The Humanities, Humanistic Behavior, and the Humane Physician: A Cautionary Note

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Efforts to teach and evaluate humanistic qualities in physicians in residency training are marred by ambiguous goals. The humane physician can be characterized by four distinct qualities: technical competence, humanistic attitude, knowledge of humanistic concepts, and humanistic behavior. Education in the humanities can foster humanistic attitudes, but it cannot promise to lead to changes in behavior. Likewise, although formal training in communication teaches the skills necessary for humanistic behavior, without an understanding of humanistic concepts these skills may not serve medical or moral ends. Evaluation of the humane physician must also include modalities that test attitude, knowledge, and behavior. Testing one characteristic does not ensure competence in other areas; knowledge of the requirements for informed consent, for example, does not guarantee one's ability to discuss this concept effectively with patients. In this article, we suggest ways to combine the humanities and communication skills in the clinical setting and we emphasize both the training and the evaluation of humane physicians.

[Indexing terms: attitude; behavioral sciences; communication; compassion; education, medical, graduate; ethics, medical; humanism; humanities; integrity; internship and residency; interview training; medical school selection process; physician-patient relations; professional competence; respect; role modeling]

> Can you tell me, Socrates, whether virtue is acquired by teaching or by practice; or if neither by teaching nor practice, then whether it comes to man by nature or in what other way.—Plato, *Meno*

STARTING in the early 1970s, medical schools around the United States initiated innovative programs with a lofty goal: the education of a more "humanistic" physician (1). Although these programs have counterbalanced contemporary medical education's overemphasis on technologic expertise (2, 3), the postgraduate (residency) training level has been left unaffected. If residents are not encouraged to integrate medical humanities into their ongoing clinical practice, they may lose sight of the practical value of the medical humanities, and the impact of innovative medical school programs will be lost.

Recognizing this problem, the American Board of Internal Medicine has charged program directors to evaluate medical residents' "integrity, respect, and compassion," the "essential human qualities." The American Board of Internal Medicine's *Guide to Awareness and Evaluation of Humanistic Qualities in the Internist* is intended to "help program directors and their colleagues prepare residents to demonstrate high standards of humanistic behavior" (4). This effort, however, risks self-destruction if ambiguities are not confronted. What defines a humane physician? Are qualities and behavior identical? How does humanistic behavior coincide with humane intent? Finally, can cognitive training in the humanities lead to behavioral goals or should these goals be analyzed as separate concerns in the development of a physician?

Current efforts to train "humanistic" physicians during residency training reflect a lack of consensus on answers to these important questions. Two models are particularly common. First, some programs have hired a humanist, often a philosopher, to teach medical ethics (5). This model often assumes that residents, knowing how they ought to behave, will behave in a more humanistic manner. The second model emphasizes programs in the applied behavioral sciences, typically focusing on communication skills (6). These skills involve the interactive techniques physicians use with patients, which include both behavioral skills, such as empathic vocalization, and cognitive skills, such as listening and interpreting body language, both of which are needed to improve the physician's ability to interact sensitively with patients. This model's underlying assumption is that teaching certain types of objective behavior will make residents more humane. Two such disparate approaches suggest that both the definition of a humane or humanistic physician and the methods used to attain such a goal are as yet unclear.

We clarify these issues in this article by defining the humane physician in terms of specific attitudes, knowledge, and behavior and describing how the humanities and communication skills might be used to train humane physicians. The limitations of using either a purely cognitive or behavioral approach to educate residents are emphasized. Finally, we suggest ways to combine education in the humanities and communication skills that will enhance the effort to train and evaluate humane physicians.

Defining the Humane Physician

Terms such as the *humanities, humanistic, human,* and *humane* are often used ambiguously. To avoid confusion, we propose the distinctions listed in Table 1. The ideal

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Table 1. Requirements for the Humane Physician

Requirement	Definition	Teaching Method	Evaluation
Humanistic attitude	Personal commitment to the dignity and worth of humans	Humanities role modeling	In-depth personal assessment
Knowledge of humanistic subjects	Understanding of disciplines concerned with values and interactions	Humanities communication skills	Paper-and-pencil testing, discussion group
Humanistic behavior	Behaving with respect, compassion, integrity	Interview training, role modeling	Observation of specific behavioral characteristics

goal of medical education is to train humane physicians—physicians who believe in and are capable of expressing respect for the dignity and worth of the human being. These physicians' concern for patients as people is reflected in their entire practice. The following is a description of four distinct qualities that these physicians possess.

Technical competence is implied in the concept of humane behavior; incompetence is inhumane because it betrays the patient's trust in the physician's desire to help and not to harm (7).

Humanistic attitude reflects the personal motivation, founded on specific values, for choosing an action. A physician with a humanistic attitude has a personal commitment to furthering the dignity and worth of his or her individual patients. For example, such a physician wants to discuss informed consent with his or her patient in part because the concept is one that involves respect for the patient's interest in furthering his or her own goals.

Knowledge of humanistic concepts affects the attitudes a physician holds. The humane physician must understand concepts such as autonomy and be knowledgeable about the effect of illness on personal interactions and patients' goals. The humanities and behavioral sciences are the primary sources for such knowledge (8).

Humanistic behavior is the way in which one expresses his or her attitudes and knowledge. A humane physician can effectively communicate respect, integrity, and compassion during interactions with patients and coworkers.

Training the Humane Physician

Given the above distinctions, how can we train humane physicians? Should we require that they receive more education in the humanities? Should residents receive more intensive training in communication skills? Considered individually, these two methods have very different emphases (Table 2). We believe, however, that these methods are interdependent and that training a truly humane physician requires integration of both humanities and communications skills.

Typical disciplines in the humanities include history, philosophy, languages, law, art history and criticism, ethics, comparative religion, and cultural anthropology (8). Expertise in each discipline usually is measured by familiarity with the substantive material and the ability to analyze such material critically. The goal of an education in the humanities is the acquisition of the analytic tools necessary to understand one's values and actions (9). This analytic process is internal to the individual and is expressed primarily through words.

Too often, medical education focuses on organ systems and their malfunctions. If sick persons, and not their diseases, are to be the primary concern for humane physicians, the humanities can be used to repersonalize physicians' biomedical knowledge (10). For example, the study of literature and the arts can be used to allow physicians to "see the diseased person simultaneously from the outside of the body, the inside of the mind, and the experience of the doctor watching the diseased" (11). The study of philosophy can enable students to reason carefully, thus enhancing a crucial but neglected skill in residency education (10). Medical ethics teaches the conceptual foundation of such tenets as "do no harm," informed consent, and confidentiality. Finally, historians can help students understand the relevance of time and place in history taking and the impact of social context on medical care. Such tools of thinking, taught by the humanities, are invaluable for the competent humanistic physician (12).

Still, education in the humanities is not enough. Although able to foster awareness, impart factual knowledge, and encourage critical analysis, the study of the humanities does not promise to lead to changes in behavior. For example, little evidence exists that taking courses in ethics makes one behave more ethically. Furthermore, even knowledge combined with good intentions is not enough. One may believe in a patient's right to self-determination, understand the conceptual requirements of informed consent, and still not fulfill one's obligation to that patient if one is unable to communicate effectively.

In contrast with the goal of education in the humanities, the goal of communications training is the acquisition of certain types of behavior. This training constitutes the behavioral component of education in human values (13). Learning typically is evaluated by the student's ability to interact with patients in the desired manner. Appropriate behaviors may be delineated by empiric observations of patient preferences (14-16) or by using normative models that assume an action's impact on the moral or psychological quality of the encounter between patient and physician (4, 17-19). In either case, the goal is to cultivate certain types of external behavior.

The potential benefit of improved communication skills is immense. Excellent interviewers can obtain significantly better information from patients than can poor ones (20, 21), and patient satisfaction is clearly enhanced by effective interaction between patient and physician (22-25). Moreover, one's ability to elicit information sen-

Table 2. Education of the Humane Physician

	Humanities	Communication Skills
Area of study	A body of knowledge and an analytic approach	Different behavioral characteristics
Goals	Analytic approach, understanding of the nonbiologic aspects of patient care	Skill at translating humanistic ideas and attitudes into humanistic behavior
Measure of competence	Cognition (includes both assimilation of the body of knowledge and the ability to apply effective analytic techniques)	Actions of patients and physicians that can be observed
Evaluators of competence	Expert in the discipline	Those without special training in field, such as patients

sitively (26), show empathy (27), and integrate psychosocial concerns (28) can be enhanced by courses in communication. Competency in these areas alone, however, does not guarantee a humane physician; interactive skills might be used to violate moral or medical ends. For example, a patient may be persuaded to assent to a diagnostic or therapeutic course that conflicts with his or her own values by a physician who appears to be warm and sensitive. Such a physician uses his or her interactive skills to undermine, as opposed to facilitate, patient self-determination. Furthermore, we can all recall the "old-time doc," beloved by all, defended by his or her patients, whose medical skills were 30 years out of date. Yet, on a videotape, both of these physicians could display exemplary interactive skills.

As the above examples illustrate, whereas good intentions without the skills to realize them are medically useless, skills without humane intentions are morally dangerous. Residency too often teaches only the acquisition of technical skills and not the thought behind the action. The result, whether it be the unnecessary placement of Swan-Ganz catheters, or inappropriate interaction between physician and patient, is suboptimal patient care. To rectify this problem, residency training programs must examine intent with the same scrutiny with which they examine behavior.

To avoid these difficult issues, others have suggested alternative ways of increasing the number of humane physicians. The two most publicized methods are role modeling by suitable attending physicians and improving the medical school selection process. Listening to a respected teacher emphasize the humane aspects of patient care reinforces the integral role of humanistic behavior in competent clinical practice. Moreover, the observation of the humanistic behavior of different role models yields a range of behavioral types that residents can incorporate into their own practice style (29). However, role modeling alone does not provide the resident with the skills or knowledge needed to cope with new situations. To gain the flexibility to meet new challenges, the resident must acquire the skills and knowledge that underlie the attending physicians' practices. We think that structured curricula in the humanities and behavioral techniques offer a more effective and efficient approach than does the traditional method of trial and error interactions with patients.

A second alternative to teaching physicians how to be humane is to select students for medical education who already embody the virtues we seek. This effort, reflected in the Association of American Medical Colleges' suggestions to broaden baccalaureate education and to modify admission requirements, is a highly desirable one (30). Unfortunately, no admissions committee has yet proved itself able to select routinely only "virtuous" men and women. Moreover, as the American Board of Internal Medicine points out, the very environment of residency training may be counterproductive because "integrity, respect and compassion are threatened and may be twisted to cynicism, indifference and callousness . . ." (4, 31). In view of such observations, it is unlikely that only virtuous candidates will be accepted for technology-intensive training and returned to the public, years later, as humane physicians.

Residency training programs therefore need to capitalize on the strengths and compensate for the weaknesses of each of the above methods. Education in the humanities provides conceptual foundations and training in the use of the analytic method; the teaching of communication skills emphasizes the learning of humanistic behavior, and role modeling exemplifies the synthesis of these qualities in practice. Together, these three methods represent the opportunity to train truly humane physicians.

Evaluation of Humanistic Qualities

Confusion about the difference between humanistic attitudes, knowledge of humanistic concepts, and humanistic behavior has plagued most attempts to evaluate these attributes in residents. Some programs claim to evaluate a resident's humanistic qualities through the use of paper and pencil tests of knowledge or psychological status (32-34). Although these tests may reflect a resident's intellectual skills and attitudes, any relationship with actual behavior is tenuous: good intentions are far different from good deeds (35). Well-intentioned residents are often ill-equipped for dealing with common impediments to humanistic behavior such as fatigue and institutional bureaucracy (36-38). More commonly, residents may seem inhumane because they cannot communicate their laudable beliefs. Paper-and-pencil examinations will not detect such weaknesses; a better strategy is needed.

The American Board of Internal Medicine believes that the most realistic approach to evaluation is direct observation of residents: ". . . the program director must make a judgement whether or not candidates' professional *behavior* [italics added] manifests the integrity, respect, and compassion that the Board requires for certifi-

cation in internal medicine" (4). Humaneness in a physician requires more than merely humanistic behavior, however. Consider the notion of respect, one of the three qualities for humaneness required by the Board. Is respect a matter of civility that can be behaviorally defined (39)? Patients could tell us whether they felt respected by a physician, and "patient-instructors" might prove useful in the first-order assessment of this quality (40). On the other hand, respect could be a far more complex subject, addressing such moral values as patient autonomy (41, 42). If autonomy is the concern, should we then be more respectful of the patient's current or future state, and should we be more attentive to the compromise in competency induced by illness, or to self-determination, regardless of outcome (43, 44)? Clearly these conceptual problems must be addressed before appropriate behavior can be identified. Otherwise one can visualize a respectful, authority-yielding interaction between physician and patient that fails to address entirely what might truly be in the patient's best interest.

Identifying a lack of integrity presents similar problems. We should be able to detect flagrant examples of deception, but how should we measure the ability to admit uncertainty (45, 46) or the willingness to acknowledge limitations? Are these qualities of self-examination, behavioral characteristics, or both?

We conclude that evaluating humaneness in physicians requires the assessment of characteristics of thought as well as of behavior. We must address attitude, knowledge, *and* behavior before we can claim to have trained truly humane physicians.

Summary and Recommendations

The American Board of Internal Medicine has enhanced the awareness of the need to train humane physicians during the formative years of residency. To do this training effectively, however, will require that program directors be clear about the objectives, teaching methods, and evaluation methods used to train humane physicians. We offer three suggestions toward the improvement of education and evaluation.

GREATER CLARITY ABOUT EDUCATIONAL OBJECTIVES

Developing clear objectives will help instructors select proper teaching techniques and methods of evaluation to realize concrete goals (47-49). Programs should include objectives that concern the attitudinal, cognitive, and behavioral qualities of a humane physician. The recognition that residents need education in all three areas should encourage programs to develop integrated curricula, as opposed to emphasizing only communication skills or only the humanities. Moreover, the categories themselves suggest appropriate methods for teaching or evaluation. For example, consider the care of terminally ill persons. The attitudinal objective that residents should believe in the importance of psychosocial and ethical factors in the care of terminally ill patients could be taught by having residents listen to a humane clinician discuss these issues in the intensive care unit with his or her patient. Cognitive objectives, such as having the resident understand the moral significance and clinical usefulness of the "withhold versus withdraw" and "ordinary versus extraordinary" distinctions would best be taught by someone with expertise in philosophy. On the other hand, a behavioral objective such as the ability to discuss therapeutic options sensitively with a terminally ill patient might best be taught by having experts in communication skills observe the interaction between patients and residents. On any given occasion, one, two, or all three of the areas could be addressed, depending on the teacher's expertise and the resident's needs.

DEVELOPMENT OF NEW TEACHING METHODS

An educational approach that can build on the interrelatedness of the humanities and communication skills needs to be developed. For example, a discussion of William Carlos Williams's *The Use of Force* can illustrate the ethical problem of maintaining respect while achieving a medical diagnosis. Complementing such a discussion, role playing a similar scenario with guidance from the behavioral sciences could equip the resident with the skills needed to cope with the conflict Williams describes (50). Literature and ethics thus become synergistic with courses that teach empathic behavior.

Two caveats must be mentioned: First, a setting in which patient care is rushed and thereby depersonalizing and disrespectful of both caregiver and patient undermines any attempt to train humane physicians. The environment in which residents train must encourage the humanistic attitudes residents are asked to adopt. Second, this new curriculum must be taught in a *clinical* setting, not as an academic discipline composed of theoretical concepts, but as a practical guide to action. This new curriculum must not be separated from the clinical setting. George Agich (51) points out:

> One can teach truth telling by reviewing the arguments regarding patient autonomy, examining the validity of paternalistic justification for nondisclosure and critically treating their limitations. . . . However, this is not the only way to teach truth telling. It can and should be taught in simulated situations and in case conferences or ward rounds. This not only fills out the abstract, theoretical considerations with the reality and complexity of the students' attitudes, beliefs and feelings . . . but brings forward a new set of objectives. In such situations, the problem is first what should the student do?

Our proposal would require addressing ethical and communication issues along with diagnostic and therapeutic decisions on ward rounds or in patient care conferences. Integration into the clinical setting emphasizes the importance of combining humanistic behavior with competent patient care. If one teaches the concept of informed consent in one classroom setting and communication skills in another, the residents may not appreciate the difficulty involved in sensitively discussing risks, benefits, and alternative therapies with sick patients. The clinical environment will also impose on teachers and residents alike the practical constraints of time and place that characterize patient care. This combined method allows the resident to achieve the connection between attitudes, knowledge, and behavior and to accomplish more

successfully the transition from classroom to clinic.

To achieve integrated teaching in the clinical milieu, increased opportunities for faculty development are necessary. Residency programs need a "critical mass" of persons sensitive to issues in the humanities and skilled at teaching and evaluating behavior. These competent clinicians who exemplify humane practice must both be nurtured as role models and encouraged to work with nonclinical faculty in complementary disciplines.

DEVELOPMENT OF VARIOUS METHODS OF EVALUATION

Humanists cannot lose sight of the eventual goal of their research and teaching in the medical context—namely, that of improved patient care. A reliable method for assessing the qualities of the humane physician must be devised. Although behavior is measurable, the ambiguities in identifying precisely what is and is not humanistic behavior remain. Similarly, testable content in the humanities is not the same as humanism in the physician. We must assess both intent (and cognitive awareness of the justifications for the intent) and action (with the behavioral skills required). Neither paper-and-pencil tests of facile cognitive manipulations, nor outdated videotapes of patient and physician encounters will suffice. Educators familiar with the contributions of both the humanities and the behavioral sciences must evaluate residents both as they work and while they participate in reflective discussion. The American Board of Internal Medicine suggests several approaches that in combination could be used in such an evaluation: patient prototypes, rounds, and observation by a senior physician to assess attitudes; paper-and-pencil tests; discussion groups led by an expert in the humanities to assess knowledge and critical analysis; and special observational methods, such as nurse or patient questionnaires to evaluate behavior (4). We intentionally have avoided recommending a specific method for teaching and evaluating the humane physician. Whether any single approach will succeed in all settings is unclear. We believe that programs should experiment with different alternatives and select the one that, given the program's unique environment and resources, works the best for it.

Further research on the humane physician and his or her impact on patient care is needed to develop more effective methods to teach and evaluate residents. The relationship between the humanities and humanistic behavior requires elucidation: for example, what is the relationship between successful performance on tests of humanistic attitudes or knowledge and that on tests of behavior (52-55)? Greater clarity about what characteristics underlie humanistic behavior could be determined by systematic study of the actions and beliefs of humane master clinicians. Once we agree on precisely what we are seeking, we need tests of attitude, knowledge, and behavior that are both reliable and pertinent to the clinical realities of medicine (56, 57). We must develop ways to evaluate the resident's ability to integrate the cognitive, attitudinal, and behavioral qualities needed for humane practice. Ultimately, we must identify the variables of outcome for humane practice, which, when measured, will provide an index of our success in achieving this goal.

Confusion or conflation of humanities, humanistic behavior, and humanism can only impede the effort to train humane and qualified physicians. We must advance in our efforts to delineate carefully the characteristics of the humane physician and to develop appropriate methods to teach them. The limits of each method must be recognized, and the potential for synergy must be acknowledged and encouraged. The challenge of the 1980s (and beyond) for educating "humane physicians" is to develop curricula that introduce integrated teaching and evaluation of the humanities and behavioral sciences into residency training programs.

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