

## Viewpoint: Teaching Respect for Patients

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### Abstract

Respect is a core value of medical professionalism. Respect for patients often manifests itself as an attitude, of which the physician is only partially self-aware. To teach respect means bringing it fully into consciousness. Physicians then should strive to make respect an inner quality, beyond being a behavior. The author illustrates the depth of

feeling involved in respecting another person by citing passages from *Let Us Now Praise Famous Men*, James Agee's classic book that describes Depression-era tenant farmers. However, major barriers inhibit teaching of respect in clinical settings. The author proposes that synergies can be achieved that overcome the barriers by combining the

effective modeling of respect in bedside teaching with formal teaching exercises involving patients and deep critical reflection using narratives wherein learners describe their experiences in patient care.

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*Editor's Note: A Commentary on this article appears on page 415.*

The dress is one of two she would not be ashamed to wear away from home: They are not yet worn-down or ineradicably spotted. In other respects it is like all her other dresses: made at home, of carefully selected printed cotton cloth, along narrow variants of her own designing. . . They are all cut deep at the breast for nursing. . . The lines are all long, straight, and simple.

—James Agee and Walker Evans, *Let Us Now Praise Famous Men*

To respect is to show esteem, regard, or honor to another person.<sup>1</sup> As a fundamental professional value,<sup>2–7</sup> respect should permeate physicians' relationships with patients. But, words like “regard” and “esteem” pale into abstraction when compared to the world of a sick patient, and to our calling, as physicians, to respect each patient's suffering. In seeking to express how one might envisage this, I am reminded of James Agee's descriptions of sharecropper families in his classic book, *Let Us Now Praise Famous Men*.<sup>8</sup> I was deeply influenced by this book in the 1960s and have revisited it throughout my career to renew my appreciation for

truly respecting other persons. Agee made respect for his subjects palpably concrete through his lovingly meticulous descriptions of the intricate details of their lives. By capturing the preciousness of their feelings, often attached to meager but prized possessions, Agee conveyed the individuality of sharecroppers' families in the 1930s. He permeated his descriptions with respect. How can physicians' respect for patients permeate their practices?

In practicing medicine, I have observed that respect often functions as an attitude. Respect or its absence may color interactions with patients in ways of which the physician is not fully aware. Respect, therefore, may receive less emphasis in education than other professional values. And, perhaps because of this unawareness, some clinicians fail to consciously integrate respect into their professional identities. We are disadvantaged in curing ourselves of flaws or enhancing our virtues, unless we are fully aware of them. To illustrate, consider this narrative written by a medical student:

The elderly husband sat miserably outside the cubicle of his wife who was intubated in an intensive care unit. The “team” of physicians and residents having rounded on the patient tramped past the husband who plaintively inquired if he could ask a question. The white coats disappeared down the hall while the husband sat, ignored, in his chair.<sup>9</sup>

Scenes like this are probably familiar to many of us. So much so, that seeing this encounter through the fresh eyes of a third-year medical student can be jarring. I worry that at times, I may grow used to

callous behavior like that displayed by this team, who are probably well-meaning physicians. Acting habitually, they may have been largely oblivious of how they affected this patient's husband. If they reflected on their actions, they probably would admit to acting inconsistently with the professional values they consciously espouse. Do they pay a kind of intellectual “lip-service” to these values, all the while demonstrating that respect (and in this case, also compassion) is not fully integrated into the moral fabric that underlies their actions?

### Importance of Respect in Practice

Outwardly, respect is manifested by behaviors that reinforce a patient's dignity: simply introducing ourselves and explaining our roles carefully; addressing patients as “Mr.” or “Ms.,” rather than using first names; asking permission before examining patients; sitting and making eye contact; paying close attention when patients speak to us; and closing doors and curtains on rounds are well understood ways to convey respect.

Nonintrusiveness is less often emphasized as an aspect of respectfulness. Patients allow physicians unrivaled access to their privacy. This vulnerability of patients must be counterbalanced by respect. Thus, we should expose as little as possible when examining private parts of someone's body and be extremely respectful of confidentiality. We should avoid discussing patients with anyone not involved in their care, and certainly never mention patients in public places.

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Nonintrusiveness may sometimes apply to expressions of empathy and closeness. We should respectfully gauge our empathetic expressions to our patients' states of mind. These expressions create an emotional intimacy, which we are privileged to have with our patients. But just as it would be uncompassionate to fail to respond empathetically to patients' stated fears and anxieties, it would be disrespectful to break down patients' defenses by encouraging them to reveal more personal information and emotional content than they can handle. This capacity to access patients' emotions should be tempered by the physician's judgment. Otherwise, patients might later feel ashamed or emotionally exposed.

To be respectful is also to be humble. Humility may be manifest by making the patient a full partner in decision making. A humble, respectful physician admits mistakes and asks for help from consultants whenever that would benefit the patient.

In a recent teaching exercise addressing cross-cultural communications skills, I was made aware that total honesty with no hint of patronizing when replying to questions may be viewed by minority patients as a test of respect. Trust may largely be won by respectful behavior. Patronizing behavior could represent a particular pitfall for teachers who wish to demonstrate respect. Asking about a patient's family photographs and personal belongings on teaching rounds or inquiries about social life and hobbies entails the risk of sounding patronizing. Yet, when done in a humbly and genuinely respectful manner, like Agee's words, such inquiries express a genuine appreciation of the patient's human worth and dignity.

Nowadays, we sometimes use literature as a teaching method in hopes that reading stories describing humanity's triumphs and travails will broaden our trainees' perspectives. I think Agee's classic book should be required reading.<sup>8</sup> The humble and appreciative detail with which Agee describes his tenant farmers and their families in the 1930s relates concretely to the reader the priceless, unique value of each person, no matter how far removed from the generally privileged, middle-class worlds occupied by many of us. In the following excerpt, Agee seeks an image—carefully folded Christmas

wrappings saved year-to-year—to capture and convey the priceless emotions he senses in a mother, the wife of an impoverished tenant farmer.

... the contents of the bureau drawers. They contain ... in one drawer ... a number of pieces of wrapping paper, each folded separately and very carefully to make no more new creases than is necessary. Some of this paper is dark blue with large gold bells and stars and small gold houses on it. Some is red and green holly on a white ground. Some is plain red or white or green or blue tissue. One is plain brown wrapping paper but has glued to it several seals of santacause and of scotch terriers and of bells in holly garlands. These papers are seamed and ridged over all their surfaces with years of wrapping and unfolding.<sup>8</sup>

Philosophically, respect viewed as a moral value can be derived from treating persons as ends and not means, which underlies the principle of autonomy. Physicians can apply this by appreciating the uniqueness of each patient, wherein we attribute special meaning to his or her life. For example, we can visualize the care with which a poor mother, who could be a patient, folds Christmas wrappings and places them in a bureau drawer, capturing a moment when she probably contemplates her love for each child, for whom the paper once wrapped some humble present, and will be used again, year after year. Here we understand the depth of feelings that make a human being priceless and unique. This understanding may provide readers of Agee's work—and would provide physicians who can achieve a similarly particular understanding of each of their patients—with respect truly interwoven into their professional identity.

Appreciating the autonomy of competent patients, their absolute right to be respected in making their own decisions, is justifiably a linchpin of medical ethics. On the level of closely held personal values, a patient's dignity is fully integrated into a physician's consciousness in part to the extent that the physician appreciates the unique particulars of that patient's life.

### Teaching Respect in Clinical Settings

Ideally, residents and students would function in a milieu permeated by respect. Unfortunately, we have yet to

achieve this.<sup>10–22</sup> But we embrace the goal of incorporating respect into our learners' professional identities. This is not just to teach a concept, but rather to make respecting others how our trainees are, as well as what they profess. I think this requires an ongoing synergy in education, whereby active learning and practicing the skills of respectfully interacting with patients alternates with reflection, the means for embedding the values that underlie skills into our learners' professional identities. Following the model of Donald Schoen, professional education proceeds exactly by practicing skills alternating with reflection.<sup>23</sup> Data from randomized trials show improved outcomes in programs employing similar approaches.<sup>24–28</sup> The challenge for medical educators is how to accomplish these goals on the wards and in the clinics<sup>29</sup> and how to seamlessly integrate humanistic learning into medical teaching, so it becomes a practice, not a theory.

I have set the bar high. A compassionate and respectful attending physician will model most of the behaviors enumerated above as indicative of respect. But, is there enough time to pay homage to each patient's uniqueness, as James Agee would have done? And even so, would our trainees take in and fully appreciate such a scene; wherein for example, an attending physician might listen in detail to part of a life story or elicit with appreciation a patient's feelings about family? Imbuing learners with respect for patients seems no small task. I suggest creating synergies by combining learning at three levels: (1) formal teaching exercises conducted in the clinical setting, (2) bedside teaching done when opportunities arise, and (3) critical reflection in small groups done away from the clinical setting. This combination plumbs the depths of students' values and also puts values into practice. What follows are three examples that illustrate the central role reflective learning plays in teaching at all three levels.

### Eliciting the patient's story: an exercise conducted in the clinical setting

My colleagues and I have termed unusually meaningful learning experiences to be seminal events. These events have profound impact and influence learners' future interactions with patients.<sup>29</sup> Below, such an event is

highlighted. This successful encounter is described by a faculty member teaching first-year medical students interviewing skills:

“I went with four students to interview a woman with AIDS. The patient was confused and lethargic. J, an exceptionally gifted medical student, handled the situation thoughtfully and compassionately, saying that she could see how the woman was tired and hoped talking might be helpful but was willing to let the patient rest. J’s composure equaled that of any staff physician that I have seen.

As we left, feeling disappointed, the patient’s sister entered the room. I perceived that this woman might want something from us, and offered to talk with her in an empty visitor’s room. Here sitting besides the patient’s sister on a couch with myself and four medical students around her, J gently elicited the story of this single woman with two children who was trying to take care of a sick, confused sister. She told of feeling overwhelmed by the needs of those dependent on her, of the disapproval of neighbors prejudiced against persons with AIDS, of her need for a respite. We sat beside this woman while she cried.”<sup>30</sup>

This teaching case, a seminal event for those who participated, also illustrates what I term the “ratcheting up” effect of important learning interactions. The medical student employed a respectful, compassionate approach in the interview with the patient and then the patient’s sister and meaningfully explored the patient’s family dynamics and social history. By approaching this patient with humility, respect, and compassion, it led to a learning experience that solidified students’ commitment to caring and humanistic interactions with patients. Perhaps afterwards the group had the opportunity to reflect on the event, it may have induced an even more profound appreciation of how developing these virtues can benefit future patient interactions. This is an example of transformative learning, which leads to professional growth.<sup>31,32</sup>

Educators believe that reflection on events like this is essential if an educational experience is to foster personal and professional growth.<sup>23,33–37</sup> Reflection could, for example, bring more consciousness into an attitude, such as respect, so that the learners fully appreciate it. Following the interaction described above, an example of posing a

reflective question might be: “What allowed this patient’s sister to be comfortable confiding in us?”

The case described above is part of a program that teaches first-year medical students to interview patients.<sup>30</sup> Could listening to the patient’s story of illness routinely become the focus of clinical teaching rounds? In today’s high stress environment, this seems more likely to be accomplished in a planned exercise like that above than in everyday practice. But incorporation into everyday practice is ultimately the learning goal. For this reason, my colleagues and I, in a previously published paper, suggested integrating teaching focused on virtues, like respect, seamlessly into patient care, which is illustrated in the next example.<sup>29</sup>

### Teaching respect on clinical rounds by role modeling effectively

A hospitalized woman who had abused intravenous substances in the past was refusing a venous cut-down necessary to treat bacterial endocarditis. The attending physician on teaching rounds negotiated learning goals with his team in a very short time.

*Teacher:* “I’ll talk to her. I want to ask for her consent in a way that respects her right of refusal. This sometimes works when a patient is suspicious and hostile. It’s also the right thing to do. Any ideas on how to proceed?” (The teacher has “primed” the learners by stating that demonstrating “respect” for the patient is his/her goal for the interaction.)

*Resident #1:* “I think you should explain the procedure to her in simple language that she can understand.” (Resident #1 demonstrates that she already has some proficiency in patient education.)

*Teacher:* “Well, yes, but first I need to set the stage for that. You can see if this works. I’ll sit by the bedside. I’ll state how tough it is to be in the hospital. This may gain some rapport before I start.” (Teacher describes a specific communication skill for residents to observe.)

*Resident #2:* “Sure, give it a try. She is hard to convince though. We were hoping you could help us.” (Resident #2 signifies that the team agrees with the learning goals.)

*Teacher:* “Once some trust is established, then I can ask her to tell us why she is refusing the cut-down? After that, I’ll be ready to ask if she truly understands why we need to do it. I want to say this in a

way that conveys genuine concern for her.” (Teacher adds additional goals: establishing trust, inquiring about the patient’s understanding of the need for the cut-down, and respectfully conveying concern.)

*Resident #2:* “Okay, we’re ready.”

This teacher then demonstrated that making this patient feel truly respected was the key to winning her informed consent for the venous cut-down. But whether the teacher succeeded was not essential for the learning exercise because “failure” to obtain consent and its ethical implication of respecting her autonomy could lead to a rich discussion. In this case, the teacher succeeded. Sitting by her bedside, listening closely, and showing interest in a humble and respectful way led to sufficient trust so that the patient was willing to discuss her decision not to have the cut-down because of previous difficulty in “getting a vein.” She allowed the teacher to explain why this particular cut-down was important. She consented, provided that an especially competent physician would perform the procedure. The skills and attitudes employed by the teacher were demonstrated transparently to the learners, who were primed to notice and fully understand their use. The teacher should then use reflection to consolidate the team’s learning. Can reflection be done in a clinical setting, “on the fly”? I have previously suggested that a teacher can carefully select one or two questions for a team like this to consider as they gather in the hallway.<sup>35</sup>

The teacher might focus on having the learners *see things through the patient’s eyes* with a question like: “So, what was it like for this patient?” and maybe a follow-up: “What did I convey that helped her to make a decision?” Two questions, a brief discussion, a moment of reflection, and then, the team could move on. Alternatively, the teacher could have decided to invite reflection on the skills and attitudes employed: “Okay, you said this would be difficult, what made it work?” and a follow-up: “So, is there something you can take away to help you in similar circumstances?” In either case, conveying respect for the patient can be an explicit topic of reflective discussion.

One doesn’t form a strong professional identity that embodies respect for patients easily in today’s clinical environment.<sup>16–22,38</sup> Yet, brief interactions with patients and just a few

moments of reflection after these interactions can be cumulatively influential because they are done as part of dealing with patients' clinical problems.<sup>29</sup>

### Opportunities for deep critical reflection: small-group exercises

Formal reflective exercises include critical incident reports,<sup>39–41</sup> narrative exercises,<sup>42,43</sup> and support and discussion groups.<sup>44,45</sup> Because a group's dynamics contribute to the educational effectiveness of intensely reflective exercises,<sup>46</sup> continuity of the groups of learners, so they reflect together over time, enhances effectiveness. Common features that contribute to a positive educational influence of reflective groups include development of trust among group members, whereby they feel comfortable disclosing difficult issues; supportiveness by others when a group member describes difficult experiences; and an opportunity to reframe or gain perspective on experiences.<sup>32,40–46</sup> This leads to reinforcement of participants' sensitivity and commitment to upholding their personal values.<sup>37,38</sup>

A good example of upholding personal values is the narrative written by a medical student that I mentioned earlier in this essay, which describes an elderly husband who sat outside the intensive care unit.<sup>9</sup> The medical student revealed a highly developed sense of moral sensitivity and an empathic identification with the husband. These feelings resulted in an outrage on witnessing the patient's husband being ignored (disrespected) by the doctors. One can readily see how support from a group of other medical students will reinforce the student's holding onto his personal values in the face of the negative influence of an event like this. At some point, the faculty facilitator might have an opportunity to shape the discussion by focusing it on the disrespect shown the patient's husband. A possible reflective question would be: "How do you think this patient's husband felt." One might follow by asking the students if they think that the doctors were fully aware of their disrespect, and asking them to consider how these doctors' actions might affect an observing medical student. Such questions place the interaction in perspective, while simultaneously reinforcing the importance of "respect" as an attitude that should be incorporated into every interaction with a patient.

Deep critical reflection with colleagues on respect for patients and similar personal and professional values provides a method to cement this learning, but I think putting the values into practice is equally important. Hence, the three scenarios provided above illustrate how experiential learning that occurs in clinical settings can combine in a curriculum with reflective exercises. This makes action and reflection on action mutually reinforcing.

### Conclusions

Respect should suffuse a teacher's interactions with patients. When the learning climate is right, clinical teachers should model respect by bringing to light their patient's uniquely human qualities. Whether done by asking about family or personal items, conveying interest in hearing the patient's concerns, or simply listening to the patient's story of illness—if done with sincerity and humility, as I tried to demonstrate using James Agee as a role model, this teaching will convey to students what it means to be a doctor.

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## Did You Know?

Researchers from Emory University School of Medicine developed, in 1994, the antiviral AIDS drug known as 3TC.

For other important milestones in medical knowledge and practice credited to academic medical centers, visit the “Discoveries and Innovations in Patient Care and Research Database” at ([www.aamc.org/innovations](http://www.aamc.org/innovations)).