroeder, S. Rovi, & L. Boyd, 2010; Dyrbye, et al., 2010; Leiter, et al., 2009). Existing literature has made clear that possessing a stronger humanistic orientation and techniques for coping with stress and burnout not only leads to better patient outcomes but also provides physicians with a mechanism to prepare for and counteract de-humanizing responses, especially in specialties that have traditionally been less patient-centered (Ghetti, et al., 2009; Maslach & Leiter, 1997).

For those who excelled at teaching humanism at the bedside, i.e. the participants in this study, observations were akin to watching a master perfect their craft. Their skill in traversing the line between patient care and teaching and providing a safe and supportive ‘classroom’ for their trainees drove home the purpose and significance of this study. The clinical faculty members recognized for their teaching of humanism stood out for a reason. That being said, in an environment where one expects empathic levels to decline, it behooves educators to extract tools and techniques that might prove beneficial for other providers. More importantly, it is imperative that we better understand how humanistic ‘outliers’ navigate and operate in specialties that traditionally exhibit lower levels of humanism.

Research Design

In order to explore humanism within the context of high and low humanistic specialties, I utilized observational fieldwork and a series of semi-structured interview. This exposure and follow-up allowed for a thorough investigation of the THA faculty members and their roles in practice and teaching. By selecting from both the higher and lower end of the humanism spectrum, this study aimed to explain and illustrate how and why humanistic clerkship instructors set themselves apart with their “outlier”-like orientations, behaviors, and attitudes. Multiple primary data sources were utilized throughout all the data collection, including pre-interview questionnaires, observations, and interviews. These sources allowed for triangulation, confirmation of any salient findings related to how and why certain phenomena occurred, and improvement in the reliability of the study (Miles & Huberman, 1994; Yin, 2009). As such, the identification and selection of humanistic clerkship instructors unfolded via two methodological processes: 1) literature review of humanism scholarship detailing higher and lower humanistic specialties, and 2) observations and interviews of the Teaching Humanism Award winners. The first phase of data analysis painted a broad sketch of the landscape of humanism within medicine and provided the necessary foundation for the selection of clerkship instructors for the final and primary phase of this dissertation – the observations and semi-structured interviews. The complete methodological process is detailed in Figure 3.1.

Figure 3.1. Summary of methodological processes



Phase One: Clerkship Specialty ‘Rankings’

In this initial phase of the study, the medical education literature was used to identify specialties that fell within the higher and lower end of the humanism spectrum. Medical education scholars have published extensively on empathy and humanism across the training timeline of medical practitioners. The literature has also examined professionalism and the prevalence of burnout across multiple specialties. Given that similar attributes reside in all of these domains, an analysis of literature on these topics provided the basis for the ranking of clerkship specialties. However, it must be noted that no scholarship has ranked every specialty or sub-specialty on these domains. In fact, scholarship has simply alluded to the specialties that fall at the higher and lower ends of the spectrum. As such, the following three specialties were chosen – internal medicine, pediatrics, and surgery. Internal medicine and pediatrics represented the higher end of the humanism spectrum while surgery represented the lower end. This ‘ranking’ of sorts has been supported by the medical education literature on empathy, humanism, professionalism, and burnout (C. M. Brazeau, et al., 2010; Coutts-van Dijk, et al., 1997; Hojat, Gonnella, Nasca, Mangione, Veloski, et al., 2002; Hojat, Gonnella, Nasca, Mangione, Vergare, et al., 2002; Hojat et al., 2005; Krain & Lavelle, 2009; Martini, Arfken, Churchill, & Balon, 2004).

Phase Two: Observations and Semi-structured Interviews of ‘Outliers’

The second and last phase of the study utilized observational fieldwork and a series of semi-structured interviews to explore how humanistic clerkship instructors perceive and operationalize their humanism, particularly within specialties that tend to exhibit lower levels of humanism. This methodological approach was used to answer Research Questions 1, 2, and 3. The main unit of analysis is a select group of clinical faculty, and their experiences and insights were captured with interviews, observations of their clinical rounds, didactic sessions, and clinical team meetings. The following describes how clerkship instructors were selected and recruited for analyses and how each research question was answered.

After identifying specialties from the higher and lower end of humanism, clerkship instructors were selected and recruited for via the awardee list for the Teaching Humanism Award (THA). The THA recognizes faculty members affiliated with the UCLA Health System who exhibit strong qualities of humanism in their teaching and patient care. Regardless of specialty, within those parameters of humanism, THA recipients have essentially been classified by their colleagues and peers as an ‘outlier’, or someone differing from all other members of a particular group. The award was implemented by Dr. Margaret Stuber, Professor of Psychiatry, and Dr. LuAnn Wilkerson, Senior Associate Dean for Medical Education and funded by the Arthur Vining Davis Foundation and the UCLA Health System. Awardees are given a stipend of \$2,500 and enrolled in a yearlong series of faculty development workshops with fellow awardees. The nomination form for the THA is provided as Appendix B.

Over the past five years, the THA has been given to 50 faculty members across the UCLA Health System. These 50 awardees represent a wide array of specialties including Neurology, Surgery, Internal Medicine, Pediatrics, and OB/GYN, to name a few. In addition to

representing both patient- and non-patient-centered specialties, nearly all THA winners currently teach, or have taught, in their respective specialty's clerkship rotations. However, it is important to note that some THA winners represent specialties that do not rotate medical students. As a result, these instructors were removed from the selection process since they had no teaching interaction with medical students. Additionally, THA winners come from various sites within the UCLA Health System. For the purposes of this study, clerkship instructors were selected from the multiple clerkship sites within the system. This allows for maximum sample representation and selection during this phase, both from specialties, gender, tenure, as well as background.

Interviews with selected clerkship instructors followed a semi-structured protocol and provided the basis for answering Research Question 1A, 1B, and 1C. A sample interview protocol is provided in Appendix C and divided up into five sections (Introduction, Guiding Humanism, Teaching Humanism, Advancing Humanism, and Wrap-up). In essence, each section, with the exception of the Introduction and Wrap-up, helped inform Research Question 1 (Guiding Humanism), Research Question 2 (Teaching Humanism), and Research Question 3 (Advancing Humanism). Prompts revolved around their approach and perception of humanism in the context of the culture of their specialty, their teaching experiences and methods, and their efforts to advance humanism within their specialty. Each interview was scheduled for approximately 30 minutes and were recorded.

Observations of clinical rounds, didactic sessions, and clinical team meetings took place prior to and after the completion of each instructor interview, depending on the availability of the instructor. Expanding upon the methods used by Weissmann and colleagues (2006), this study placed added emphasis on the observations and analysis of didactic sessions and clinical team meetings. These observations helped inform how I interpreted interview responses pertaining to

Research Questions 1, 2, and 3. Clinical rounds are the “classrooms” where much of the teaching takes place between teacher and student. Using the patient as a case study, medical students are given a hands-on opportunity to perform procedures and take patient histories under the supervision of the clerkship instructor. Observing the interactions between teacher and student helped paint a clearer picture of the interview responses of clerkship instructors. However, in cases where I was unable to schedule observation in time, follow-up questions were added to the protocol to ask about particular interactions and behaviors during observations. This allowed me to further pinpoint strategies and tools that instructors use while teaching.

Didactic sessions are essentially lectures that take place in the hospital for medical students on the clerkship rotations. These are taught by clinical instructors and supplement much of what the students learn during their rounds. Observing these sessions not only provided me with a better idea of who the clerkship instructors are, but also a different perspective on how they teach. Because these sessions were in a lecture format and did not take place bedside, these observations shed light on each instructor’s approach to teaching as well as how humanism took shape in their lecture content. Clinical team meetings typically took place before rounds began and consisted of updates given by interns, attending residents, or clerkship instructors. These meetings provided a behind-the-scenes look at the rounding process and informed how instructors plan out their “teaching materials” for their rotating students. These observations gave me a better sense of the instructor and their humanistic orientation when medical students and patients were not present.

Observations lasted approximately one week per clinical faculty member in order to capture an entire cycle of rounding, any scheduled didactic sessions, and clinical team meetings. Whereas Weissmann and colleagues selected specific patients to observe during clinical

rounding (2006), this study focused on all patients during the two week observation period. This allowed for an array of clinical encounters that may trigger different methods of teaching. Because the nature of clinical rounds, didactic sessions, and clinical team meetings tend to repeat every week and are dependent on patients' stay, one week was more than sufficient to capture how selected clerkship instructors behave and operate within their specialty. Follow-up interviews with each participant were scheduled on a case-by-case basis if additional questions arose after observations are completed.

Description of Teaching Humanism Award Winners

The aforementioned humanistic 'outliers' are officially recognized as Teaching Humanism Award (THA) winners annually by the UCLA Health System. The award is given to clinical faculty members hand-selected by a faculty committee from a pool nominated by their peers. Since 2009, the THA has been given to 58 clinical faculty in the UCLA Health System. These clinical faculty represent 13 different specialties and sub-specialties, ranging from Anesthesiology and Surgery to Psychiatry and Internal Medicine, among many others. Of the 58 THA winners, 57% are male and 43% are female. The average estimated age of a THA winner is 44 years old, with the youngest and oldest faculty members recognized being approximately 32 and 70 years old, respectively. Nearly 85% of THA winners received their medical degree from a medical school located in the United States. However, 97% of THA winners completed their internship, residency, or fellowship at a hospital or medical center located in the United States. Sixty-two percent of THA winners also completed at least one fellowship following their residency. Most importantly, THA winners were recognized for their bedside teaching and manner an average of 13 years after completing their residency.

Given the established methodology for this study, the eligible pool of THA clinical faculty members was pared down to 29 physicians. Using the literature as a guide, these 29 instructors were divided into two sub-groups – the first group representing specialties from the ‘higher’ end of the humanism spectrum, i.e. Internal Medicine and Pediatrics, and the second group representing specialties from the ‘lower’ end of the humanism spectrum, i.e. Surgery. Based on this criterion, ten faculty members from Surgery and 19 from Internal Medicine and Pediatrics were included for study recruitment.

Recruitment and Data Collection

Selected THA winners ranged in age, race, gender, duration of career with the UCLA Health System, and number of years teaching. Once clerkship instructors were identified and chosen, recruitment of participants into the study was guided by Dr. LuAnn Wilkerson. Because all THA winners have at some point interacted with Dr. Wilkerson, I worked with her to establish contact with selected instructors. Given the considerable investment that THA winners have made in humanism through the THA-driven faculty development workshops and the positive nature of my study’s inquiry, the likelihood of each instructor participating in the study is high.

As a result, 29 THA winners selected for study recruitment were contacted in early winter 2015 to request their participation in the observational fieldwork and semi-structured interview components of this study. Over the course of the next nine months, 15 faculty members opted to participate in the study, two declined, three were unable to schedule observations or interviews due to scheduling complications, and nine did not respond to the invitation and several follow-up requests. Of the fifteen faculty members that agreed to participate, five had an appointment in the Department of Surgery and ten had an appointment in

either the Departments of Internal Medicine or Pediatrics. Due to scheduling complications, recent changes to their faculty appointments, or sabbatical, four out of the 15 participants were not followed for observations. However, all fifteen THA winners were interviewed.

From early winter 2015 to early fall 2016, observational fieldwork took place at three different hospital sites within the UCLA Health System – Ronald Reagan Medical Center, Santa Monica Hospital, and the Greater Los Angeles VA Hospital. After agreeing to participate in the study, THA faculty members were asked for their teaching service calendar and observation dates/times were scheduled within a mutually available week of service. On average, within a given teaching service week, each faculty member was observed for four days of rounding. Within Internal Medicine and Pediatrics, rounds typically began early in the morning (7:30AM-9:00AM) and lasted for approximately 2-3 hours. Within those 2-3 hours, an average of 10-13 patients were rounded on. For each internist and pediatrician, an average of 8-12 hours was spent observing their teaching in a given week, i.e. 3-4 separate days of rounds. It is important to note that of the 10-13 patients seen each day, nearly all remained during the course of the week. In total, nearly 90 hours of observations, were completed for nine different THA winners who fell within the ‘higher’ end of the humanism spectrum. Within Surgery, observations of teaching rounds were only available post-operatively. Although they typically also began at 7:30AM in the morning, post-operative rounds lasted approximately 30-45 minutes. Within those 30-45 minutes, an average of 6-8 patients were rounded on. As opposed to Internal Medicine and Pediatrics, these patients rotated out on a more frequent basis, i.e. there were more new patients throughout the course of a week. For each surgeon, an average of 2-3 hours was spent observing their teaching in a given week. In total, approximately five hours of observations were completed for two THA winners who fell within the ‘lower’ end of the humanism spectrum. Note that three

of the five surgeons who were not observed were either on sabbatical from teaching, no longer taught for the medical school, or unavailable due to scheduling complications.

In concurrence with the observational fieldwork, interviews were also scheduled and conducted with the fifteen participating THA winners. Interviews took place in locations of convenience for clinical faculty and ranged from offices and conference rooms to coffee houses and cafeterias. For a majority of study subjects, interviews were scheduled after observations in order to follow up on questions or issues that arose during teaching rounds. However, for some faculty members, scheduling complications led to interviews being conducted prior to observations. As such, on a case by case basis, follow-up questions from teaching observations were emailed to the faculty members. Faculty interviews typically lasted between 30 minutes to 1.5 hours. Following an 18-item semi-structured interview protocol (see Appendix C), THA winners were asked to reflect on prompts ranging from the development of their teaching style and their preferred techniques and tools for teaching humanism to how they felt their specialties integrated humanism into their curriculum and culture. All interviews were recorded with the permission of each clinical faculty member and transcribed for deeper analysis.

Qualitative analysis focused on three phases of coding – open, axial, and selective (Corbin, 2007). Initial review, or open coding, of the interview transcripts aimed to identify any themes relevant to the three research questions of this study. A secondary review, or axial coding, was conducted in order to refine and define these themes. Lastly, a final review, or selective coding, was completed to choose the most salient themes for inclusion in this study. During the process of coding, member checks, triangulation, peer debriefing, and external audits were employed in an effort to verify analyses (Lincoln & Guba, 1985). Member checks were conducted with select THA faculty members from both Surgery and Internal Medicine.

Triangulation incorporated interview transcripts, observational fieldwork notes, and pre-surveys collected during interviews. Peer debriefing occurred regularly throughout the analysis of qualitative data with scholars in the higher education, science, and assessment disciplines. External audits, similar to member checks, were conducted closer to the end of analysis, with colleagues in medical education who had significant experience with teaching and learning within the medical school. Additionally, an audit trail was comprehensively detailed throughout the course of this study to aid in replicability and transferability of study design and results.

Limitations

This study had several limitations. First, this study focused on a single medical institution – the UCLA David Geffen School of Medicine. The school is comprised of several clerkship sites which accommodate rotating medical students throughout the year. Each site possesses its own unique culture and climate based on its surrounding community and constituents. One hospital may cater to a military veteran demographic while another hospital may be situated in a lower-socioeconomic area. However, because THA winners must be employed within the UCLA Health System, the parameters of this study are restricted to that of the School of Medicine’s UCLA Health System clerkship sites. It is important to note that clerkship experiences are embedded within a patient care system that caters to a diverse demographic with specific medical needs. Therefore, the medical interactions that students and clerkship instructors describe may be reflective of a certain type of patient care and may only shed light on how humanism unfolds for a specific patient and caregiver population.

Second, the THA process highlights the work of physicians with a clinical faculty appointment in the David Geffen School of Medicine. Removed from this entire process is the work of residents and attending residents without faculty appointments who also contribute to

the experiences of medical students during their rotations. Though the frequency with which medical students interact with faculty members and residents is unpredictable, this study only shed light on a piece of the humanistic development process in medical education. Additionally, with more hospitals relying on interprofessional collaborations to improve patient care, nurses, nurse practitioners, nutritionists, and other patient care professionals who round with medical students may have had a profound impact on teaching and practicing with humanism. This collaborative approach to teaching and practicing within the context of patient care was not appropriately addressed in this study and deserves further study.

Third, the study did not include a control group. No comparative data was analyzed to assess the differences between THA winners and non-THA winners. This could have provided further insight into how THA winners set themselves apart from their colleagues. Future studies should examine THA winner practices versus non-THA winner practices. Fourth, the study relied on a fairly restrictive sample. Of the entire pool of THA faculty winners, approximately 30% participated in this study. Though the study design parameters and the literature did restrict the selection of faculty in other specialties, the exclusion of nearly 45 THA faculty perspectives raises questions about practices, techniques, or interventions that could have contributed to this study. As such, the applicability of this study's findings may only be relevant to surgery, internal medicine, and pediatrics. Future studies should simply explore the humanistic practices of all THA faculty in an effort to gather as much data on how these outliers operate.

Fifth, the study design may have benefited from a chronological shift in recruitment and data collection. As noted in Chapter 3, in addition to a monetary reward, THA winners enroll in a year-long workshop dedicated to teaching at the bedside. Though many THA winners noted that this workshop was essentially a support group of sorts, these discussions also revolved around

different teaching practices and experiences that may have shaped the already-humanistic orientations of THA faculty. How much of an impact this workshop had on the THA faculty is difficult to assess. However, if the true, raw humanistic orientations of the THA winners were of interest, capturing this prior to a formalized intervention, i.e., the workshop, may have provided some additional insight.

And finally, the selection of positive deviance as the guiding framework for the third research question was premature. Operating on the assumption that THA faculty were actually positive deviants and already affecting widespread change misguided the interview protocol. As a result, data from this portion of the interview was preliminary and largely speculative. Additional research should apply a conceptual framework more aligned with the thought processes and motivations of leaders. This may provide valuable insight into the nascent developmental stages of change-makers, outliers, or positive deviants, which may better describe where most THA faculty are in their trajectory of ‘deviance’. As an alternative, the third research question could also benefit from a re-framing that focused more on the impact of the THA faculty interventions and activities. These findings could have been used to launch further studies on what has been most effective in advancing humanism across specialties.

Positionality of Researcher

My experiences, both in and out of the classroom, have shaped my views on medical education as well as my approach to research. Prior to beginning my undergraduate education, I had long desired to pursue a career as a physician. The prospect of a profession that embodied service, excellence, altruism, and respect, for whatever reason, resonated with me. As a result, for the first three years of my post-secondary education, I completed premedical courses such as organic chemistry and molecular biology. However, the culture and climate I was exposed to

within premedical education courses began to deteriorate my aspirations of practicing medicine. Ultra-competitive students who studied purely for the grade, faculty members with minimal teaching experience, and curriculum that were designed to weed students out rather than build students up began to wear on me. Friends that shared similar aspirations and dispositions began to leave the premedical pipeline and pursued disciplines that provided more personal satisfaction and value. The culture and climate of premedical education was not worth the negativity. Though I persisted and eventually completed my science degree, I had already decided to pursue a career in higher education based on my co-curricular and extra-curricular experiences in student affairs and administration.

Fast forward several years and using my experiences in premedical education as well as my professional work in academic affairs administration, I entered graduate school with an aim to further examine the culture and climate of premedical education and science, technology, engineering, and mathematics courses (STEM). Exploration of the inequities and disparities in STEM branched into topics and issues pertaining to the pipeline and what happened to premedical students during and at the end of their medical education. In other words, issues that had influenced my educational and career decisions years prior began to inform my research and inquiry. Specifically, I became interested in health professional shortage areas, or underserved areas where physicians are very much in need. Though the government has identified numerous regions where the number of primary care physicians is dwindling, medical school graduates and residents continue to opt out of practicing in these high-need populations. I began to question how and why medical students and residents were not heeding the call to serve those most in need. Perhaps the culture and climate in premedical education as well as medical school had eroded any sense of empathy and compassion the students and residents had? The emergence of

declining behaviors and attitudes such as compassion, empathy, sympathy, kindness, or integrity during a physician's education weighed on my mind as I juxtaposed these thoughts with what had attracted me to medicine years ago – a desire and ability to serve those who needed it most. Was 'doctor' no longer synonymous with being humanistic and caring?

Regardless, the idyllic and prestigious qualities seemingly exuded by the medical profession, that first drew me to medicine, never changed for me. I still, to this day, believe that the work of medical doctors is of the noblest cause. That the responsibilities of medical doctors are some of the most important in society and the people that assume these roles are, at the very core, good people. The notion that humanism was diminishing over the course of a physician's education was concerning for me and the ivory tower that medicine and doctors represented in my mind seemed to be slowly crumbling. In some ways, this study is an attempt to restore my faith in the medical profession. My inclination to recapture this idea of honor and prestige, in my mind, helped guide me to identify and translate best practices, strategies, and tools that can improve humanism across all medical specialties. No matter how small or discrete, an experience, story, or insight observed in this study can be the keystone for changing how a low humanistic specialty recruits, trains, or acculturates its physicians. This desire fueled me as I searched for a common thread that might unlock how humanism can be taught to all physicians and shape how the teaching and learning of humanism is disseminated and modeled.

Recap of Methodology

In order to address the three research questions of this study, my approach centered on observations, pre-interview questionnaires, and semi-structured interviews with THA faculty members. Using clerkship instructors as the primary unit of analysis for this study, my aim was to investigate the motivations for and operationalization of their humanism, the development of

their humanistic teaching and patient care practices, and the roles and responsibilities in their specialty and amongst their colleagues, all within the context of a culture and environment that exhibits low humanism. The study began with the analysis of the humanism literature. This allowed for a broader understanding of how humanism has evolved, if at all, in medicine and more importantly, identified specialties that represent the higher and lower ends of the humanism spectrum. Following the identification of these specialties, I selected clerkship instructors that were appointed in these specialties from a list of current and past THA recipients. The final phase of the study concentrated on semi-structured interviews with these instructors, observations of their clinical rounds, didactic sessions, and clinical team meetings. These methodologies informed a research design that offered a unique look into how humanistic clerkship instructors inform their humanism in relation to general consensus, operationalize their humanism via their teaching practices, and propagate their practices amongst their peers, all vis-à-vis their specialty.

Chapter 4: Findings

Framing the Educational Context

“It is very important for you to always remember that it’s a privilege what you’re doing, because you are taking care of somebody’s most valuable possession at the worst time of their lives.”

-Teaching Humanism Award Winner, Pediatrics

The pediatric intensive care unit (PICU) is fairly quiet at 7:30AM. During the middle of summer, the windows in the patient rooms allow the light from the rising sun to creep into the middle of the hospital floor. Save for one nurse at a computer inputting notes into a patient’s chart, there is nobody else in the ICU. The dissonant beeping from over a dozen cardiac monitors in the patient rooms provides the only other sign of life. Every now and then, a phone rings, someone relaying additional orders and tests for one of the patients in the unit. In a matter of minutes though, the PICU awakens. Parents of patients begin to wake up and roam the hospital floor – looking for updates on their sons or daughters or trying to walk off the anxiety, frustration, and sadness that comes with caring for their sick child. The overnight nurses check in on their assigned patients and transfer updates to their colleagues and those transitioning into their morning shifts. All the health care providers on this floor seem to operate with a sense of purpose and urgency. There is no wasted movement and every decision seems calculated and precise. Each, a step towards recovery for the patient, in what may or may not lead back to a life interrupted by sickness and pain.

It is hard to ignore the aura of mortality that pervades the PICU, never mind the entire hospital. Admission into a hospital – for whatever medical reason – surrenders every patient into a sense of vulnerability, whether one wants to acknowledge it or not. For many patients, this is

abnormal. In fact, the time they spend in the hospital and the care they receive may shape how the rest of their life unfolds – from less invasive changes such as more frequent check-ups, lifelong prescriptions, and changes in lifestyle to more life-altering interventions like transplantations or chemotherapy. Each attending physician is responsible for overseeing and guiding the health and wellbeing of their patients. More importantly, each patient is in the hands of their medical care team.

The medical care team that steps out onto the floor that morning is comprised of two medical students, three residents, one fellow, and one attending physician. The two medical students are both in their third year of medical school and are rotating through their pediatrics clerkship. They are somewhere in the middle of their required eight-week rotation. The three residents – one intern, one R2 (2nd year resident), and one R3 (3rd year resident) – look poorly rested. It is clear that two of them had been up for most of the night checking on their patients. All three are carrying large cups of coffee as they congregate for morning rounds. The residents rotate on the mobile clinical workstation – a computer used to update patient charts during rounds. Whoever is not presenting on a patient is typically charting on the workstation or managing the rounding cell phone and everybody's pagers. The fellow and attending, the leaders of this care team, begin their rounds at the corner of the PICU.

As the medical team migrates to each patient's room, the nurse responsible for each patient and the patient's parents joins the care team's rounds. In the PICU, rounding takes place directly outside the patient's room. The R3 begins with overnight updates on the first patient. Halfway through, a pager goes off and the resident assigned to the workstation steps away to place a phone call. Another resident steps in to continue charting. During the assessment and plan for the patient, the attending's cell phone rings and he steps away to talk. It is unclear who

he is speaking with but the conversation is about another patient. The rounds continue without the attending and the fellow fills in for the attending. Soon after, the attending returns to the group and checks in with the patient's parents. The parents ask several questions about symptoms that arose overnight. They sound exhausted. They look overwhelmed.

Surrounded by children with varying levels of prognosis, 'overwhelming' does not begin to describe the atmosphere on the 6th floor ICU. As patients and their families face an unknown future, their only solace seems to be the care they receive from their medical team. For many patients teetering between life and death, morning rounds provide a brief glimpse into a potential path back to normalcy, to health. Positive results from a medical test, a new clinical drug trial, or a hopeful conversation with one of their care providers can – for maybe one day – disrupt the constant grind of tension and fear. It takes some time to come to terms with this – this finite sense of existence. A perpetual tug-of-war between sickness and health, between life and death, between pain and comfort, pervades the entire hospital. Yet, this is where teaching and learning happens.

Teaching and Learning in a Hospital

Teaching and learning in a traditional higher education environment, and even the first two years of medical school, conjure up images of whiteboards and desks in a classroom or lecture hall. With recent technological innovations in higher education, one might also envision a digital projector and clickers in the classroom and laptops for a majority of those students. There is an instructor at the head of the class and likely tens of students paying their full attention to the teacher. The teacher is tasked with a singular responsibility of teaching while the students' only job is to learn. In this physical environment, teaching and learning take place during the day and rarely at night. Textbooks and readers are used as course materials and a structured syllabus is

distributed prior to the start of the course. Learning assessments range from submitted homework assignments and class presentations to quizzes and midterm/final examinations. In large part, teachers are aware of what their course entail and students have a good sense of what they expect to learn. There is an evident sense of discovery and curiosity and nearly every educational institution strives to support that eagerness to learn and succeed. In essence, the traditional higher education environment is structured and well-defined.

Now, consider the medical education environment in a hospital. Clerkship rotations during the third year give medical students their first exposure to patient care - typically done at the bedside, in full view of the patients. Although attending physicians are the official instructors during clerkships, they do not design the 'syllabus' for their trainees. This is provided by the patients. Changes in a patient's health dictate when, how, and most importantly, what will be taught to the trainees. 'Lessons' are taught in dimly lit patient rooms where teaching involves not just the instructor and the student, but the patient's family members and additional care providers and instructors. Discussions revolve around much more than the basic science fundamentals learned during the first two years of medical school. They involve navigating health insurance coverages, juggling primary care and specialist provider schedules and appointments, and setting up hospice or palliative care. Oftentimes, these difficult and sensitive discussions are relegated to the trainees after rounds in a more individualized, almost isolated, environment. However, teaching does not stop once the attending and trainees leave the patient's room. It continues as the rounds circulate up and down the hospital hallways, from the corners of nursing stations to outdoor picnic tables, in the early hours of the day to the wee hours of the night. In a hospital, the parameters for teaching and learning are boundless. It can happen anywhere and at any time.

Perhaps what sets medical education in the hospital apart the most from higher education are the informal and implicit nature of teaching and learning and how the hospital environment shapes the delicate dynamic between instructors, trainees, and most importantly, patients. Though trainees expect to learn how to care and treat a patient while on clerkship rotations, there are no explicit learning outcomes tied to a particular service or specialty. No syllabus, no weekly homework assignments, or dedicated textbook readings. In numerous observations of attending faculty, not one instructor carried a guiding document for their rounds. A large majority of attending physicians simply carried a blank sheet of paper to jot down notes for their own record keeping. Despite this, each observed clinical instructor developed some aspect of nearly every patient update into a teachable moment or exercise. This undefined, amorphous teaching structure was seemingly compensated by an instructor's curricular and pedagogical flexibility and versatility.

Moreover, teachable moments and exercises were rarely declared beforehand and occurred almost spontaneously, regardless of who was present, the time of day, or where the service team was located. As such, errors in medical judgement or missteps in patient care by the trainee left them vulnerable to feedback and critique, not only by the patient but the instructor as well. With the patient's health and wellbeing at stake, trainees were under constant pressure to make accurate decisions at the right time – not only for the patient's sake but their own as well. Strong evaluations from clerkship instructors can lend themselves to letters of support for residency applications. Additionally, instructors consistently straddled the line between providing a high standard of patient care while accommodating each trainee's learning trajectory. It is within this balancing act of teaching and learning in the hospital that clinical instructors and trainees are expected to teach and learn humanistic patient care.

Preface to Research Questions

Through the course of gathering and analyzing the observational and interview data, multiple themes emerged pertaining to the three research questions guiding this study. As these themes are described throughout this chapter, it is important to note the role of place. The context of education, or educating, is strongly influenced by the culture and pace of a hospital. Regardless of specialty, the hospital is a unique setting for teaching and learning to take shape. However, within this place, are people who turn the hospital into a living and breathing personification of their differing values and norms. Surgeons, internists, pediatricians, among many others, contribute to various forces that have molded, and continue to mold, the humanistic orientation and pedagogical style of each of the participants in this study. That being said, the defining element of this culture, of the hospital context, continues to be the people with which these participants interacted with, learned from, practiced with, taught to, or were inspired by. This general theme aligned with the use of social learning theory as the principal framework and positive deviance as the secondary framework for this study.

Guiding Humanism

Throughout the interview portion of data collection, Teaching Humanism Award winners shared details and moments in their career trajectory that have guided their humanistic orientation. Although all acknowledged various dimensions of the Gold Foundation's definition of humanism, the path towards exemplifying and teaching those attributes and qualities revealed three salient themes – 1) role modeling, 2) specialty-specific context, and 3) clinical expertise, confidence, and comfort. Suffice it to say, the humanistic orientations of Teaching Humanism Award winners were complex, multi-factorial, and the result of various sources of inspiration and motivation.

Role Modeling

The THA winners interviewed for this study all alluded to the importance of role models in shaping and guiding their humanistic orientation. During the analysis of the semi-structured interviews, several sub-themes within the realm of role modeling emerged. Namely, who these role models were, how they influenced the humanistic orientations of the study participants, and the temporal nature of role modeling itself. First, several THA winners nodded to role models within their specialty that embodied the traditional sense of role modeling, i.e., from expert to novice. Additionally, a number of THA winners described role models outside of the medical realm, including family and patients. The theme of ‘status-blind’ modeling continues throughout this section. Second, many THA study participants described ‘unrecognized’ techniques and processes that they observed from their role models. In other words, outside the context of required training hours, role models were demonstrating behaviors that THA recipients picked up on, that otherwise would have gone unnoticed. This notion of self-directed improvement, or constantly preparing and doing things for the betterment of the patients and trainees, regardless of attention and recognition, is also carried through this section. And finally, many THA recipients touched on the timing of their interactions with their role models. That is, much of what the study participants took away from their role models were from fairly brief encounters, i.e., no more than a few days in length. Despite this, some of their interactions continue to resonate to this day.

When thinking about role models, one typically envisions people in positions of power, prestige, or status. In the process of this traditional sense of role modeling, transference of knowledge traditionally occurs between someone with a vast array of experiences or wisdom and someone with minimal experience. Within medicine, this typically happens between an attending

physician or senior resident and an intern or medical student. As such, it is not surprising that several THA winners revealed that their most memorable and impactful interactions with their role models - within the domain of humanism - took place while they were interns or medical students.

“I remember Dr. [X] who was our residency program director when I was an intern. One day I was in the emergency room and we had a situation in the emergency room and he happened to be walking by and he walked into the emergency room and he saw the situation. And my attending at the time - the ER attending - was trying to fix the situation and was having a hard time. So Dr. [X] came by, introduced himself. He didn't say he was the program director, he goes, 'I'm [Dr. X], I'm one of the pediatricians' and he took the mom's hand and held her hand and then sat down and sort of, as he was sitting down on the bed, the mom sat down on the bed too, as he was holding his mom's hand.

And suddenly the entire thing was diffused. I mean it was – the tension, everything was gone. And so they just had this nice conversation, back and forth, before they even started talking about the kid who was on the bed. So, it was very nice to see how he sort of understood where that mother was coming from, tried to calm the mother down, tried to understand even more about what her concerns were without even talking about her concerns. That left a significant impression on me.”

-Teaching Humanism Award Winner, Pediatrics

A THA surgeon also shared a similar impactful role model interaction with a senior surgical resident when the surgeon was a medical student. However, what is particularly meaningful about this role modeling experience was the context in which it happened. The surgeon shared that her grandmother had been admitted to the hospital due to her deteriorating health. Coincidentally, the THA surgeon also noted that her grandmother was one of her biggest role models and was the reason why she had pursued medicine to begin with.

“My grandmother - my mom’s mom - was a nurse, and had she been born a generation later, she definitely would have been a doctor. She wanted to be a doctor, and they told her she could either be a doctor or be a mother. She couldn’t be both. And so, she decided that she wanted to be a mother, and so, she went into nursing school. So, she was constantly telling me stories growing up about being a nurse, so she definitely planted the seed for me to become a doctor.”

-Teaching Humanism Award Winner, Surgery

Her grandmother had been admitted one day before her sub-internship rotation had begun. As such, the THA surgeon spent a couple hours with her grandmother before her rounds and then would visit her for several more hours after rounds. These visits took place daily for almost a week and a half. After about a week and a half, during one of her post-rounds visits with her grandmother, she ran into the senior surgical resident.

“She [senior surgical resident] was on call and she was down on the medicine floor, seeing a consult, and she was like, ‘What are you doing here, it’s like 9 o’ clock?’, I was like, ‘Oh, my grandmother is admitted, and she was like, ‘What, why didn’t you tell us?’

And so, I was like ‘Well, I didn’t want to – that doesn’t have anything to do with rotation.’ So, she made her part of rounds, so even though she didn’t have any surgical issues, we rounded on her as part of her day. So, it was amazing, because, my grandmother got to see me with my team and my little white coat and doing what she wanted me to do, and what she wanted to do, for like two weeks or so, so I was really – I mean it was amazing.”

-Teaching Humanism Award Winner, Surgery

Her grandmother passed away one day after the THA surgeon finished her sub-internship. This story was particularly significant because for two weeks of her sub-internship rotation, she was in constant contact with two powerful role models in a specialty and rotation that has traditionally not been known for humanism.

As noted in the earlier story, role models did not solely exist within the instructor-trainee dynamic. In fact, role models were prevalent in various contexts including family and patients. For many, sources of knowledge and inspiration came from anyone who provided something valuable and noteworthy for their patient care and teaching. This seemingly ‘status-blind’ approach to the way THA winners viewed their role models enabled them to regularly self-improve their practice and teaching while strengthening their humanistic orientation. Though family members possessed minimal clinical knowledge to model for THA winners, their role in guiding the humanistic orientations of THA winners emerged via the actual care of patients. For example, many THA winners cited interactions with their family as a motivation to better relate to their patients and in short, strengthen their humanistic orientation.

“I am the mother of twin boys who are almost 14 years old now. I took six months off when they were born and when I came back to work, I was working as a hospitalist, a Peds hospitalist at [hospital] and I remember the first day back, I was rounding on a baby in the hospital who was the same age as my twins. And I walked into the hospital room, the mother had stepped out of the room because the baby was sleeping, the baby was taking a nap. And I walked in there to do an exam and looked at that baby sleeping in the crib and thought if somebody walked into my boy's room at home and woke them up in a nap, I'd kill them. And I walked – I backed out of the room and closed the door.

And this was the first time in my professional life that I had felt that as powerfully. It's not to say that I wasn't sympathetic to parents when they were dealing with their kids not being able to sleep in the hospital because you know I don't think I was – I don't think I ever blew anybody off before or said, you know or whatever, you know, that's not important, even in my mind I think I was respectful and appreciated that. But I didn't feel it at the core of my being in the same way that I did that day.”

-Teaching Humanism Award Winner, Pediatrics

Additionally, THA recipients noted that interactions with their own family members highlighted the role and importance of family in a patient's care. For those THA winners who interacted with family members during rounds, this was particularly meaningful because it helped them better relate to the needs and desires of a patient's family members and how they contributed to the medical decision-making process.

“I think it made me realize how much more important the family was in the whole picture of the patient, you know, being the father and everything that you can just relate better to the daughter who’s concerned, you know the son who’s concerned or the parents that are concerned for the patient.”

-Teaching Humanism Award Winner, Internal Medicine

What has emerged is a shared sentiment that THA winners carry with them a drive to continually improve and better themselves across all contexts, inclusive of humanistic attributes - for the betterment of their patients and trainees.

“I think what’s common about all these physicians, I think, is that they have worked extremely hard, sacrificed a lot to learn so much. I mean, I think it’s like another component of humanism, you know, you work so extremely hard to get to this point, always studying, being as knowledgeable as you can about the most recent information and then, taking the time to think about all that stuff and really listening.”

-Teaching Humanism Award Winner, Internal Medicine

They are open-minded to where and when they receive tools and practices that may help with their ability to take care of their patients. A THA internist highlights this by commenting on the inclusivity of his quest for better, and more relevant, techniques and processes.

“I always try and learn from peers so even if I’m just sitting next to someone and I hear them call a family member and explain something and they might do it a little differently than I would, and I say I like that. I’m going to take that next time I do it, or even just trainees, medical students, residents - they might come up with a good approach or a good fact or I just like the way that they communicated

something that they did their exam or they found something in the text book that you know escaped me over the last 15 years or so, definitely not hesitating to say like 'Oh, that's pretty cool, I'm going to try that too, I'm going to pick up on that and use it.'"

-Teaching Humanism Award Winner, Internal Medicine

Role modeling, however, was not solely a bedside-based occurrence. In fact, several THA winners indicated that their role models demonstrated behaviors outside of the clinical setting. That is, humanistic behaviors and attributes were not picked up at the bedside or during huddles, morning reports, conferences, or team meetings – environments where clinical faculty are clearly and intentionally observable. In short, humanistic behaviors and attributes were observed when seemingly no trainees were ‘supposed’ to be around. These behaviors and attributes would have gone unnoticed but for whatever reason, THA winners were present to observe.

“He [the role model] would go in there, the night before, and see the patients so that you have more time to think about what you are teaching the next day. It's like preparing a lesson plan. I mean if you just show up that day without thinking beforehand you are less, you are a less capable teacher in some ways. So, I got here [UCLA], I started doing that and people were looking at me like I was crazy. 'What are you doing here? We're on call tomorrow. Why are you here tonight?' I was saying 'Well, if I can just try to get some nuggets of information and think about it, I can come more prepared to teach.'"

-Teaching Humanism Award Winner, Internal Medicine

Additionally, it seems as though unrecognized, unnoticed humanistic behaviors amongst trainees were also valued by the THA winners. In other words, hearing about humanistic care from their trainees in contexts that did not necessarily involve instructor oversight were sources of motivation and reinforcement for the humanistic orientations of THA winners. This is highlighted by an anecdote shared by a THA internist.

“I’m always really inspired when the trainees will sort of do that spontaneously and sort of, go above and beyond and you know, not complain and call family back from home at 9 o’clock at night and you don’t find out about it until the family member tells you a couple days later. ‘It was nice when Dr. Smith called me at 10 PM because I was really distraught’ and they didn’t tell you about it. They weren’t trying to get credit or get a good evaluation as a medical student. They just took that as their professional duty and went one step beyond. So, on a day to day basis, I always find that inspiring.”

-Teaching Humanism Award Winner, Internal Medicine

Though it is clear that role models made an impact on the humanistic orientations of all THA winners, their stories underline the temporal nature of the role modeling they experienced. For many, the most impactful role modeling interactions occurred over the course of a few days, at most. In the earlier story shared by the THA surgeon, the senior surgical resident shared about a week on the wards with the surgeon. However, after the THA surgeon shared her story about her grandmother, she indicated that her experience with the senior surgical resident still resonates with her today. The conversations and teaching processes described previously may not have lasted more than ten minutes, but when asked over a decade after experiencing them, THA recipients immediately shared powerful stories of how their humanistic orientations were molded

into what they are today. The resonance of these interactions with role models continues to reverberate for THA winners, even as much as twenty years after its original occurrence.

“He [the role model] was this incredible model of humanism because he got their level of suffering in a way that was tremendously influential to me at that moment. You could probably tell from me telling the story that, you know, this is – I don't know 20 years ago maybe. I've not forgotten that story. He was a huge influence to me.”

-Teaching Humanism Award Winner, Pediatrics

Specialty-specific Culture

In addition to role modeling, THA recipients also shared how the way their specialties operated and what attracted them to their specialties guided their humanistic orientations. Initially, the pace and mechanism of practice within each specialty attracted the THA recipients to pursue a career in their respective fields. These parameters for practice facilitated how their time was allocated and valued, particularly in surgery. Ultimately, specialty pace and mechanism as a function of time shaped the context in which humanism was molded and developed. Subsequently, this created a framework within their specialties that led to differing cultures and climates for emotional expression. This led to the humanistic orientations of surgeons being communicated and interpreted differently from those of internists and pediatricians. As a result, these three factors – pace of practice, mechanism of practice, and acceptance and prevalence of emotions – not only set the foundation for the humanistic orientations of THA winners but also mildly reinforce how they humanistically operate to this day.

According to THA surgeons, the strongest appeal of surgery was being able to see immediate results. This pace of practice was echoed by all surgeons at some point during their

interview. This notion of instant gratification and addressing a patient's medical issue was universally cited as the main selling point of surgery.

"It's an instant gratification specialty, surgery. Broken bone? Put a plate on it, put a rod in it. You know it's going to heal and they are out of the hospital and walking inside of a week."

-Teaching Humanism Award Winner, Surgery

Some indicated that this desire was a result of being impatient and not being able to wait to resolve a patient's sickness or illness. Depending on the type of surgical service, the pace of identifying a medical issue, selecting a way to address the issue, and then actually entering the OR and fixing the medical issue could happen in the course of hours, if not minutes.

"I'm impatient. I want to see immediate results of something. So, that actually works well with surgery."

-Teaching Humanism Award Winner, Surgery

Regardless of surgical service though, whether it was trauma, vascular, or orthopedics, all THA surgeons enjoyed being able to quickly respond to a patient's concerns and 'fixing' them as soon as possible. This process provided immediate feedback as well. In other words, though surgery provides a medium to immediately solve a given medical problem, it also gives surgeons immediate feedback on what did not work. This is highlighted by the following quote from a THA surgeon describing the desire for clinical excellence and being comfortable with the potentially good and bad outcomes of surgical practice.

"Honestly, you are actually doing something with your own body, with your own hands to make somebody better and you can see the outcome right away or you can see your failure right away. Surgeons are very much - we want to know what

we know, know it well, make a decision quickly, and then go to the OR and fix somebody.”

-Teaching Humanism Award Winner, Surgery

Following this thread of clinical excellence and immediate results, a number of surgeons commented that being an expert in their field of practice afforded them a sense of control. This control not only gave them confidence but it also ensured that when they did go into an OR and fix somebody, they were doing what was best, clinically speaking, for their patients.

“I find that I’m a person who likes to be in control and I think I didn’t want to guess a lot. I think with surgery, it really fulfills that part of your satisfaction, because if there’s an ailment, you’re going to actually open it up to see what the problem is.”

-Teaching Humanism Award Winner, Surgery

This idea of ‘fixing’ somebody and opening them up, or as one THA surgeon put it, ‘committing a direct, invasive assault’ on someone’s body, required a focus on dexterity and the use of hands. This mechanism of practice was another strong selling point for surgeons. In fact, even though one surgeon had never thought about surgery prior to medical school, the THA recipient gravitated back to surgery after rotating through clerkships because the work involved so much dexterity. Oddly enough, one THA surgeon went as far as to categorize surgeons in the same blue-collar fields as miners and mechanics.

“A surgeon is a working person. I always tell people that we are like miners. We go into the mine early in the morning and we work our butts off and we come out at night tired and dirty, and that’s what we do. We work with our hands. We are

like car mechanics, miners, any of these things really fits our specialty's description pretty well."

-Teaching Humanism Award Winner, Surgery

Though this comparison may discount the education and training necessary to operate at such a high level, it provides a stark comparison to internal medicine and pediatrics. In these 'higher' humanistic specialties, there exists an almost cerebral, yet intimate, nature to the pace and mechanism of clinical practice. For one, treatment in both internal medicine and pediatrics is far from immediate, especially in the hospital. During observations of internists and pediatricians, some patients were in the middle of multi-week stays in the hospital and treatment plans shifted as numbers and tests changed. Significant results would probably not be seen for weeks, if not months. This sentiment was shared by a THA surgeon, though generalized and a bit condescending, when describing why surgery was a better fit for their skillset and personality.

"When I did my pediatrics rotation I felt like these people are very good listeners, but they don't really do anything. I mean they listen to this mother with the sick child for an hour. 'Yes, I understand what you're saying, yes I'm sorry this is happening to you', but at the end of the visit nothing gets done really of substance.

-Teaching Humanism Award Winner, Surgery

The mechanism of practice, however, focused more on diagnosing as well as connecting with the patient. These two processes not only emphasized the cerebral nature of internal medicine and pediatrics but also the emotional connectivity between patients and practitioners. Differential diagnosing and formulating treatment plans were likened to 'puzzle pieces' and many THA winners in internal medicine and pediatrics noted that this was a challenging yet

rewarding aspect of their specialties. It is important to note, however, that there was also a similar drive for clinical excellence but it was operationalized not through ‘opening up’ a patient, but communicating, explaining, and answering questions from the patients.

“In general, I think, you know, because it’s a specialty where we don’t necessarily do procedures, and that’s not to say the procedural specialties aren’t humanistic, but the majority of our time is spent talking and communicating with the patients. I think we all value that, counseling a patient, sitting down with them, trying to explain things, asking if they have any questions, those are all parts of what we do.”

-Teaching Humanism Award Winner, Internal Medicine

“Medicine is very cerebral, and you spend time with patients. You figure things out with them. You design plans that are tailored to each patient and you have a conversation. So, just to bond with patients that you have as well as the ability to really think and provide things, and to think and provide things to your patients that you may not otherwise be able to do if you were in another specialty.”

-Teaching Humanism Award Winner, Internal Medicine

Interestingly enough, another THA surgeon, after completing their clerkship rotations, commented on the mechanism and pace of practice in internal medicine and pediatrics.

“I just got very frustrated with not doing something and just thinking about things all day long.”

-Teaching Humanism Award Winner, Surgery

Though also generalized and a bit condescending, it provides some insight into the level and amount of analysis that goes into, not only diagnosing and treating, but also communicating and counseling patients.

Despite, or perhaps because of, these two cultural elements – pace and mechanism, surgeons and internists/pediatricians view emotional expression of humanism differently. As the literature has shown, internal medicine and pediatrics tend to be on the ‘higher’ end of the humanism spectrum; thus, humanism is widely accepted and seemingly expected of all their practitioners. On the ‘lower’ end though, surgery seems to propagate a climate of non-emotion – the near antithesis of being humanistic. For the most part, this seems to be the modus operandi of most leaders in the surgical field.

“I remember thinking, ‘Oh wow, this [being selected as a Teaching Humanism Award winner] is so cool, I really want to be a part of this’, but also thinking, ‘Wow, how can I even tell any of my bosses in surgery that I want to be a part of this, because they are going to think that this is so stupid?’”

-Teaching Humanism Award Winner, Surgery

That is not to say that emotional expression, or the capacity to, does not exist amongst surgeons, it simply is not fully operationalized or accepted in the clinical or teaching setting. This is best demonstrated during a story shared by a THA surgeon. The THA surgeon had experienced the first death on their rotation and after treating the recently passed patient for some time, it had hit home. In an effort to not cry in front of the patient’s family, the THA surgeon went to an isolated area of the hospital and ‘totally bawled.’ Yet, as the THA surgeon grieved, this quote from their story stood out –

“[THA surgeon’s name], you can’t – you got to buck up. You’re a surgeon, you can’t get all emotional.”

And what resonated from this story was that this occurred multiple times as the THA surgeon responded to the first few deaths in their career. The culture and expectations of surgery and surgeons were quelling the THA surgeon’s natural attempts to emote, to grieve, to share in the patient’s pain – to empathize. That being said, though this climate had guided the humanistic orientation of surgeons to a certain point, upon reaching a certain level of clinical expertise and comfort, THA surgeons shucked the norms and expectations of surgery and operated at their own level of comfort, or humanistic expression.

“I had this thought that, you know what, I actually never want to stop getting emotional when somebody dies, like, that to me, in that moment meant that I would lose my caring, lose my humanity if I stopped crying when somebody dies. So, I sort of decided then and there that I certainly couldn’t decompensate in front of the family and not be able to do my job, but that it was perfectly okay to go by myself and cry about it.”

-Teaching Humanism Award Winner, Surgery

This turning point seemed to occur at a time when clinical expertise, confidence, and comfort had risen to a level where surgeons did not care what others thought of them. In fact, this transitions seemed to occur for all the THA winners.

Clinical Expertise, Confidence, and Comfort

Reaching a level of clinical expertise and being confident and comfortable in this space, regardless of specialty, provided THA winners with the space and freedom to be humanistic. In other words, what also guided the humanistic orientations of these physicians was knowing

enough, clinically speaking, to treat their patients, being confident in their knowledge to care for their patients, and being comfortable in their patient encounters to branch out beyond clinical diagnoses and treatment plans. According to all the THA recipients, this phase of their humanistic orientation required possessing ‘the whole package’ – a mastery of the science and human elements of medicine. On one end, the scientific element included being an excellent clinician with experience and knowledge. On the other end, the human element required a sense of emotional intelligence that allowed for strong patient rapport.

“You need to be intelligent and thorough and clinically well-trained. But you also need to be sensitive and compassionate and exhibit kindness and understanding and patience. So, I think it’s sort of the whole package. You’re not going to be that powerful physician if you don’t know any medicine but you’re just a wonderful human being.”

-Teaching Humanism Award Winner, Pediatrics

Therefore, as THA winners moved through their career, their humanistic orientations were better expressed, or even revealed, as they hit this critical time point in their practice. However, it is important to note that this was not described as a cause and effect relationship. Simply entering a space of expertise, confidence, and comfort did not lead to a stronger humanistic orientation. In fact, one THA winner stated that some physicians simply stay in this space and if anything, drill deeper into the scientific element of their care.

Based on pre-interview questionnaires and demographic analysis of training milestones, the THA study participants received their award, on average, a little over ten years after completing their residencies. This timeframe increased to a little over 16 years if one were to measure from the reception of their medical degree. This analysis did not account for fellowships

or additional degrees pursued by any of the internists, pediatricians, or surgeons. Moreover, this timeline was also consistent with the general THA winner population, i.e., those who were not recruited for this study. However, it seems as though, upon receiving a medical degree, the focus of training is on mental checklists and making sure no wrong is committed. It is a cautious and safe approach to patient care and this apprehension hinders emotional connectivity with the patients because the capacity to focus on building patient rapport simply is not there. As a result, trainees do not allocate enough time for this.

“You can see it on the trainees and I don’t know if you observe younger trainees or students that interview patients, how robotic they are when they talk to the patients and how – they have a set of answers and a set of behaviors. And they are trying to preserve themselves as well. And they are trying to reassure the patient that they understand they know what they are doing to kind of to hold their authority position.

And you can see that it’s not a genuine interaction, but you would really have to see it to understand what I’m talking about so they would frequently go and tell the patient Mrs. Jones I’m so and so, nice to meet you. Uh-huh, okay so we are going to do this procedure you understand? okay so like they are asking questions they answer themselves and they don’t really want the patient to have any objections I think.

It’s a very – they just do the mechanics of interaction, but I don’t think they really genuinely engage with a patient in a conversation. I think that comes with age

and if you go see older patient, older surgeons, older physicians you can see that their interactions and dialogues are much more genuine.”

-Teaching Humanism Award Winner, Surgery

For THA recipients though, after approximately ten years, their reputation as clinicians, in the technical sense, had been cemented. They felt confident in their clinical abilities and skills and they now felt the freedom to expand and express their humanistic orientations, even in the most difficult situations.

“I mean I think that this sort of idea of being able to both at the same time incorporate the patients’ goals as well as help them by my clinical knowledge is based on the confidence that I have in my clinical abilities. And I think that until you sort of gained confidence, it’s also very difficult to work with challenging patients to practice your humanism with them. If you don’t have confidence in your clinical abilities, that can be challenging in those situations.”

-Teaching Humanism Award Winner, Internal Medicine

Clinical confidence and comfort and its relationship with expressing humanism was more apparent for surgeons because they could now operate out in the open. They no longer felt self-conscious about demonstrating their humanistic traits.

“I had worked so hard to be a good resident that people respected me as a good resident, so I felt like by the time I was like a fourth year, I was on pretty solid ground, in terms of reputation, so I was – I felt like I had some wiggle room in order to be like, oh she is getting into this touchy feely stuff, but that’s okay, she is a really good resident, she is a really good surgeon.

So, I was willing to let that, my reputation potentially be associated with these touchy, feely things that surgeons aren't supposed to care about.

But, I've sort of accepted it, I don't care, people want to say that's touchy feely stuff, fine, that's who I am, that's who I wanted to be, that was the person I wanted to be when I was a third year medical student, and I'm lucky enough that I can be that person now, and if people want to say that, it makes me bad surgeon than talk to my patients about it, I don't care, talk to my residents about it."

-Teaching Humanism Award Winner, Surgery

The significance of establishing a technically sound 'reputation' was more apparent in surgery than internal medicine or pediatrics. Without this reputation to build off of, expressing humanism, or the 'touchy feely stuff', was not an option. In fact, one THA surgeon noted that clinical expertise was arguably the most important facet of a surgeon's reputation.

"Especially in surgery, the number one thing, your reputation is staked on is whether you are a good surgeon and that's still the same. You are not going to be considered overall a great surgeon if you don't have the technical skills and the medical knowledge."

-Teaching Humanism Award Winner, Surgery

For internists and pediatricians though, reaching a level of clinical expertise, confidence, and comfort allowed them to focus more of their time on connecting with the patient and realizing that scientific element of medicine was not the end-all, be-all of patient care.

"I used to think more about the technical details but then really in medicine the little things don't always matter as much as you think they do. I mean, even the

best treatment in the world [...] maybe help one in a thousand, two in a thousand people, so it's not like you are dramatically curing everybody who comes in with something. It's easy to do often in medicine; unfortunately, we end up just saying we can't do much for you.

There is that old Chris Rock joke where he says “the blind man goes to the doctor and the doctor is useless, he is like well here is a dog and a stick” which there is something to that. I mean, hopefully we can do more than that, but a lot of it is, I've realized, is at least showing you care about the patient, taking the time to explain things. I guess now I try to spend more of my time connecting with the patient, explaining things, trying to understand their perspective and a little bit less of just strictly giving numbers and these things without really getting feedback from the patient.”

-Teaching Humanism Award Winner, Internal Medicine

Regardless of specialty, the interview data indicates that reaching a level of clinical expertise, confidence, and comfort frees up time, energy, and focus to shape and guide the humanistic orientations of THA winners. This newfound time, energy, and focus provides THA winners with an opportunity to bring humanism to the forefront. The technical, or clinical, piece of the patient encounter becomes effortless and as a result, THA winners begin emphasizing practices and techniques that personify humanism. This not only benefits the physician-patient and physician-trainee relationships but may also strengthen wellbeing and help minimize burnout and stress (Dunn, Iglewicz, & Moutier, 2008). One of the THA winners summarized it best by describing this shift in focus as ‘finding purpose.’

“I think what happens is that you get more and more clinically trained, the clinical side of medicine becomes easier because you pick out things [...] and you actually start to now bond with patients. And because you can figure out a lot of things quickly and then you start sensing purpose. Your patients, you start now seeing them long-term, or you find out ‘Hey, you know, how was your son’s wedding?’ You know, you kind of bond with that and it gives you purpose too. So, I think after you become good at clinical medicine, then you have time to find purpose.”

-Teaching Humanism Award Winner, Surgery

Teaching Humanism

The second research question was primarily guided by observational fieldwork that focused on how THA winners imparted their humanism to medical students and residents. Follow-up on imparted humanistic practices was conducted during interviews. During these observations and interviews, discussions with THA faculty touched on their use of implicit and explicit teaching. Many THA recipients acknowledged that explicit pedagogy including reflections and feedback was a better, more effective way of teaching humanism. Oddly enough, only one THA winner – in surgery no less - who participated in this study indicated that they solely relied on explicit teaching throughout their service. Although no observational fieldwork was conducted for this particular participant, the THA surgeon revealed that the rationale for explicit teaching was due to the time constraints and pressures of training.

“If someone has to kind of figure it out, then it takes too long. For example, I don’t need to always ask a resident a question, when my goal is to make sure they know the answer. I don’t need to keep trying to test their knowledge by pimping

them if you will. I just tell them what I need them to know because I feel that residency trainings are already limited, they're already nervous, they're already under the gun, and so if they can at least capture why I'm explicit about every step that I do for what I do, I think it's more effective."

-Teaching Humanism Award Winner, Surgery

That being said, interview data as well as observational fieldwork for all other THA faculty pointed to a strong reliance on implicit teaching - namely role modeling. As a result, this section will nod to some of the explicit pedagogical techniques used by some of the participants but primarily focus on the humanistic practices that were role modeled by nearly all the THA winners.

Prior to the start of rounds, several THA faculty oriented the trainees on their expectations and goals for that particular week of service. In addition to laying out particular preferences for how patient updates were relayed, THA surgeons, pediatricians, and internists explicitly included their rationale for bedside teaching, the importance of humanistic patient care, and how they expected the trainees to communicate and interact with the patients. One THA internist in particular made it very clear that humanism will be a critical component of trainee evaluations.

"When I start wards, I always tell people that these are my expectations and I built – the humanistic piece as part of those expectations. So, one of the things that I'm going to evaluate you on is your humanism and I emphasized to them that it's one of the most important parts of being a physician, and a physician that's respected and well liked and build rapport with the patients. So, that messaging goes to both the residents and the students, and I take it to heart and whenever I

do an evaluation, I make a point of commenting on their humanism, that they went above and beyond for their patients or that they, you know, the rapport that they build with their patients and their families, I think it's a very important piece."

-Teaching Humanism Award Winner, Internal Medicine

After a specific patient encounter or at the conclusion of rounds, several THA faculty utilized specific feedback tools and reflection techniques with their trainees. For example, one THA internist picked up on particular humanistic behaviors amongst the trainees and recognized them after patient encounters or at the conclusion of rounds. Sometimes, these occurred in private, i.e., between the physician and the trainee, and at other times, it was publicly commented on as the team walked from patient to patient. This was followed up in the subsequent interview with the THA internist.

"And so, and that was something I recognized and I would say thank you for because – so those are the, like, acknowledging when people are doing things that are, I think are humanistic, or if a physician – sorry for a resident or a student, you know, leads a discussion with the family I always give them feedback right away, that was excellent. I loved how you talked to them about this. You're very patient, kind with this. Good job with this and thanks for advocating for your patient. You know, just the recognition I think is so incredibly important, because it's kind of like positive reinforcement to get praise from your attending hopefully mean something to them."

-Teaching Humanism Award Winner, Internal Medicine

Additionally, as a form of reflective technique, another THA internist debriefed with trainees about the 'big picture' when the discussion surrounding the patient became too nitty-gritty. As a

result, this reflection forced trainees to then circle back and re-evaluate the diagnoses or treatment plan. In the interview with this internist, this was brought up again as one of their explicit techniques for teaching humanistic patient care.

“I definitely push students and residents to really make sure that they are understanding the big picture, they tend to be very detail-oriented and they sometimes miss the big picture and I think that if you were to practice humanistic medicine it’s really about taking care of the whole person and understanding the big picture. So, that I very consciously try to teach them.”

-Teaching Humanism Award Winner, Internal Medicine

It is important to note, however, that these explicit techniques were used by a minority of THA faculty and were not universally observed or discussed in interviews.

Five Typologies of THA Faculty

As noted above, the humanistic practices of THA winners were primarily imparted via role modeling. Though implicit, it embodies the ongoing teaching and learning paradigm in medicine of see one, do one, teach one. However, what emerged from the observations of role modeling and the follow-up questioning during the interviews were the prevalence of certain humanistic practices that were repeatedly modeled across all three specialties. Based on these practices, five typologies were created to personify the various humanistic practices that were modeled on a consistent basis over the course of the observational fieldwork. Some THA winners concentrated on 2-3 of these practices during their teaching services while others touched on all five. These five typologies are: The Storytellers, The Active Listeners, The Sensors, The Communicators, and The Guardians.

The Storytellers

“Yeah, I want people to be comfortable when we’re making rounds.”

-Teaching Humanism Award Winner, Pediatrics

Storytelling has long been used as an effective method of teaching. Scholars have cited the use of oral narratives as a way to promote memory and enhance learning based on its emphasis on sequencing and an appeal to affect (Charon, 2001; Hensel & Rasco, 1992). Particularly in medicine, with stories about challenging patients, differential diagnoses, and inspirational physicians abound, storytelling can be a powerful, yet relatable way of delivering information. That being said, during observations, a number of THA faculty utilized stories during their teaching. Given the time constraints of surgical rounds, storytelling was more often used in internal medicine and pediatrics. One prime example of this came during observational fieldwork with a THA pediatrician.

Over the course of a week, observations with said pediatrician took place on three separate days. On average, during each day of service, approximately 10-12 patients were seen by the rounding team. The team included the THA faculty member, one fellow, one nurse practitioner, three residents, and two medical students. As the team moved from one patient room to the next, the nurse responsible for said patient joined the team. Additionally, since these rounds were in pediatrics, the family of the patient – oftentimes the mother or father – also participated. The time spent on each patient during these pediatric rounds hovered around 8-15 minutes. This provided flexibility for the THA faculty to pursue medical questioning with the trainees, possible treatment options with the fellow and nurse practitioner, and background and context with the patient and family. It was during these conversations that the THA faculty member seamlessly integrated anecdotes from their training, past patient experiences, and childhood – all with a particular teaching point relevant to the issue being discussed. These short

stories ranged from quick 30-second flashbacks of a learning moment from their residency training to a nearly 3 minute narrative about their tonsillectomy from their younger days.

In isolation, these stories were enjoyable to listen to but in this context, they served two purposes: 1) the stories provided trainees, colleagues, patients, and families with a teaching point - a rationale for a treatment plan, the effectiveness of a particular procedure over another, or a communication technique that worked well for patient rapport, and 2) the stories put the trainees, colleagues, patients, and families at ease. Within the context of this research question, the latter seems most relevant. Stories can humanize the patient, their family members, the trainees, colleagues, and the attending physician. What the THA pediatrician did rather well was initiate a conversation with a team member, inquire about a particular topic, and share a piece of their experience with them. The stories did not come off preachy or boastful but instead, captivating, engaging, at times humorous, and most importantly, approachable.

With the use of stories, the THA faculty member found a way to connect with each team member. As a result, the trainees looked visibly less stressed and more comfortable in their patient updates. It seemed as though these connections had created a safe, supportive learning environment for the trainees and thus, a welcoming, supportive atmosphere for the patients.

The Active Listeners

“Again, listen, listen, listen. It’s like real estate, what is it? Location, location, location? In humanism, it’s listen, listen, listen.”

-Teaching Humanism Award Winner, Surgery

According to the medical education literature, the average time till interruption by doctors when speaking with patients is 18 seconds (H. Beckman & Frankel, 1984). In a fast paced hospital environment where everybody is trying to relay massive amounts of critical

information, it is not surprising that practitioners attempt to share what they know to whoever they can as soon as possible. At the start of observational fieldwork and knowing this element of interpersonal communication, it was refreshing to see that nearly all THA winners utilized active listening during their teaching rounds. Active listening is based on complete attention to what a person is saying, listening carefully while showing interest, and not interrupting. Being a good active listener requires different skills including, but not limited to, appropriate body movement and posture, facial expressions, eye contact, showing interest in the speaker's words, minimum verbal encouragement, attentive silence, and reflecting back feelings and content.

Throughout the course of observations, active listening was the most recognized, regularly used humanistic practice imparted by THA faculty. For surgeons, internists, and pediatricians alike, active listening was observed with both patients and trainees. For example, during teaching rounds with one THA internist, each medical student or resident was responsible for presenting on each of the patients. After presenting, the team would enter the patient room and the THA internist would step back and let the presenting trainee take the lead. More often than not, the discussion would require the participation of the attending physician – either for follow up inquiries by the patient or to step in and provide additional support for the trainee. Throughout every patient encounter, the THA internist was focused on the patient and nodding their head. What was most striking though was the eye contact. Whenever the patient spoke or a trainee spoke with the patient, the THA internist was engaged and attentive, and their eye contact never wavered. Additionally, the THA internist also made sure to level with the patient by either squatting or pulling up a chair next to the patient. This was mentioned during the follow-up interview and the faculty member confirmed the pivotal role of eye contact, and more importantly, active listening.

“And so I always, you know, my eye contact is always 100, is always very important with the patients because you have to – they feel like you're listening to them. And one thing that I always do and it wasn't – it was – it's so natural for me, I did not realize I was doing it until someone pointed it out to me, but I always squat and so that I'm below the eye level of the patient, and I'm not above staring at them from, you know, they're lying in the bed and I'm here staring.”

-Teaching Humanism Award Winner, Internal Medicine

Active listening also carried over to trainee teaching. In a separate observation of an internist's teaching service, the week's service covered 11 patients. Again, trainees were responsible for presenting on these patients. During these updates, the trainee shared with the team what happened overnight including latest vital signs, inputs and outputs, assessment and plan, and other pertinent information. On average, rather than the 18 seconds noted in the literature, this THA internist remained silent for nearly 2-3 minutes before contributing to the discussion. Despite not saying a word, the internist was focused on the trainee and nodding their head. Very rarely did the internist interrupt sooner than the average 2-3 minutes and if so, it was because the trainee had committed an egregious error. Oftentimes, the presentation would conclude at the two minute mark so a space for questioning would open up. Although these are two examples, active listening like this occurred on a regular basis across all specialties observed.

Due to the prevalence of this humanistic practice, this topic was followed up on during interviews in an effort to explore the rationale for active listening and its relationship with humanism. What emerged from the interview data was the role that active listening can play in not only finding out more about the patient but allowing trainees to learn more effectively.

“I think in general one principle that I sort of try to impress upon people is that most of us talk too much. When you go in the room there is a saying in palliative care, “don’t just do something, sit there.” You just sort of sit there and say, “How are things going,” and make sure that you’re just listening to what the family and the patient has to say.”

-Teaching Humanism Award Winner, Internal Medicine

“I remember that my favorite clinicians were the ones who had an open mind and kind of let you carry forward your plan because then you can see what happens and you’re really learning from that situation and seeing what happens. So, when I sit back there and listen, it’s essentially to see if the plan is a reasonable plan.

I just remember like some of the attendings that I did not prefer were the ones who were like we’re going to do this, we’re going to do that, and you’re like what am I here for, you know.”

-Teaching Humanism Award Winner, Internal Medicine

In other words, listening and not interrupting was beneficial in two separate contexts: patient care and teaching trainees. First, in patient care, active listening opened a line of communication with the patient and allowed the practitioner to explore avenues that may not have been available beforehand. Second, in teaching, not interrupting trainees provided them with an opportunity to carry out their own line of thinking while not being forced to follow a prescribed plan. Given its value in translating across these two different contexts, it is not surprising that it is one of the more utilized humanistic practices by THA faculty.

The Sensors

“I tend to put my arm around patients. I think that’s a big point, people like human contact.”

-Teaching Humanism Award Winner, Surgery

The space around a patient’s bed is often taken up by medical equipment monitoring the health of the patient. In a typical patient room, an elevated tray table is on one side of the bed, a hanger holding fluids is on another, along with heart and respiratory monitors. Without moving any of these items, accessibility to the patient’s body during teaching rounds can be limited. This is important because physical touch and proximity to the patient during these interactions is beneficial for both the patient and the physician. For the physician, physical touch during examinations provides information on the presence or absence of physical sign as well as the patient’s comfort and emotional state. More importantly, for the patient, physical touch and proximity to the patient allows for reading of facial expressions, interpreting the fingertip pressure of physical exams, and responding to said gentleness or aggressiveness to inform how they might proceed with the encounter. In essence, touch and proximity to the patient can be interpreted as the physical manifestation of humanism.

Throughout the observational fieldwork, many THA recipients incorporated physical touch in their teaching at the bedside and utilized the space in and around the patient in a way that engendered warmth and compassion. Examples of this occurred in all three specialties observed over the course of this study. In surgery, one THA surgeon was always positioned at the side of the bed closest to the upper torso of the patient. Oftentimes, this THA surgeon would move the elevated tray table or fluid hanger to make room to get closer to the patient. Once positioned, the patient interaction began and almost unconsciously, their hand would either fall on the patient’s arm or hand. Sometimes, depending on where on the body the patient was

recovering, the THA surgeon would place their hand on the patient's leg or foot. Additionally, all THA surgeons mentioned that they incorporate physical touch in the OR as well. Prior to the patient going under, THA surgeons indicated that they held the hand of the patient until they were unconscious. This was done because they thought that this provided a 'sense of warmth and comfort' to the patient at a time of uncertainty and fear.

In internal medicine, one THA internist squatted down to the eye level of the patient and held the patient's hand throughout the duration of their conversation. In pediatrics, because the family was heavily involved in rounds, one THA pediatrician began conversing with a patient's mother to address her anxiety and concern. Throughout this conversation, the pediatrician, at multiple time points, put their hand on the mother's arm and back, specifically during moments of the discussion that required a certain 'softness'.

"I think touching is important. I told you earlier I'm a touchy-feely person. But not everybody likes to be touched, not every parent likes to be touched. So, you have to understand where you are, who you are, who you're talking to, whether you can touch them or you can't touch them."

-Teaching Humanism Award Winner, Pediatrics

These instances were not few and far between. In fact, this was the norm for observations of THA winners. The use of physical touch was done so seamlessly and unconsciously, if one did not look for it, it would have easily gone unnoticed. In essence, the THA faculty that employed physical touch and proximity sensed the surroundings of the patient and capitalized on what was available around them to create a more intimate care experience for the patient.

The Communicators

"There is no start and end time, because my patients never die alone."

-Teaching Humanism Award Winner, Pediatrics

Over the course of a week of teaching service observations, one theme that emerged from the THA faculty was the importance of being present and engaged with their patients. This primarily included creating and maintaining an open line of communication with them and being in constant contact with their patients directly or being updated on the status of their health. Based on observations and interview data, this line of communication was established for two reasons. One, it assured the patients that there was an attending physician available and ready to support in case any questions or emergencies arose. Two, it modeled to the trainees that being a physician was not a 9:00AM to 5:00PM job and that a higher level of commitment and sacrifice was necessary to ensure that the patient was receiving the best care possible, at all times during service. Providing this constant, reassuring presence was echoed by numerous faculty as they described yet another humanistic practice that they modeled to their trainees.

“I always make sure that everybody understands that being a physician is not hanging your stethoscope around your neck coming to work at 8 o’clock and going home at 4 o’clock in the afternoon, having the weekends and holidays off [...] there have been days that I’ve been at the hospital for two days. I haven’t gone home, because how do you leave that family alone when their child is dying?”

-Teaching Humanism Award Winner, Pediatrics

“If your patient is not doing well at 7:00, you’re there until they’re doing okay, or they’re stabilized or you’ve done an appropriate handoff or whatever the case may be, but you can’t just leave. I mean, I can’t tell you the number of times that you cancel plans because you just can’t go to things.”

-Teaching Humanism Award Winner, Internal Medicine

Opening this line of communication took shape in various forms throughout observations and were acts that seemingly went above and beyond the call of duty. For instance, one THA internist regularly handed out their business card with multiple forms of contact information. Along with the business cards, this internist also informed their patients that they were on service for the week and their sole responsibility for that given week was the present patient.

“For me, when I’m on service and people hear me say this, my patients are my number one thing right now. Not my administrative work, not this, not that, not my social life, but my patients. And so, that’s how I feel and I vocalize that quite a bit.”

-Teaching Humanism Award Winner, Internal Medicine

“Little things that can kind of lighten up the mood for a little bit, giving out my phone number. It’s actually not uncommon for me to kind of give out my number and trying to model that behavior where you’re trying and making yourself accessible to the patient as much as possible.”

-Teaching Humanism Award Winner, Internal Medicine

Interview data also revealed that these ‘little things’ also included re-visiting the very same patients from morning bedside rounds to spend more time with them. Increasing face time with the patient and making oneself available to the patient and their families simply demonstrated the level of investment each THA faculty was making into the patient.

This line of communication provided a bridge between the physician and the patient and role modeled to the trainees the importance of staying in touch with the patients and never leaving them ‘alone’. As mentioned earlier, a hospital stay can be intimidating, full of anxiety

and fear, and relatively scary. Undoubtedly, questions arise at all hours of the day with answers that may or may not change the trajectory of a patient's health. That being said, having an open and accessible line of communication with the attending physician on service for the week can provide patients and their families with peace of mind and comfort. Ultimately, this only serves to reinforce to the trainees the physician's role of healer and caretaker and how the capacity for humanism is contingent on physical and mindful presence.

The Guardians

"I mean it's hard in the hospital. It's a very unrespectful place. Not disrespectful, but just unrespectful."

-Teaching Humanism Award Winner, Surgery

The pace of the hospital moves very quickly. There are always more patients to see, more tests to run, and an endless array of tasks and phone calls that need to be done on any given day. There is simply not enough time to do everything thoroughly and with the attention that it deserves. As quoted above, the hospital is an 'unrespectful' place simply because people get carried away and things fall through the cracks. Small things that may not seem like a big deal can make a difference to the patient as well as the trainees. In essence, those in this typology focused on humanizing the patient, protecting the sanctity of the patient and their care, and being an advocate for the patient. A prime example of this occurred during bedside observations of a THA surgeon. Almost like clockwork, before the patient interaction began, the surgeon always made sure the door to the patient room was closed or the curtain around the patient was wrapped around the bed. At the same time, the surgeon would ask the patient if the lighting in the room was okay and if any accommodations could be made to the quality of their stay.

In addition to protecting the privacy of the patient, many THA faculty also maintained a sense of respect for the patient's body. One THA internist shared an anecdote involving a role model and a lesson that still resonates today about humanizing the patient and their body.

"I remember we were going through our physical diagnosis rounds and we were talking to this patient that had an interesting heart murmur. We were talking about what this heart murmur could be and we all took turns to listen to this patient's heart. So, we go and we listen to the heart but when it was her [the role model] turn, she sat down on the bed, she introduced herself, she went through all the motions of kind of asking the patient if it's okay to listen. She made it a little bit more of an elaborate deal but really addressing the patient as a person when all the med students kind of put the stethoscope on the patient's chest without even really thinking about it. So, that made an impression on me, that we really should be treating patients like people because they are people."

-Teaching Humanism Award Winner, Internal Medicine

The essence of this anecdote was prevalent across all observations of THA faculty. Whenever physical exams began, THA faculty, regardless of specialty, asked for permission to touch their patient's body. In internal medicine and pediatrics, it typically involved listening with a stethoscope or pressing into different areas of the patient's abdomen or back. In surgery, this involved opening up surgical wounds and checking on recovery.

Another humanistic practice involved the introduction of the teaching team to the patient. At times, the teaching team could reach up to 6-8 trainees, depending on the service. That being said, as a patient, waking up to see twelve pairs of eyes trained on you can be intimidating and uncomfortable. Particularly in a medical teaching institution, this can occur on a regular basis.

“You’re at the whim of whoever, you get woken up every five minutes for your vital signs, you get poked, you get prodded in a medical school, you get 5 million people checking your pulses in your groin, groin incision, you got to do it three times a day, because you got a new set of people coming in, so it’s – I mean it sucks to be the patients, so whatever little things we can do to help people.”

-Teaching Humanism Award Winner, Surgery

As such, several THA faculty made it a point to introduce every single team member to the patient and their role on the team prior to bedside teaching. What made this noteworthy was that these faculty members also made it a point to introduce any non-teaching team members as well, including observers. Not only did this create a less intimidating atmosphere but according to one THA internist, it provided a unified, cohesive front to the patient with regards to their care.

“As well as what it does for the patient to have the whole team together and can you imagine how difficult it is for patients. They see so many people coming in and out, they don’t know whatever, it presents a cohesive and sort of consolidated plan to the patient which I think is also important for them.”

-Teaching Humanism Award Winner, Internal Medicine

Outside of the patient rooms, THA faculty continued to reinforce this notion of respecting and humanizing the patient. One THA internist commented during their interview that if trainees joke about a patient, malicious or not, or engage in negative behavior, he/she is quick to comment on that behavior and make sure that it does not continue. This is particularly relevant when trainees begin to refer to patients in a dehumanizing manner. For example, at times, trainees were overheard identifying patients as their respective diseases or symptoms, rather than their names. This occurred once during observations and the THA faculty member was quick to

comment on the behavior. Unfortunately, it remains unclear whether that reaction was a result of their humanistic orientation or the presence of an outside observer.

Following this thread of protecting the privacy and sanctity of the patient, several THA faculty were also strong advocates for their patients. This was more readily apparent in pediatrics where younger patients were at the whim of their parents. As such, several times during observations, THA pediatricians had to step in and engage the parents during rounds on what was best for the patient. In one instance, one THA pediatrician became embroiled in a discussion with an angry mother about the direction of her son's care. In the presence of the entire team, the pediatrician calmly and coolly advocated for the patient's health and provided the best possible recourse for the patient, the mother, and the hospital. Afterwards, the pediatrician gathered the team and reinforced the notion of advocating for the patient and not feeling coerced into any medical action that did not seem appropriate. This was touched upon in the follow-up interview with the THA pediatrician.

“It’s important for residents to know that yes, your primary goal is the patient, because that’s your primary goal. So, you have to make sure to be a patient advocate, because a child can’t talk for himself, can’t make decisions for himself. And if you think that the family is not making the appropriate decisions then you really need to get people involved to help you, to get the family to understand how to take care of that kid.”

-Teaching Humanism Award Winner, Pediatrics

Observational data as well as interview analysis indicated that each humanistic practice of this typology was utilized at some point by all THA faculty – some more than others. However, they were all integrated into practice and modeled for one common goal - treating the patient like a

human being, respecting their space and body, and ensuring that trainees recognized patients as more than just a disease, symptom, or procedure.

Advancing Humanism

Changing the culture of a specialty, no less a hospital, requires significant human resources and innovative policy and practice. Particularly in a field where number of patients seen and research dollars take precedent, changing the culture of medicine to focus on compassion, empathy, and understanding amongst physicians, trainees, and patients can be challenging. Given that the humanistic orientation of medical trainees drops as they go through medical school and residency programs are battling issues related to burnout and wellbeing, a shift towards a more humanistic culture may provide meaningful change. Effectively teaching and practicing humanism has been shown to increase patient health outcomes and strengthen trainee mindfulness and wellbeing as a remedy to stress and symptoms of burnout. However, these cultural shifts do not occur spontaneously. More often than not, what sparks gradual shifts in ways of thinking and practice are unique, powerful incidents or an individual, or individuals, with a vision for change.

As such, prior to the start of this study, positive deviance was selected as the guiding framework for this particular research question. Positive deviance refers to the transformation of culture and practice as a result of the leadership of outliers, or deviants. These transformations are seen as beneficial to the group in question and as a result of the work of these outliers, the perceptions, values, and beliefs of those around them evolve. That being said, the examination of the Teaching Humanism Award winners seemed to be an ideal choice for a sample of ‘positive deviants.’ They had all been nominated and selected for teaching humanism at a level of excellence and presumably either possessed a stronger humanistic orientation than their peers or

better expressed their humanistic orientation during teaching and practice. Additionally, these THA winners represented a bevy of specialties and sub-specialties, indicating that in spite of or because of their specialty culture, THA winners were doing something different to set themselves apart from their colleagues. In an effort to explore how these THA winners advanced humanistic practices within the context of their specialty culture, the interview protocol was designed to target their roles in the medical school and hospital, any relevant curricular, pedagogical, or administrative commitments pertaining to humanism, and their perspectives on current practices revolving around teaching humanism at the bedside.

Pulling from the pre-interview questionnaire and the interviews themselves, three themes emerged from the data. The first theme directly addresses the research question but to some degree, describes the extent to which humanistic practices were advanced by THA winners. The latter two themes emerged as a way of summarizing the vision that THA recipients conveyed when describing how they would advance and strengthen humanistic practices within their specialty and beyond. Although largely unprovoked during the interviews, this is important to share because given the position, power, and orientation of nearly all THA faculty, it may only be a matter of time before humanism is magnified and elevated across all specialties.

First, the advancement of humanistic practices by THA winners seemed to be varied, relatively small in scope, and largely localized. In other words, a select number of THA winners were involved in smaller efforts within their own department or unit at a selected hospital that targeted a selected population. Additionally, these efforts were varied and ranged from curricular interventions to workshops and orientations for medical trainees. For example, one THA surgeon shared that at the beginning of residency training orientation, he/she would emphasize humanistic care as an expectation of all trainees. This surgeon also led workshops and guest

lectures at different meetings on the role of humanism in patient care. However, no other efforts were made to reflect on this expectation or follow up at any point after the orientation training. Two other THA internists indicated that they had been involved in an elective course at the medical school designed to train first-year medical students on providing humanistic care and combating burnout and cynicism. This course, however, was not a curricular requirement for medical students. Based on additional research of the course described, this curricular intervention seemed to be the most formalized and largest in scope. Besides the orientation training and elective course, THA winners did not mention any additional efforts within the domain of humanism.

Based on these activities and interventions, though small in scope and localized, their impact is largely unknown. However, these small acts may make a big difference. Setting the tone for a trainee orientation or interrupting the traditional medical curriculum could plant the seeds for further transformation and improve trainee self-efficacy. Additional research should examine the role and impact of these THA-led practices as well as other informal or formal commitments that allow THA faculty to shape curriculum, policy, or training with a more humanistic bent. Commitments such as ad hoc faculty committees, administrative taskforces, and faculty executive committees, though unmentioned in the interviews, could represent the starting point for THA faculty to, either consciously or unconsciously, advance their explicit humanistic orientations amongst their colleagues and specialty.

Despite the localized and targeted nature of the aforementioned humanistic interventions, pre-interview questionnaire data did reveal that all THA faculty held, on average, three additional appointments within the medical school or hospital. That is, in addition to their appointment as a clinical faculty member in their specialty, THA recipients also held positions

overseeing curriculum, training, administration, or student affairs. As such, it is not surprising that several THA faculty viewed humanism as the core essence of their leadership in these different realms.

“A successful leader needs humanism.”

-Teaching Humanism Award Winner, Surgery

One THA internist dug deeper and defined a specific humanistic quality - care - that encompassed their version of leadership.

“When you look at, just even what makes a good leader, again I’m going to go back to caring because if you care about your work product, if you care about doing what’s right for your residents as a Program Director, for your students as an Associate Dean of Students or an Associate Dean for Curriculum or whatever the case may be, you’re going to -- that’s the quality that you have that people always find you available, that people always find you approachable, that you want to do what’s right.”

-Teaching Humanism Award Winner, Internal Medicine

Another THA recipient commented on how humanism and its qualities of compassion, understanding, and empathy, among many others, can translate from patient care to working with students, colleagues, and other professionals.

“We can be using humanism when we engage with everybody, it’s sort of a component of professionalism.”

-Teaching Humanism Award Winner, Internal Medicine

This notion of humanism in the context of professionalism and subsequently, interprofessionalism should be explored further, particularly as it related to team-based care.

Regardless, these leadership positions provide THA faculty with exposure and access to the training and development of both medical students and residents. Though it is uncertain if THA faculty plan to leverage these positions to impart their humanistic orientations in some way, shape, or form within their specialty or hospital, some did mention that they wanted to capitalize on their positions of influence and change what they thought did not work in their particular specialty.

“I think a lot of the stuff I learned really has been things that I just did not like in surgery and now that I'm in a fortunate position to be in a position to actually change that, I will.”

-Teaching Humanism Award Winner, Surgery

Though further studies can examine the influence and clout of THA faculty within the domain of humanism, THA winners did describe what their potential ‘deviance’ may look like moving forward in their leadership roles.

The second theme from the interview data centered on various calls for cultural shifts in surgery, internal medicine, and pediatrics. The two sub-themes that emerged from the qualitative data were recognizing humanism – both institutionally and philosophically- and creating buy-in amongst fellow medical leaders as well as trainees. First, from an institutional standpoint, some THA faculty believed that not enough weight was placed on humanistic care. For example, when asked about the recognition of the Teaching Humanism Award in their specialty, nearly all faculty noted that the leadership did not believe it to be a ‘big deal.’ In fact, a majority of THA recipients could not recall being formally recognized by their chair or colleagues. As such, a first step recommended by a THA internist was improving the process of recognizing those who excelled in this humanistic capacity.

“We could do a better job within our group of communicating people’s awards and accolades.”

-Teaching Humanism Award Winner, Internal Medicine

Additionally, on a broader institutional level, one THA pediatrician believed that practicing humanistically, or rather encouraging more humanism in medicine, could benefit from more recognition, or a stronger emphasis, in the compensatory process. That is, in addition to focusing on number of patients seen or research grants, including a measure for humanism may provide dividends in the future.

“It’s [RVUs – similar to billable hours for a lawyer] very quantifiable and very important for promotions and salaries and such in many settings whereas being a good person may not formally be recognized the same way and I think that’s a shame.”

-Teaching Humanism Award Winner, Pediatrics

However, the mindset and mechanism for implementing a more humanistically-oriented value system in a teaching hospital requires answers to bigger, more philosophical questions. Logistical issues such as how it is recognized and encouraged as well as how it can be supported and modeled will need to be addressed. As one THA pediatrician put it, the shift to a more humanistic culture requires more than saying ‘Okay, on Tuesday mornings, you go and learn how to be a good person and how to treat patients nicely.’ That being said, one of the biggest obstacles in the face of a culture shift of this magnitude is creating buy-in from the faculty as well as the trainees. One THA surgeon addressed this challenge and noted that many faculty in the hospital believe that humanism is not an issue for them or for the trainees. As a result, any further humanism related work would be deemed useless or irrelevant.

THA (Surgery): I think the problem is you got to get buy-in, that's the hard part, so even though you're going to create a course on teaching, you have to have some kind of reason for people to do it, that's the biggest obstacle that you're going to have, to get people through the door. 99% of people in my department wouldn't go to that course.

Interviewer: How come?

THA (Surgery): Waste of time in their eyes. Because they have clinical duties, and teaching duties. To attend a course on being compassionate? Many may have this idea that 'I already am and I don't need someone to teach me this'.

This further highlights the challenges associated with integrating a humanistic element into a hardened, traditionalized culture. However, all THA faculty believed that curricular interventions were the most effective pathway towards preserving the humanistic orientations of medical students and preparing them for the stresses of patient care. In fact, every THA faculty interviewed recommended that a humanism-oriented course be a requirement for all medical students. However, it is worth noting that regardless of specialty and training background, all faculty stated that current efforts at the medical school were insufficient and could be improved. The one, resounding suggestion from all THA winners was contextualizing any potential humanism course and integrating it into the clinical training of medical students.

"I think it would be better to have through your clinical years. I think it's really hard for someone to talk about humanism when they are not taking care of patients, you know, in the first two years, the pre-clinical years [...] those kinds of things, I think it's more valuable in that setting."

-Teaching Humanism Award Winner, Internal Medicine

“I think experience matters. Seeing a lot of patients with different problems matters and I think that’s why part of our medical education, the way we’re going is more classes and more simulation. And I think simulation and all of that stuff is good for tasks and cognitive skills but it’s not good for this [humanism]. I really have a big problem with simulating humanism because patient’s feelings cannot be simulated.”

-Teaching Humanism Award Winner, Surgery

“That [humanism] cannot be taught in an abstract class. Unless you have the genuine experience, you cannot relate to it. All this stuff early in medical school is meaningless because these people haven’t really seen patients suffer, people crying, and families sensing the loss and all this stuff. So, when you talk about it in the abstract form and a very young healthy lady is sitting in front of you and acting as a patient who is very sick, it doesn’t quite click. So, I think that doctoring curriculum is for the most part I think a waste of time [...] You need to have a genuine human to human experience.”

-Teaching Humanism Award Winner, Surgery

These three quotes were from three separate THA faculty. Each stated the importance of providing a clinical backdrop for teaching humanism and recommended that a future course, intervention, or experience be intertwined with any clinical experience that the trainees received.

These recommendations for ‘deviance’ as put forth by the positive outliers in this study were just that, recommendations. As such, the guiding framework of positive deviance seemed to cover more than what was operationalized in this study. However, through this conceptual lens, broader issues emerged from the interview data as well as the observational fieldwork as to what

challenges needed to be overcome to actualize a humanistic shift in training and practice. Additionally, the positive deviants, or THA winners, in this study provided valuable insight into how to re-interpret the landscape of medicine to perhaps create more buy-in for the role and value of humanism, teach humanism more effectively and practically, and train faculty and students to better express and translate their humanistic orientation for their patients and colleagues.

Chapter 5: Discussion

Over a nine-month span, this study provided an opportunity to follow and explore the academic and clinical lives of fifteen Teaching Humanism Award winners across three different specialties. After nearly two hundred hours of observational fieldwork and interviews, it became clear that these faculty members were not better or superior to their colleagues. In fact, all THA faculty interviewed found themselves no different than their colleagues within the domain of humanism. Whether this was actually the case or simply a reflection of their deep humility, conversations with these faculty revealed something that shed new light on how this study was conceived and operationalized. Namely, physicians should not be viewed as simply humanistic or non-humanistic, or more humanistic or less humanistic.

Expressing Humanism

Contrary to what the literature might convey, working in a surgical specialty does not mean surgeons have little or no humanism. Just like working in internal medicine or pediatric specialties does not necessarily mean pediatricians or internists have a wealth of humanism. This dichotomous approach to classifying specialties and physicians as either humanistic or not seems to contrast with what THA faculty shared and what the literature also seems to suggest. As one THA faculty put it, if ‘you’re working in medicine, there is something about helping and serving others that attracted you to this work.’ Many critics may point to the money as a motivating factor for entering medicine but recently, physicians have noted that the compensation is not nearly enough given the hours, the endless amount of training, and stressful nature of the work (Konrad et al., 1999). Additionally, based on the same scholarship that found that empathy dropped during medical school, one can easily argue that a humanistic orientation existed prior to the decline during the third year (H. M. Shapiro, 1993; Wolf, et al., 1989). In other words, in

order for empathic levels to drop, they must have been higher to begin with. That being said, if this initial desire of doing good for others is true and valid, all physicians possess a humanistic orientation. Coupled with the notion put forth by THA faculty that they are no different from their colleagues, one can safely argue that the crux of the issue is not instilling a humanistic orientation, or better yet, teaching the importance of humanism. Rather, the real issue is – how can trainees and practitioners be taught to better express, and in some cases, protect, their pre-existing humanistic orientation?

The medical education literature has clearly shown the hierarchy of humanism amongst medical specialties. Surgery, radiology, and other specialties that have minimal patient exposure tend to have lower levels of humanistic qualities such as empathy and compassion. On the flip side, specialties like pediatrics and internal medicine that tend to see more patients have higher levels of humanistic qualities. This humanism spectrum was discussed in detail with THA recipients and all were in agreement with the literature. In fact, when the ‘lower’ end of the spectrum was described without even identifying a specialty, more often than not, interviewees mentioned surgery - surgical THA interviewees included. Despite this, THA winners from all three specialties did not distinguish themselves from their colleagues. They did not feel that they were more humanistic than their peers. Some even stated that they knew of several others who should have received the award in their place. So, what is it about these THA faculty that earned them this recognition?

After analyzing the data and conducting member checks with select THA faculty, it became clear that, in fact, what these THA faculty do better than their colleagues is *express*, and perhaps protect, their humanistic orientation. The clinical faculty who participated in this study did not have a stronger humanistic orientation or were not more humanistic than their

counterparts. They simply expressed their humanistic orientation to their trainees, patients, and colleagues more explicitly. Simply put, these THA faculty were *outspoken* about their humanistic orientation. The findings seem to support this implication. In short, THA faculty successfully navigated the culture of their specialty to showcase their humanism at the right time and place. What guided the humanistic orientation of these THA winners – role models, specialty-specific context, and clinical expertise, confidence, and comfort – all contributed to a clearer, more transparent expression of their humanism.

Expression or Possession of a Humanistic Orientation

Throughout the course of this study's observational fieldwork, THA faculty excelled at demonstrating and modeling five humanistic practices. These five typologies, or personified humanistic practices, were the epitome of the expressions utilized by the THA winners. Whether these practices were actually picked up on and integrated into the humanistic orientation and expression of trainees remains to be seen. However, following through on this study's use of social learning theory, the typological expression of these practices and what is picked up by the learner is an interesting issue to raise. If there is, in fact, an interest in determining the impact of these modeled practices on trainees, one must take into account the learner's perspective as well. Social learning theory implies that learners must already possess intrinsic values that attract them to certain role models and their behaviors. In other words, THA winners in this study were drawn to their role models because their values aligned with what they observed. But, if a shift towards expressing humanism is what is needed, perhaps it does not matter if the learners possess the *same* values as their role models. Perhaps what is more important is teaching these expressive techniques as explicitly and transparently as possible.

This move towards teaching how to be humanistic rather than the importance of humanism certainly raises some concerns. The most pressing concern being, will this devalue the importance of possessing a humanistic orientation? Will this lead to trainees or physicians ‘going through the motions’ with patients or colleagues? Without ensuring that a physician has a strong humanistic orientation, how can one be sure that the expressed humanistic practices will be effective? Thus, it is important to again look back at the primary motivations of medical students to enter the medical field. The humanistic orientations are there. The desire to help, serve, and heal others is there. The question is - what can be done to make sure it is protected?

Protecting Humanism

The notion of protecting the humanistic orientation arose from the emerging body of literature on mental health and wellbeing. Additionally, it was referred to multiple times by THA faculty throughout the interview process. As mentioned earlier in the study, the empathic levels of medical trainees drop as they go through medical school. Specifically, during the third year, when trainees begin their clerkship rotation, they are exposed to patients, disease, and the realities of medical practice. As one THA surgeon noted, trainees in clerkships are ‘trying to get mass information, trying to learn it’ and in the process, ‘objectifying people to do so.’ As a result, patients become ‘Diagnosis A’ and ‘Diagnosis B’ and ‘there is no human being behind’ those diagnoses. This de-humanizing experience, according to the THA surgeon, may contribute to the drop in humanism, along with the workload and exposure to the darker sides of medicine, i.e., sickness and death. However, this drop may be unpreventable. The exposure to the realities of medicine is certainly necessary for training purposes. But, perhaps there are mechanisms or practices that might help trainees grapple with these realities and preserve some semblance of their humanistic orientation. Teaching trainees to protect their humanistic orientations may be as

important, if not more, than teaching how to express it. Some of these practices – coping mechanisms, mindfulness strategies, wellbeing practices – may benefit the trainee down the line during residency when burnout becomes a bigger, more difficult challenge to address. Regardless, teaching how to protect one’s humanistic orientation and the impact of such practices deserves further study.

Adapting Humanism

Becoming an outspoken humanistic physician and protecting one’s humanistic orientation, however, required adaptation, especially for THA faculty in surgery. Surgical THA participants consistently commented on the masculinity of their specialty. Behaviors and attitudes that valued showing little to no emotion in patient care and ‘always being strong’ were, and in many ways, continue to be the norm for surgery. In fact, several THA surgeons stated that, within their specialty culture, showing emotion was connected to possessing a weaker clinical skillset. As such, in an environment that traditionally pushed humanistic values to the side, THA surgeons were forced to adapt. For many, this resulted in concealing, or selectively expressing their humanistic orientation, until their clinical reputation was intact. Even then, they still were identified as the ‘touchy-feely’ practitioner. In comparison to the more supportive, more ‘humanism-friendly’ climate of internal medicine and pediatrics, THA surgeons seemed to have fought harder to maintain and express their humanistic orientation. In other words, there seemed to have been a cost to adapting, to being humanistic. This raises an interesting potential avenue of research. First, what circumstances dictate adaptation? In other words, why did THA faculty adapt versus others? Though THA faculty in surgery can be viewed as outliers, this notion of adaptation begs the question – what happens to the other surgical faculty, i.e., non-THA winners, during this adaptive process?

Regardless, the adaptive process - in response to specialty culture – seemed to affect the humanistic trajectory of the participating THA faculty. In other words, though all THA faculty interviewed noted that they reached a point of clinical expertise, confidence, and comfort before becoming *outspoken* about their humanism, this transition may look different for surgeons versus internists and pediatricians. For a significant portion of their training, THA faculty were operating at the cultural norm for their specialty. In internal medicine and pediatrics, this norm valued humanism and supported its expression. In surgery, this norm was quite the opposite. However, reaching a point of clinical expertise, confidence, and comfort and subsequently winning the Teaching Humanism Award identified these faculty as outliers. However, given the difference in humanistic climate, this move from the norm to outlier can be interpreted differently. For THA internists and pediatricians, transitioning into this frame of mind may have allowed them to truly excel and flourish within their humanistic domain. However, for THA surgeons, this may have been an inauguration of sorts. As such, the meaning and impact of the THA for these faculty differ. For internists and pediatricians, the THA may be a recognition of being ‘the best of the best’ within their specialties and another ‘feather in the cap’. Whereas for surgeons, the THA could signal a ‘green light’ for the way they’ve practiced and taught and provide a system-wide validation of their humanistic efforts.

This newfound perspective has framed the work of surgeons in a different light, particularly the THA winners. It has created a non-traditional view of surgery and the humanistic orientations of THA surgeons. In particular, this new insight has begged an interesting question – does fighting harder, or paying a higher price, to maintain and protect one’s humanism lead to a stronger humanistic orientation? That is, since the surgical context seems to make it harder to express humanism, if a surgeon is able to keep their humanism, or even develop it, does that

make them more humanistic than a physician who may have trained in a more humanistic climate? Though unlikely, these questions have provided a new lens to examine the implications of the typologies provided in Chapter 4. Namely, what practices can best translate over to contexts such as surgery? How can these practices best be taught so everybody is comfortable expressing it within their respective specialties? And how can humanistic practices be taught without ‘preaching to the choir’?

Humanism as a Clinical Skill

One possible resolution may be to elevate humanistic practices into the realm of ‘clinical skills.’ This was echoed by a majority of THA faculty. In fact, several THA recipients questioned the existence of a Teaching Humanism Award, commenting that it represented a ‘sad reality’ of medicine. Internists, pediatricians, and surgeons alike felt that humanism and practicing medicine were synonymous and recognizing a physician for doing what they were supposed to do was needless. However, if this is the case, humanism should also be treated as a clinical skill. Similar to conducting a physical examination or starting an IV, humanistic practices or techniques can also be taught at the bedside. As such, it would require clinical faculty to utilize explicit teaching methods to ensure that their trainees were learning. In addition, it would strengthen the role of humanism in patient care and increase its prevalence in all specialties.

Now, a shift towards teaching humanistic practices as a clinical skill may sound prescriptive. But in today’s landscape of humanism, being prescriptive may be an improvement. Simply using the Gold Foundation’s acronym for humanism – IECARES (integrity, excellence, compassion, altruism, respect, empathy, and service) – as a guiding framework is not enough. In other words, asking or telling trainees to be empathetic, compassionate, or respectful is not

sufficient. Asking a trainee to be empathetic is similar to asking a trainee to assess the health of a patient. More guidance and instruction is needed to ensure that the trainee understands what and why things need to be done and that the patient is receiving the best possible care. However, taking into account the context and culture of each specialty, being humanistic may look and feel different in surgery versus pediatrics. As such, a more prescriptive and explicit curriculum, responsive to each specialty's goals of care and processes, may provide institutions and instructors with the tools and resources to best teach how to be humanistic.

For example, at the Greater Los Angeles Veterans Affairs Homeless Patient-Aligned Care Team clinic, a curricular intervention called the Humanism Pocket Tool is being developed. This tool is designed to be translatable to various disciplines including internal medicine, nursing, social work, pharmacy, psychiatry, and psychology. Within this tool are multiple humanistic practices designed to build patient rapport, humanize the patient, increase mindfulness, and combat de-humanizing responses including anger, disgust, or fear. This multi-disciplinary tool is prescriptive and explicit yet responsive to the needs of the trainee, instructor, and patient. Another example is the translation of the Intergroup Relations curriculum to the medical education realm by a group of pediatric faculty – called Intergroup Dialogue to Enhance Action on Diversity – at the UCLA David Geffen School of Medicine. Intergroup Relations has long been a tool used by faculty in undergraduate institutions to teach undergraduate students to understand and empathize with different groups of students (Hurtado, 2001). In essence, it is a curriculum designed to teach empathetic skills and mechanisms. The curriculum has been modified to use with pediatric faculty as well as pediatric residents and preliminary results have been positive (Walker, Soh, Tran, Isabel-Jones, & Gordon, 2015). This curricular tool is also prescriptive and explicit and can be easily integrated into the medical training curriculum.

Disaggregating and Contextualizing Humanism

Based on this, the Gold Foundation's definition of humanism may need to be disaggregated and contextualized for different specialties. The IECARES acronym may be too broad and vague for practical implementation. With resources such as the Humanism Pocket Tool and Intergroup Dialogue to Enhance Action on Diversity being developed, it seems as though various specialties are now beginning to create curriculum to teach to the core elements of the Gold Foundation's humanism framework. However, these groups are conducting preliminary work and have yet to scale up their practices. Based on the findings from this study, it may behoove medical educators to begin laying the groundwork for teaching how to be humanistic by specialty. For instance, given the shortage of time described by several THA surgeons, disaggregating and contextualizing humanism into quick, easy, and convenient practices may be easier to pick up for surgical trainees. Humanistic practices such as the appropriate integration of physical touch, closing the door to the patient's room, wrapping the curtain around the patient's bed, or making sure a patient's gown covers their body can be 'time-saving' techniques for surgery. For specialties with more time flexibility, practices could include the use of storytelling or active listening.

This notion of time emerged as one of the underlying themes of this study. For surgery, it revolved around the completion of a seemingly endless array of tasks in a short amount of time. For internal medicine and pediatrics, it centered around a constant desire for more time with patients and trainees to build relationships and teach more. For all specialties, it pertained to the number of training hours allowed for students and residents that constantly drove instructors to pick and choose what was most important to teach. This issue with time, however, may be one of the motivating factors for role modeling. Role modeling humanism is not time-intensive and

does not distract too much from the scientific medical lessons of each patient. That being said, time is likely one of the biggest challenges to overcome in order to make teaching humanistic practices more explicit. Although some THA faculty were already implementing various aspects of explicit humanistic teaching, moving from a largely implicit style of teaching to an explicit pedagogical paradigm for all clinical faculty may require a larger conversation about the use and availability of time for patients and trainees.

Recommendations for Practice

The findings and implications from this study lead to a singular recommendation for practice – the integration of and emphasis on teaching how to express explicit humanistic practices into the medical school curriculum as well as residency training. Humanistic practices should not only include techniques and tools that advance the expression of humanism but also protect and maintain one’s humanistic orientation. Put simply, training should not only focus on ‘how to be nice’ but also on ‘how to not be mean’. This may include tools similar to the Humanism Pocket Tool mentioned previously which includes mindfulness exercises, wellbeing-focused techniques, and stress reduction tool. It is clear that a certain educational and career trajectory exists for medical students and residents as they progress through their education and training. Intervening along this trajectory with an appropriate dosage of humanism, in an explicit way, can nudge trainees in the right direction. Strategically timing these interventions during medical school or residency can both establish and nurture humanistic orientations of trainees as they adapt into their respective specialties and clinic sites. Whether they be integrated into pre-clinical curriculum, emphasized during orientations, or extensively and explicitly role modeled during clerkships, finding and honing in on these time points will be critical for expressing, protecting, and adapting humanism amongst all medical trainees.

Although these humanistic practices may include the five typological expressions discussed in Chapter 4, they should largely consist of the following qualities: 1) curriculum for humanistic practices should primarily be taught explicitly, 2) practices and techniques should be near-prescriptive as a foundation, 3) curriculum should be translatable for each specialty, and 4) curriculum and practices should be contextualized to take into account the norms and culture of each specialty. The explicit nature of teaching was discussed in detail in Chapter 4 and would require a shift in focus, from role modeling and other implicit pedagogy to more explicit techniques such as reflection and feedback. The prescriptive nature of the curriculum refers to incorporating step-by-step resources that provides a foundation for trainees to build off of. This may include scripts that trainees can use to integrate appreciative inquiry techniques in their patient encounters or self-talk scripts that trainees can internalize when encountering a challenging patient or situation. Most importantly, this curriculum should be translatable and contextualized for all specialties. This means that teaching an empathic expression to trainees may look different for anesthesiology versus psychiatry. Despite this shift in curriculum and pedagogy though, the empathic expression is still identified as the learning objective.

Future Research

Though several recommendations have been made for further exploration, these findings as well as the future work of THA faculty opens the door to a rather interesting implication for future research. This future research should focus on the relationship between humanism and medical education leadership. Scholars have noted the need to strengthen the medical education leadership pipeline and humanism may be a critical factor in selecting who will best succeed in their roles (Boyer, 2009; Cohen, 1998; Collins-Nakai, 2006; Dowton, 2004). Teaching Humanism Award winners have demonstrated an excellence in their teaching and practice. This

demonstrated excellence has been forged, in large part, by their commitment to understanding, listening, and service – all components of a strong humanistic orientation. Given that many THA winners indicated that humanism is translatable into non-patient realms, it is not surprising that nearly all THA faculty participants were involved in several other leadership capacities with the medical school and hospital. Similar to how medical schools seek to refine the admissions process to find the best possible applicant, the THA, or the identification of humanism as an attribute or quality, may shed light on how to refine the training and development process to find the best possible medical education leaders. This deserves further study.

Additionally, following this thread of leadership, a follow-up study should examine the role and impact of Teaching Humanism Award faculty via their leadership positions on their trainees, peers, specialties, and hospitals. Put simply, are they there because they want to affect change and are they actually affecting change? This would shed light on the relationship between humanism, leadership, and cultural change. The capacity for cultural change relies heavily on those in power and if humanism is prioritized as a necessary value by THA faculty in leadership roles, this could lay the foundation for establishing the critical role that humanism plays in patient care, trainee development, and interprofessional collaboration. Though this requires a more longitudinal analysis, this also deserves further study.

Conclusion

Prior to the start of this study, the motivation for exploring the realm of humanism stemmed from a desire to re-evaluate and re-connect with the essence of what a physician entailed. After negative experiences in the pre-med curriculum, my image of physicians deteriorated and my desire to pursue a career in medicine eventually faded. That being said, it was not surprising to learn that humanistic orientations weakened during medical school.

However, throughout my experiences in medical education, there was always talk and chatter about a select group of physicians – internists, pediatricians, psychiatrists, and surgeons, among many others – that both medical educators and clinical faculty always spoke very highly of. These names continued to come up during training sessions, clinical observations, educational research projects, and departmental meetings. I later found out that these faculty members had all won the Teaching Humanism Award.

This only increased the level of intrigue and mystic around these clinical faculty members. Around that same time, I had just finished reading Malcolm Gladwell's book, *Outliers*. It got me thinking about what set these THA faculty apart from their colleagues. Better yet, in those specialties that were traditionally less patient-centered and less humanistic, how did THA faculty in those fields become who they are today? In my mind, these faculty members were simply more humanistic than their peers. They possessed a stronger humanistic orientation, more empathic, more compassionate, and more understanding than their colleagues. However, what these THA faculty taught me was that every physician possesses a strong humanistic orientation. Practically speaking, the compensation for physicians is not nearly enough given the long hours, extensive training, high levels of stress, enormous accountability and responsibility, and significant amount of non-patient care related tasks. Add on top of that the sacrifices they make with their families and friends and the only reasonable explanation is their sense of humanism. Though the THA faculty did seem to *express* their humanism better than their colleagues, this revelation not only changed the lens through which these results were interpreted but also shifted my bias and positionality for this study. The countless hours I spent with THA faculty transformed my view of doctors, their commitment to care, and the role of medical education in their practice.

This *expression* of humanism can be attributed to the people that passed through the lives of these THA winners. The mentors, former attendings, past and present trainees, or family members provided each clinician with a sense of belonging that could not be taught via lecture or didactics. In fact, this sense of belonging could have been imparted during brief interactions on the wards, outside of the classroom, or via individual meetings. This interpersonal transmission of knowledge, practices, and a sense of belonging highlights the role of social learning theory in medical education, specifically for attitudes and behaviors that cannot be easily captured or taught. Though this empathic connection between two beings requires a pre-existing alignment of values, the THA winners overwhelmingly acknowledged that these values were present in all practitioners and simply needed adjusting and fine-tuning.

Ironically, one of the most powerful adjustments of this study occurred with me during an observation with a THA surgeon. It was my first observation with a surgical clinical faculty and dozens of questions swirled around my head. How did this THA surgeon defy the culture of their specialty to become the clinician today? As we walked to meet the trainee team, we became engrossed in a conversation about the culture of surgery and the expectations of surgical faculty with regards to humanism. Up to this point, several of my peers had taken an interest in my study and commented that humanism did not matter to them, just as long as their physician was technically skilled and could cure whatever ailed them. I, for one, did not know how to respond to my peers. How did humanism fit in if the patient was okay with a non-humanistic physician? I raised this predicament with the THA surgeon.

Immediately, the THA surgeon's mood changed. The surgeon had also heard this many times before and found this predicament bothersome. At that point, the surgeon exclaimed, "Why can't you be the best surgeon in the world AND the nicest surgeon in the world?" I remember

those words so clearly because it was a moment that re-shaped how I viewed this study. Up to that moment, I had operated on an ‘either/or’ paradigm. A physician either is humanistic or not. A surgeon either is technically proficient or humanistic. Humanism was always black or white, yes or no. But after that conversation and seeing the THA surgeon teach, I began to re-interpret my previous observations, interviews, and knowledge base in an ‘and’ paradigm. A physician could be compassionate and a great clinician. A surgeon could be technically gifted and ‘touchy-feely’.

This epiphany opened my mind even further to the experiences of these faculty, how their orientations, behaviors, and attitudes might be imparted to their trainees, and how medical education might capitalize on their best practices. Along with other THA faculty, this THA surgeon taught me to become more understanding of the experiences of clinical faculty, more compassionate of how they interpreted their experiences, and more empathetic of what humanism looks like through their eyes. Though the findings do point to the THA faculty still operating implicitly, there seems to be a cohesive cohort of clinical faculty intent on blending their humanistic orientation with the curriculum and policies affecting trainees. Hopefully, as more THA faculty get recognized, more structures will be put in place supporting the teaching of humanistic practices and expressions. However, the moment that I shared with the THA surgeon will continue with me as I further explore this realm of medical education. In hindsight, given their impact on this study and myself as a researcher, it looks as though I was on the receiving end of what all these THA faculty have been recognized for – teaching humanism.

Appendices

Appendix A: UCLA Health System Teaching Humanism in Medicine Award

NOMINATION FORM

Qualifications:

MD or PhD faculty member affiliated with the UCLA Health System

Active involvement in medical student or resident teaching

Self or peer nomination

Name of Nominee

Faculty Title & Department

Patient Care Site

Qualities of Humanism demonstrated by this faculty member

Current Teaching Responsibilities

Nominator Name and Title

Appendix B: Pre-Interview Questionnaire

Pre-Interview Questionnaire

- 1) Please list all administrative/clinical appointments you have at UCLA along with approximate start dates (month/year).

- 2) How long have you worked in [specialty]? _____
 - a. At Ronald Reagan Medical Center (RRMC)? _____

- 3) Approximately how much of your time (appointment % or % time) do you spend with:
 - a. Teaching (clerkships, didactics, etc.)? _____
 - b. School service (e.g., committees, task forces, non-practice/teaching related, etc.)

 - c. Patient care? _____

Appendix C: Semi-Structured Interview Protocol

Semi-Structured Interview Protocol (*subject to revisions*)
30 minutes

Research Questions:

4. *What guides the humanistic orientation of physicians who display a high degree of humanism?*
5. *How do these physicians impart humanistic practices to their trainees?*
6. *How do these physicians advance humanistic practices or orientation within specialties?*

Thank you for your participation in this study on humanistic physicians. The purpose of this study is to understand how physicians, like yourself, define, teach, and advance humanism within their specialty. As one of the winners of the Teaching Humanism Award, I will be asking you questions related to your roles as a teacher, former student, medical practitioner, and colleague within your particular specialty. Your information will be kept confidential and you may stop the interview at any time without any repercussions. Before we begin, do you have any questions?

Introduction

Questions	Supplemental/follow-up questions
1. Were there any particular moments or experiences that shaped your desire to become a physician? a) To practice in your specialty?	

Guiding humanism (RQ #1)

Questions	Supplemental/follow-up questions
2. As mentioned earlier, you received the Teaching Humanism Award from the UCLA Health System... what does humanism mean to you?	
3. How do you currently define 'humanism' in medicine? a) Has your definition changed over time? b) If there was a change, what experience stimulated that change? Role models? A particular event? <i>Please share anecdotes or experiences.</i>	

4. If you were to speak on behalf of colleagues in your specialty, how would they <u>define</u> humanism?	
5. Do you see yourself being different in this domain than people that you work with in your specialty/sub-specialty? a) What percent would you say share your perspective?	
6. What, if any role, does humanism play in patient care?	
	<i>Do these role models continue to play a role in your humanistic development?</i>

Teaching humanism (RQ #2)

Questions	Supplemental/follow-up questions
7. How do you go about teaching it?	
8. What efforts do you make to ensure that learners around you pick up what you are modeling/teaching?	
9. How did you develop your current clinical teaching style? What is currently shaping it?	
10. Why do you think you received the THA? a) Since winning the award, has your skill or confidence in teaching humanism changed?	
11. <i>[if applicable]</i> I noticed that you do “_____” when interacting with your patients. Is this similar to how you interact with your friends and family?	
12. <i>[if applicable]</i> I noticed that you do “_____” when interacting with your students. How did you incorporate this into your teaching style?	

Advancing humanism (RQ #3)

Questions	Supplemental/follow-up questions
13. How is teaching humanism, or humanism in general, valued in your specialty?	<i>Does this play a role in career advancement?</i>
14. How have your colleagues received your THAship? Is it recognized? By who? If not, how come? a) How are other teaching awards viewed? Are there some that are more valued by	

<p>your colleagues?</p> <p>b) How would you celebrate/disseminate this to your department, if at all?</p>	
<p>15. Are there efforts within your specialty, or RRMC as a whole, pertaining to advancing the teaching of humanism? Why/why not?</p>	<p><i>In your opinion, how successful have these efforts been?</i></p> <p><i>Have there been obstacles/challenges?</i></p> <p><i>Has the THA helped with these efforts?</i></p>
<p>16. Have you taken on new administrative/clinical responsibilities since receiving the THA? Before receiving the THA?</p>	
<p>17. Would you recommend that teaching humanism be a part of medical education, i.e. taught to students and residents?</p> <p>a) Should we be doing more for students and residents?</p>	

Wrap-up

Questions	Supplemental/follow-up questions
<p>18. What do you think are the most important aspects of a humanistic physician? How about a physician in your specialty?</p>	

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