Teaching the Human Dimensions of Care in Clinical Settings

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Despite repeated calls to emphasize the humanistic dimensions of care during medical education, these are few known techniques for effective teaching of humanism. We describe the barriers that inhibit humanistic teaching and suggest pragmatic teaching methods to overcome such barriers and teach humanistic care in clinical settings. We began by asking participants at a conference on patient-physician communications sponsored by the American Academy on Physician and Patient in June 1998, "What can we do in the patient's presence to improve and teach the human dimensions of care? Please provide one or more examples of approaches you found to be effective." We augmented this information with suggestions from a number of colleagues in other settings. In a series of iterations, we analyzed all their suggestions to identify key teaching methods. We found that barriers to teaching humanism largely consist of elements of the informal and hidden curricula in medical schools. We then defined methods to help teachers overcome these barriers. Specific methods fall into the 3 categories of taking advantage of seminal events, role modeling, and using active learning skills. We believe that formal courses and other well-motivated endeavors that take place away from patients fail to foster humanistic care. In contrast, we present pragmatic teaching methods that can be used in the fast-paced setting of the clinical environment.

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THE PRACTICE OF MEDICINE combines the life sciences with humanism. Throughout history, both physicians and patients have referred to the "science and art" of medicine. In clinical settings, both science and art combine as students and residents learn to competently apply the biomedical sciences to individual patients. Several professional organizations have repeatedly called for more emphasis on the humanistic dimensions of medical education.[1-3] It is generally assumed that humanism is learned by medical students and residents through observing faculty physicians as role models. However, little evidence supports the effectiveness of faculty role modeling as currently practiced.

Several authors have claimed that teaching the human dimensions of care has recently become deemphasized or lost altogether.[4-9] Because underlying values and attitudes create a learning climate that influences how any teaching methods are received by learners, the existing learning climate may often impede humanistic care.[10-12] We address ways that educators might influence the attitudes and values held by students, residents, and faculty members, and then discuss 3 specific teaching methods: taking advantage of seminal events, effective role modeling by faculty members, and using active learning methods.

Process of Developing Recommendations

The authors, who share an interest in teaching humanism, first met at a meeting on patient-physician communications sponsored by the American Academy on Physician and Patient in June 1998. We define *humanism* in medicine as the physician's attitudes and actions that demonstrate interest in and respect for the patient and that address the patient's concerns and values. These generally are related to patients' psychological, social, and spiritual domains.

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We began by asking participants at the conference to write a brief answer to the question: "What can we do in the patient's presence to improve and teach the human dimension of care? Please provide one or more examples of approaches you found to be effective." We collated answers from more than 50 faculty members and discussed their applicability according to our own experiences. We augmented these initial data with informal interviews with colleagues at our home institutions. In a series of conference calls and in discussions, including a workshop presented at the annual meeting of the Society of General Internal Medicine in May 1999, we sought to obtain as many additional ideas as possible and then to reach a consensus on common themes and practical suggestions. The results of at least 10 rounds of this process led us to a consensus about barriers to teaching humanism, as well as teaching methods ranging from broad changes in attitudes to specific method to address such barriers (TABLE 1).

Establishing a Climate of Humanism

Before embarking on new teaching methods at any institution, clinician-teachers should identify the informal and hidden curricula that are ubiquitous in hospitals and medical schools.[10-12] Although these elements of medical education are seldom explicitly recognized or acknowledged, they deeply affect the behaviors and attitudes acquired by medical students and residents. The theory of the informal curriculum states that cultural mores exhibited by students, residents, teachers, and administrators at an institution transmit strong messages, which are learned and internalized by novices. These messages may have more educational impact than the lessons taught by the faculty in the formal curriculum. For example, students may have learned to ask about patients' emotions in a communications course. If students later observe that none of the residents during their internal medicine rotation ask patients about their feelings, they may question the value of that part of the curriculum. The formal teaching to include patients' emotions in the medical interview may be further undermined if that student's supervising residents tell the student to be efficient and not to get into patients' emotions. Surveys of residents and medical students document the pervasive impact of the informal curriculum, which promotes cynicism in trainees.[4,8,13]

Powerful messages are mediated not only by individuals. For example, a medical center that gives important leadership roles predominantly to individuals who do not espouse or exemplify the practice of humanistic care may lead students to conclude that these functions of the physician are less valued than biomedical knowledge or technical competence, regardless of explicit statements to the contrary. Medical center systems that are unfriendly to patients and their families convey a similar message.[10-12]

These tacit messages given by a medical center's official hierarchy constitute the so-called hidden curriculum.[10,11] Since learning medicine involves the integration of values and attitudes into the knowledge and skills of medical practice, learners undergo a process of socialization into the culture of medicine through exposure to the informal and hidden curricula. Although the informal and hidden curricula are often considered only to transmit undesirable qualities, this need not be true. We suggest that the effective application of specific teaching skills can result in positive influences of the informal curriculum. Consider the following 3 examples. In the first, an attending physician influences by example:

One of the authors cites the example from his own experience of calling an infectious diseases consultant for an urgent nighttime consultation. The consultant, who happened to be chief of medicine, not only came to the hospital at 4 AM to interview and ex-

Table 1. Educational Strategies

Establish a Climate of Humanism
Involve the learners in the process of clarifying the mission, goals, and ground rules for the clinical experience that embody humanistic values.
Encourage presentations that integrate relevant psychosocial as well as biomedical information and management strategies.
Move clinical round discussions to the bedside (in most cases), and encourage presentations that recognize the presence of the patient.
Get to know learners as persons and address their individual and human needs.
Promote a cooperative, respectful, and supportive, as opposed to a competitive, learning environment, where team members are encouraged to admit their mistakes and to communicate rather than hide their learning needs.
Recognize and Use Seminal Events
Giving bad news: recognizing, eliciting, clarifying, and dealing with feelings, concerns, or expectations.
Focusing attention on the use of excellent communication skills or the use of dehumanizing language.
Assisting a patient at a time of transition.
Role Model
Demonstrate desirable skills or behaviors.
Comment on what you have done.
Explain what you have done.
Actively Engage the Learner
Involve learners in tasks that require humanistic skills, such as eliciting the concerns of patients.
Ask questions and encourage learners to reflect on and to discuss what they have done or on what they have observed.
Provide feedback to learners on what they have done.
Engage the learners in projects that are likely to include the human dimensions of care, such as defining the team's mission.
Be Practical and Relevant
Respect the limitations of time and resources.
Make a humanistic approach integral and relevant to patient care.
Focus on humanistic behaviors that are likely to improve outcomes.
Focus on communication skills and management strategies that are feasible for the learner and are generally applicable.
Use Ongoing and Multiple Strategies
Reinforce and build on previous learning.
Address differences in individual learning preferences.

amine the patient, he also performed his own Gram stain. The author, who was a resident at the time of this consultation, learned the value (and expectation) of personally evaluating important evidence in a timely fashion.

In the second example, the attending physician recognizes and corrects the use of dehumanizing language:

We all know the stories of referring to patients as "diagnoses," making crude or derogatory comments, and so forth. What I didn't realize was that these things still happen with alarming frequency, even on my [medical] team. What was further shocking to me was that in the beginning these things were sliding past without my even noticing. It was not until after the session when I was reflecting on [these] things that I began to realize what was happening. At that point, I began to look for it and simply point it out when I saw it. For example, when a resident presented, "Mr. X is the 'pancreatitis' with a high white blood cell count," I would interrupt, saying, "Do you mean Mr. X is the gentleman we are taking care of who suffers from pancreatitis?" To my pleasant surprise, I found that the residents and students were as shocked as myself and began pointing our these moments to each other. The team began to make mountains of progress, when it was able to raise its awareness of this "transparency of dehumanism" that had pervaded our rounds.

In the final example, the attending physician actively engages the ward [medical] team in developing their own mission statement:

I have begun to introduce an activity at the beginning of the month in which I sit down with the team and write a mission statement. We usually start this activity by me stating that organizations write mission statements to tell the world what they are about and why they exist. I then go on to explain that we, too, our team, can have our own mission statement that talks about why we are here and what we want to achieve during our month together. I then facilitate a brainstorming session by soliciting ideas for what should go in such a mission statement, encouraging participation by all members of the team. We then boil our ideas down into a succinct statement, and I write the statement at the top of the patient board in the team's office and leave it there for a month. I am usually careful not to introduce my own content into the mission statement, but rather point out that this statement was written and belongs to the team, it is their own mission statement. I usually do not refer to it in any regular way during the month, but suggest that the team members may find it useful to refer to when they are feeling overworked, underappreciated, or having difficulty with patients or the work of the wards. On several occasions, team members have said to me things like "I had to look at the mission statement last night" or "the mission statement helped me out there [during rounds]." I have encountered resistance to my removing the mission statement from the team office at the end of the month, as the teams often want it to stay there.

In this example, writing a mission statement connected the medical team to the meaning of their work. It fostered a humanistic climate by providing a benchmark for the team to identify as they went about their daily work.

The above examples illustrate the power that faculty can have in shaping attitudes and behaviors of trainees. While attending physicians in brief medical rotations or preceptors in outpatient training settings may not be able to do much to change the total culture of their institution, they can affect the local culture of their team and the team's general attitude toward patients. If several attending physicians contribute, there is a multiplier effect that can alter the institutional climate.

A humanistic learning climate would simultaneously treat learners with respect, establish an atmosphere of trust and collaborative learning between teachers and learners, and attend to the human needs of the learners. Students and housestaff work in a stressful environment. They may be overworked, overextended, sleep deprived, and focused entirely on getting the job done.[9] They also face challenges of dealing with difficult and sometimes unpleasant patients while perhaps coping with troubling personal circumstances. It is therefore important for teachers and learners to know one another. Often, the attending physician provides the principal emotional support of students and housestaff.

Teachers may inquire how an intern or resident is doing, especially if there are clues, such as altered behavior or unusual comments, that suggest a housestaff member is burned out or depressed. Regular feedback sessions can be held partway into a clinical rotation. The teacher can encourage residents and interns not to stay excessively late in the hospital when they could be signing out to other team members. A medical mistake or unexpected death of a patient may prompt a session to discuss the team's feelings in a supportive and constructive atmosphere. Such a session can be a memorable event for residents and interns. In a caring and supportive atmosphere that promotes trust and mutual respect, learners are more likely to be receptive to the type of interventions that we describe later .[9,14]

Finally, clinical teaching interactions can be structured in a manner that creates opportunities for teaching the human dimensions of patient care. An important method is to move clinical teaching to the bedside or into the examining room. Learners who are unfamiliar with bedside rounds can be prepared by engaging them in discussion of their benefits and limitations and of guidelines for presentations and discussions in the presence of the patient. Most patients prefer such presentations,[15-23] which allow students and residents to adapt their presentations in ways that acknowledge the presence of the patient, eliminate unnecessary jargon, and invite and control input from the patient. While total time spent during rounds may diminish or stay the same, total time spent with patients increases, thus creating increased opportunities for teaching the human dimensions of care (TABLE 2).

Clinical Teaching Techniques

Taking Advantage of Seminal Events. Sometimes events happen in clinical settings that uniquely shape the values and attitudes of students and residents who witness and participate in them. A seminal event of this type may shift the informal curriculum in a school or teaching hospital toward a more humanistic learning climate and also may have a lifetime beneficial effect on a student or resident. For example:

I remember going with a mentor regularly on bedside rounds even before I entered medical school. He was a well-known cardiologist. Rounds were quite a pageant with the great professor, his fellows, the residents, and finally the medical students trailing behind. They went on for hours, and I have a distinct memory of a number of rumbling stomachs as lunchtime came and went. After interviewing the patient at the bedside and discussing the findings, encouraging students to experience specific aspects of the patient's examination, he would synthesize the essence of his thinking and dictate this to his fellows who would record it in the chart. He signed the note with a thick fountain pen. As I progressed through my own medical training, I became increasingly fascinated with the patients' stories, which came tumbling out as my mentor seemingly magically opened some lock around the patient's heart. I remember a particular patient who had survived more than one episode of malignant ventricular arrhythmias. The professor began exploring what the patient thought had triggered these life-threatening events. She told the story of her life in Germany and survival in a concentration camp as a musician for the German officers, her attempts to smuggle food to her parents and siblings in the camp, and her despair and guilt when they were exterminated. His back was turned, but I could see the patient's face. Her eyes were riveted to my mentor's as she told her story quietly. When she was done, he turned slowly to face the group. Tears were streaming down his face. I will never forget that moment. The meaning of listening and allowing the patient's experience to enter you—sharing the experience in one's heart and re-emerging with a connection to the experience forever embedded in my mind. As time went on, I came to realize that when he turned to face us, I too had shared not only the experience with the patient, but also his experience. I knew he was teaching me what it meant to be a doctor.

Seminal events of this nature have great capacity to be moments when one can absorb invaluable lessons about patients. This event influenced a young physician throughout his entire career. But by their very nature, such major seminal events are unlikely to happen frequently or for everyone during training.

Teachers nonetheless can create mini seminal events. These may not be the once-in-a-career type of story described above, but they may be made memorable by including the learner's participation in the process. Events also may be memorable because they are laden with emotion, are thought provoking, provide solutions to dilemmas or difficult problems, or lead to a sense of accomplishment. Teachers can take advantage of clinical events that commonly occur, such as giving bad news, dealing with emotion, or assisting patients at times of transition. One author provided the following example:

A new third-year student was assigned to my office for the ambulatory aspect of her medical clerkship. We had a new patient scheduled one morning so I sent her in to start taking a history and then I joined the two of them shortly. The patient was a thirty-eight year old woman who had moved to the area five months prior, had gotten a job, and was just coming in to establish care. The student found on review of systems that the patient had lost twenty pounds in the previous four months which she had attributed to working hard and eating less. On examination, we found enlarged posterior and anterior cervical lymph nodes—when asked about them, the patient said that a year ago a previous doctor had told her that as long as they did not get any bigger they were OK [sic]. The rest of her examination was normal with the exception of enlarged axillary and inguinal nodes. I expressed my concern with the weight loss and adenopathy and we ordered some labs including an HIV [human immunodeficiency virus] test, which came back positive several days later. I told the student the results and that I wanted her to come in with me when the patient returned. I also gave her an article on delivering bad news and we talked about the strategies mentioned. When the patient came back to the office I told her the results and we sat, listened, and held the patient as she started to digest the news. We had quite a long visit during which both the patient and the student began crying. After the patient left we discussed how we felt about the visit, the personal stresses of giving bad news, how we approached the patient, and the patient's and our coping

Table 2. Educational Content[29,32,43,44]

Social Amenities
Greeting the patient
Explaining roles
Introducing team members
Asking patient's permission when appropriate
Attending to the patient's privacy
Verbal Communication Skills
Gathering information using open-ended and closed questions, active listening, and obtaining psychosocial information
Eliciting, clarifying, and attending to patients' emotions, beliefs, concerns, and expectations
Providing patient education and facilitating behavioral change
Timing
Tone and pace of voice
Nonverbal Communication Skills
Position, such as maintaining appropriate eye contact, placing oneself at the same level as patient, and including patient in circle during rounds
Facial expressions
Touch
Observational Skills
Patient's verbal and nonverbal communications and communication styles
Patient's dress and surroundings
Patient's family and social interactions
Colleague's communication and decision-making skills
Humanistic Care
Attending to the patient with respect as a unique individual
Providing care in the context of the patient's values, beliefs, history, needs, abilities, culture, and social network
Providing care in the context of what is meaningful for the patient
Giving bad news
Providing humane care at the time of transitions, such as loss of functional status
Providing care at the end of life
Relieving suffering
Being honest and genuine on how one portrays oneself to the patient
Self-awareness
Being aware of the emotions that are evoked in the context of a patient interaction
Being aware of the communication skills that one has used
Being aware of one's values, beliefs, history, needs, and culture
Being aware of how the above self-awareness points affect one's interactions with and care of the patient
Using this information to improve one's care of the patient and achieve mutual benefit

mechanisms. Later that day and the next day I checked in with the student to see how she was doing.

By using a relatively common clinical event, the teacher created an opportunity for learning. This opportunity did not involve a rare, unique encounter with an unusually eminent teacher, but rather relied on giving the learner a framework for the interaction with the patient.The opportunity to reflect on the experience allowed the learner to process the interaction, to realize its importance to her personally, and to think about how it could affect future interactions with patients. Taking advantage of such opportunities adds to the repertoire of techniques available to faculty for teaching humanism.

Role Modeling Skills. The majority of faculty that we polled mentioned role modeling[24-28] as their sole teaching method. Most of the role modeling examples they provided were passive, with the attending physician modeling desired behaviors for the learners. Despite the passive nature of this method of teaching, the cumulative effects of this role modeling by clinical teachers may effectively influence learners to treat patients compassionately and respectfully. A common theme of the examples was for the teacher personally to attend to the patient's comfort by adjusting pillows and bedspreads, replacing trays, modeling respect by asking permission to sit or enter the room, ensuring privacy by pulling curtains, and/or paying attention when the patient was short of breath or in pain. Other examples described how the teachers could model emotional support by touching the patient, sitting down beside the patient during rounds, and/or asking about patients' personal lives or family as well as their concerns and fears. Teachers may convey attentiveness by carefully noting details of the patient's conversation and nonverbal clues, to which they can respond with appropriate questions.[29] One physician wrote that he measures the pulse while conducting the bedside interview. This touching conveys his attentiveness and also his therapeutic role through the symbolic gesture of measuring the pulse. This physician also said that he sometimes gets down on his knees to examine the patient's feet to convey symbolically the concept of service of the physician to the patient. Such compassionate and respectful actions can be melded into the routine of teaching rounds.

The effectiveness of role modeling can be enhanced in several ways. We previously mentioned the importance of establishing a collaborative learning environment that promotes openness and trust between learners and teachers. By discussing role modeling with learners before the clinical encounter, teachers can focus attention on the role modeled behavior thereby making it more likely be noticed and absorbed. For example, teachers and learners may have a prior discussion of how the teacher will address patients' concerns, such as discomfort, unhappiness with hospital routine, refusal to agree to diagnostic studies, or need for an advance directive or informed consent. Similarly, creating moments for discussion and reflection immediately after the event can promote understanding of the observed behavior and help solidify learning.[9,30,31]

While rounding [sic] on a particularly anxious woman, the resident made a comment that obviously upset the patient. As we had previously established a goal of dealing with difficult communication issues in real time, I was able to touch the resident on the arm and ask, "Can I try?" I was then able to discover what it was that was troubling the patient and why the resident's comment had evoked the response that it did. By dealing with the patient's anxiety head-on we were able to reestablish rapport and get to the necessary end point. After leaving the patient's room we were able to dissect this encounter and learn something about dealing with a patient's anger or frustration in a real life situation.

Similarly, establishing humanistic care and communication skills as team goals allowed the following interchange:

A patient on our team had been admitted recently with a large anterior myocardial infarction. It had been determined that she had developed a large ventricular aneurysm. She and her family had been advised of this, and it was felt prudent to obtain an advance directive. I asked the resident how he wished to proceed, and he stated that it would be beneficial if I would do this on rounds so he and the rest of the team could observe. I agreed and we were able to discuss this with the patient and her family during our daily rounds. The result was that she and her family agreed to a "no-code" status. After rounds, we discussed what had transpired, I believe to the benefit of the entire team. As fate would have it, the patient's ventricle ruptured 48 hours later.

Active Learning Methods. Active learning methods engage learners in doing, discussing, and reflecting. We believe that active learning methods more effectively promote humanistic skills, attitudes, and values than does the passive approach of having learners simply observe another person's interactions. Humanism implies a way of doing that is tailored to the needs of the specific patient and situation, and its mastery requires practice coupled with reflection. When well done, humanistic care is seamless, transparent, and leads to healing, for both the patient and the physician. However, even if learners witness high-quality humanistic care, they may not fully absorb these lessons when they are passive bystanders or if they do not consciously recognize its occurrence or processes. Most of the teaching examples that we initially collected involved role modeling and seminal events in which the learners were passive observers. We think that these teachable moments can be enhanced by transforming them into active learning exercises. For instance, the teacher in the vignette about Mr X with pancreatitis created a conducive learning climate and involved learners by molding a mini seminal event into an active learning exercise. Role modeling can be made active, as described in the previous section, by methods that promote attentive observation, reflection, and discussion.

Perhaps the most important way for an individual to learn skills and behaviors is to practice them, be observed, receive helpful feedback, reflect on his or her performance, and then repeat the cycle (TABLE 3).[32-37] Such active learning exercises are usually planned in advance by the teacher and learners, who begin by defining mutual learning goals.

Table 3. Stepwise Approach to Active Learning of Humanism[38-41]

Step 1: Plan the Exercise
Recognize a teachable moment or challenging encounter
Engage the team's interest
Set mutual learning goals
Assign roles, such as interviewing the patient or giving feedback after the exercise
Plan or structure the exercise, such as planning how to explain the exercise to the patient and obtain consent or naming a time keeper
Provide helpful advice to the learner if requested
Step 2: Perform the Exercise
Observe as the learner interacts with the patient
Only intervene with the learner's permission
Keep time and follow the structure that was agreed upon
Step 3: Feedback and Discussion
Give the learner first opportunity to dissect the exercise
Elicit feedback and discussion from the group
Consider additional learning exercises, such as replay with a role play or plan a follow-up with the patient
Offer a general rule pertaining to the patient as a summary point
Step 4: Reflection
Pose a question for reflection, such as "So what did we learn from this?"
Place the exercise into the larger context of patient care
Step 5: Additional Feedback, Planning, and Reflection
At a later time revisit the exercise
Plan or modify the approach for future exercises

Planning may be done in the conference room or spontaneously outside the patient's room. Active learning exercises may take a variety of forms, including interviewing or examining patients, role playing,[38] working with standardized patients, or other types of interactions. In teaching of humanism, active learning exercises generally coincide with teaching rounds. Following learner participation in the exercise, there should be the opportunity for self-assessment, additional practice, feedback, and reflection.[35,40] Additional practice may consist of a brief role play. Active learning exercises help to connect learners directly to the subject or process that they are learning. As Sutherland and Bonwell have noted, "students are simply more likely to internalize, understand, and remember material learned through active engagement in the process."[41]

Parker Palmer takes the principle of active learning a step further, by describing the "community of truth,"[42] in which learning occurs through mutual relationships between patients, teachers, and students:

> As we try to understand in the community of truth, we enter into complex patterns of communication-sharing observations and interpretations, correcting and complementing each other, torn by conflict in this moment and joined by consensus in the next. The community of truth, far from being linear and static and hierarchical, is circular, interactive, and dynamic.[42]

As conceived by Palmer, the community of teachers and learners might serve as an antidote to undesirable aspects of informal and hidden curricula. We believe that attending physicians will most effectively foster humanistic care by promoting active learning in the context of such a group, which on the level of clinical teaching includes attending physicians, residents, interns, and students. All members of the team are encouraged to participate in the humanistic care of patients and their families.

The attending physician, therefore, must not only deliver humane care but also involve the residents and students in that care.[38] The attending physician in the role of the teacher must then foster active reflection and introspection by the learners.[30,31,37] For example, in the vignette about the patient hearing the bad news of her human immunodeficiency virus test result, it was not enough for the attending physician to have the student passively watch while the event unfolded; rather, the attending physician facilitated the student's participation in the care, reflected mutually with the student on the exercise, and facilitated a discussion of the case at a level that was respectful to the patient and to the novice learner. A learner with more experience, such as a resident, might have been invited to take the lead in the discussion with the patient. The true power of role modeling and seminal events is realized when the team possesses the openness, safety, and respect (as a community of learning) that allows learners and teacher alike to share their thoughts, fears, ideas, and experiences as they participate in the humanistic care of patients.

Active learning related to humanism may encompass special activities (as in the example of developing a mission statement) in addition to activities that occur at the bedside. We encourage teachers to bring their own creativity to the design of active learning strategies, guided by the following questions:

- How can I foster broad participation in this activity?
- How can I foster a safe environment for learners to share their own fears, concerns, and dilemmas?
- What opportunities exist for practice, feedback, and discussion?
- What opportunities for reflection exist during this activity?

Fostering a community of active learning may require teachers to share of themselves with learners and to challenge the hierarchical walls that often exist in medical centers, and which are buttressed by hidden or informal curricula. However, we believe that teachers who successfully include learners as active participants in providing humanistic care to patients can create a humanistic climate of care and facilitate the development of humanistic skills, behaviors, and attitudes in their learners. The daunting task of changing attitudes fostered by the nonhumanistic informal and hidden curricula requires enhancing the collective self-awareness of faculty, housestaff, and students of their roles in promoting the humanistic care of themselves and their patients.[43-45]

Conclusion

Many currently used strategies to induce humanism are probably ineffective. Admonitions from leaders in medical education, recommendations by official bodies, and even special events, such as the "white coat ceremonies," have so far failed to create a sufficiently humanistic climate in academic medical centers.[1-3,46] We have aimed our approach at clinical or front-line teachers. Several similar efforts have been reported.[32,40,41] Some have adopted small-group and experiential teaching methods that address patient-physician relationships and medical ethics in required courses for medical students.[10,40,47] The skills in patient-physician communication and abilities to improve interactions with patients are taught effectively using the active learning methods used by these courses.[48-50] Students' appreciation of the human dimensions of care appear to be enhanced by learning in small groups, where sufficient trust can be established to allow for a deep, critical reflection on the issues faced during clinical training.[39,40,47] Large-scale faculty development programs associated with such efforts may also assist in establishing a learning community composed of faculty and students who share common goals and values.[32,40-42,47,51]

The challenge remains to make the informal and hidden curricula more humanistic in the clinical settings, because this is where patient care is delivered and key role modeling and learning occur. Many previous efforts have occurred in classrooms or in special courses outside of the clinical setting.[32,39,40,47,51] Without teaching in the presence of patients, such methods may be partially effective but will probably not bring about widespread change. Such change, we suggest, entails creating a new, more open learning climate and a community of front-line teachers who are dedicated and skilled in teaching humanism at the bedside.

A humanistic approach to patients should be integral to patient care and not thought of as window dressing or icing on the cake. It is important that all members of the team participate; humanistic care is not confined to the domain of an eminent professor or of a medical student with few other responsibilities. It is important to make humanistic care do-able by being explicit about the skills used, such as those listed in Table 2, and by being practical. Attending physicians will need to alternate time-consuming learning exercises with time-efficient teaching interventions that focus on the issues at hand. To teach in the context of patient care means making humanism relevant to patient care by asking the question, "How will this help us to care for the patient?"

Teachers should strive to become proficient in the variety of educational approaches, as listed in Table 1. Strategies then can be specifically chosen to match the needs of a learning situation, its content (Table 2), and the needs and preferences of learners.[52] When several different educational strategies are used over time, learning can be reinforced and refined.[52] For example, teaching the provision of care in the context of patients' values and preferences could involve both the role modeling and active learning of appropriate interviewing techniques, as well as the integration of such information into the discussion and making of clinical decisions.

Accomplishing these goals may require enrolling significant numbers of attending physicians, especially influential faculty members, in faculty development programs that aim to change the climate of medical teaching by incorporating skills for teaching humanism.[51,53] We recommend that during the process of faculty development, faculty set aside time for small-group reflection by the faculty on their values and attitudes.[9] It is through an alternation of practical problem solving—as in practicing specific skills and methods for teaching humanism—with opportunities for reflection, whereby the meaning, importance, and purpose of this work can be integrated with one's teaching skills, that true psychological growth and change occur.[30,31,33,47,52-56] In Palmer's words, for teachers to bring humanistic concerns to medical education requires that "we find the way to be 'true to ourselves' in our interactions with learners, much as we attempt to express ourselves . . . in our caring interactions with patients."[42] We foresee that a similar process could involve residents and interns, who are role models for each other and for students, which would further enhance the clinical learning climate.

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