Patient Education and Counseling 98 (2015) 162–167

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Medical Education

# Teaching professional and humanistic values: Suggestion for a practical and theoretical model

William T. Branch *

*Division of General Internal Medicine and Geriartics, Emory University School of Medicine, Atlanta, USA*

ARTICLE INFO

*Article history:*
Received 13 May 2014
Received in revised form 6 October 2014
Accepted 18 October 2014

*Keywords:*
Communication skills
Curriculum development
Faculty development
Professional development
Humanistic values
Professional identity formation

ABSTRACT

*Objectives:* To suggest and describe a practical and theoretical underpinning for teaching professional and humanistic values.
*Methods:* The author describes four learning methods that together comprise a model for teaching professional and humanistic values. The author defends this model by citing evidence and relevant literature as well as his extensive experience with numerous colleagues in successfully applying the model in large scale programs.
*Results:* The combination of teaching methods that comprise the model evolved over 30 years from the experience of several large collaborations with educators in teaching learners at all levels of medical education. The four teaching methods are (1) experiential learning of skills, (2) critical reflection, (3) a supportive group process, and (4) a sufficiently longitudinal curriculum. Together, these methods create a theoretical model with mutually reinforcing elements for enhancing commitment to core values and optimizing professional identity formation.
*Conclusions:* This paper describes the combined model and the methods in detail and reviews evidence favoring incorporation into curricula.
*Practice implications:* The combined model educationally enhances core values that underlie the professional identity formation of physicians. The model is practical and generalizable, and should be used by curriulum planners.



## 1. Introduction

Calls for humanism in medicine are not new [1], but official bodies now recommend strengthening humanistic values and virtues as centerpieces of professionalism in medical education (Table 1) [2–7]. Caregivers widely embrace these virtues and values [8]. Leading educators believe that internalization of the core values and virtues is foundational for accepting the social roles, corresponding behaviors and ways of being that lead to the formation of professional identity [9–15]. But, although various recommendations for teaching professionalism have been suggested, few studies have objectively evaluated the effectiveness of these recommendations [12,16]. A recently published systematic review of the topic concluded that there is no consensus on how to optimally teach professionalism [16]. In collaboration with numerous colleagues, I have addressed this issue for more than 30 years at every level of medical education [17–23]. Our efforts were always predicated on the belief that capacities for empathy, compassion, caring, respect, service, and other core professional values can be strengthened and developed through an educational process. By trial and error, programs that I and my colleagues designed eventually combined four educational methods with mutually reinforcing elements into a coherent educational model (the combined model) that predictably enhances learners' commitments to humanistic values in medicine, and positively influences their professional attitudes and behaviors. We have now evaluated this model used in faculty development, with statistically significant positive results in two multi-institutional studies [20,23]. Although perhaps implicitly understood, no one has previously explicitly described how this combination of learning methods enhances the learner's professional and humanistic practices. Here, I hope to clearly explain the rationale for use of the combined model. I will argue for its widespread adoption by medical schools and medical teaching programs.

The combined methods of the model are: (1) experiential learning of skills, (2) critical reflection on one's experiences, (3) a supportive and validating small-group environment, and (4) a sufficiently longitudinal cohesive program to allow molding of the

* Correspondence to: Division of General Internal Medicine and Geriatrics, Emory University School of Medicine, 49 Jesse Hill Jr. Drive, Suite 446, Atlanta, GA 30303, USA. Tel.: +1 404 778 1610; fax: +1 404 778 1601.
*E-mail address:* wbranch@emory.edu

http://dx.doi.org/10.1016/j.pec.2014.10.022
0738-3991/

**Table 1**
Core values and virtues of the physician.

| Arnold P Gold Foundation [6] | Project Professionalism, ABIM [7] | Physician Charter, ABIM, ACP, EFIM [9] |
|---|---|---|
| Integrity | Honor and integrity | Primacy of patient welfare |
| Excellence | Excellence | Patient autonomy |
| Compassion | Altruism | Social justice |
| Altruism | Respect for others | |
| Respect | Accountability | |
| Empathy | Duty | |
| Service | | |

Core values and virtues that underlie skills, attitudes, knowledge and behaviors comprising the human dimensions of care. From: Arnold P Gold Foundation [6]; Project Professionalism, American Board of Internal Medicine (ABIM) [7]; Physician Charter, American Board of Internal Medicine Foundation (ABIMF), American College of Physicians (ACP) and European Federation of Internal Medicine (EFIM) [9].

whole. As illustrated in Fig. 1 and explained further on, the first three methods of the model are mutually reinforcing, while the fourth (longitudinal process) reinforces all.

## 2. Derivation of the combined methods model

My understanding of the combined model shown in Fig. 1 emerged in the 1980s and 1990s from my experiences with the required longitudinal, small-group-based patient–doctor courses implemented on a large scale at Harvard Medical School [17,18]. I observed students in the small-groups embrace reflective learning and master communication skills. I observed them identify with their carefully selected faculty facilitators as role models for becoming doctors. Qualitative analyses of student-written narratives provided insights into their many struggles with socialization into medicine [24–26]. Students were frustrated when their empathy for their patients often contrasted with perceived lack of empathy by other caregivers on clinical services [24]. Students sought to maintain their core values and moral principles when exposed to less-than-savory aspects of the hidden curriculum [25]. I observed how reflective learning assisted the students in working through these struggles, especially when coupled with peer and faculty-support in the small-groups [27]. When also provided with skills taught in the course to communicate with patients and deal with difficult dilemmas and clinical challenges, students seemed better enabled to function as caregivers without relinquishing their empathy or values [26]. Recently published work shows that the issues faced by our medical students in the late 1980s and early 1990s remain at the forefront of medical education today [27].

There were early adopters of courses similar to Harvard's Patient Doctor Course [28,29]. Other authors have emphasized the importance of enhancing professional values in medical education [5,9,12,30,31]. Authors subsequently recommended learning methods thought best suited for assisting students with professional identity formation. Rabow et al. believe faculty role modeling and mentoring are central [12]. Others add feedback and effective integration into communities of practice [13–15]. Stern and Papadakis also emphasize feedback, reflection, and role modeling [32]. Various institutions have developed programs in narrative medicine, appreciative inquiry, mindful practice, guided reflection, and integration of spirituality in medicine for teaching humanistic and professional practice [33–37]. Reflection has received particular emphasis, and official bodies in medicine have called for its incorporation into all levels of professional education [4,9,10,38,39]. Although no inventory has been published, reflections by medical students are now included in the curricula of many schools. As discussed below, many essential elements of the above recommendations were incorporated into the four reinforcing educational methods included in Fig. 1 [17,18,20,23].

## 3. Components of the combined methods model

### 3.1. Experiential learning of skills

Skills are best acquired through deliberate practice. Looking back, we can observe that many elements of deliberate practice

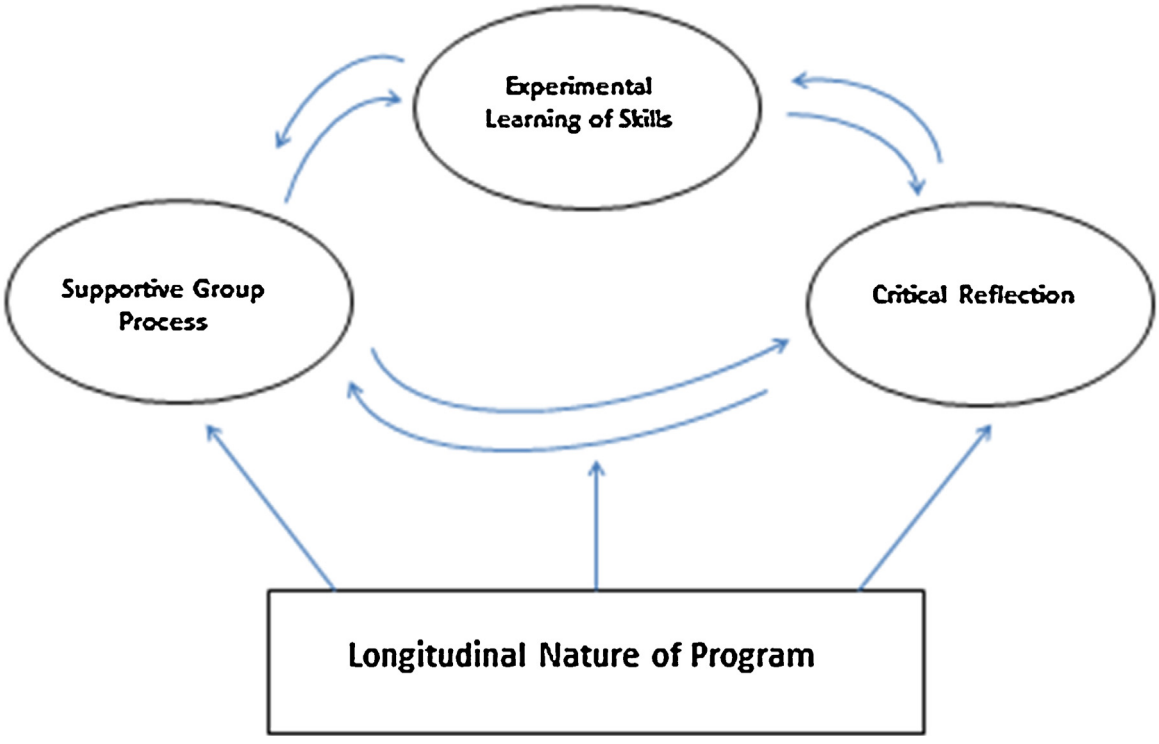


**Fig. 1.** The combined model for teaching professional and humanistic values. Arrows indicate reinforcing elements of the model.