

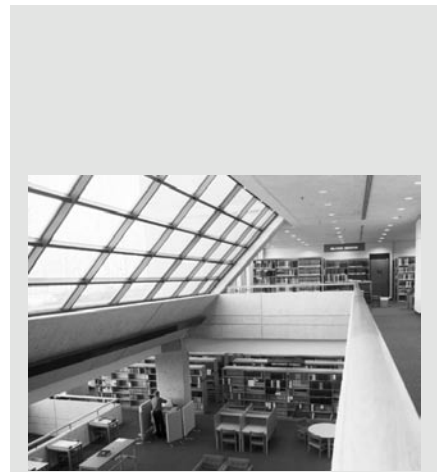
## **Who Benefits when Patients, Families, and Medical Educators Work Together?**

*Medical education programs need new ideas, motivated teachers, affordable resources, and effective teaching methods. In the communities surrounding medical schools and residency programs, there is an untapped source of creative ideas, enthusiasm, and quality teaching. When medical educators partner with patients and families, everyone benefits: medical students, residents, faculty, curriculum planners, patients, and families. Anyone willing to take the initiative to involve patients and families in planning and co-teaching can engage this resource to develop a stronger curriculum, a more effective approach to teaching the professional qualities of medicine, and a more rewarding experience for both teachers and learners.*

## **What Forms the Basis of a Partnership Between Patients and Medical Educators?**

Physicians and patients share a unique and important relationship. Physicians acquire the expertise needed to practice medicine and promote healing with compassion and dutiful commitment, and patients rely on physicians to apply their professional expertise and seek the well-being of their patients. The profession of medicine lays the foundation for this relationship at the societal level through an understood commitment of physicians to seek the well-being of patients. Individual physicians and patients establish relationships with the understanding that the values of the profession will be upheld and medicine will be practiced with technical competence.

Experienced physicians have a responsibility not only to fulfill their duty to patients, but also to convey the expertise, attitudes, and values of the profession of medicine to each succeeding group of medical students and young physicians.<sup>1,2,3,4</sup> Accrediting organizations for both undergraduate and graduate medical education articulate this responsibility through objectives and competencies for medical education, requiring attention not only to the knowledge and skills needed to practice medicine, but also to the professional attitudes and behaviors that are important to relationships, communication, and trust between patients and physicians. Medical educators work within this framework



*Leaders in medical education have called for increased emphasis in medical education on the relationship between patients and physicians.*

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*When medical educators partner with patients and families, everyone benefits: medical students, residents, faculty, curriculum planners, patients, and families.*



of responsibility to meet the challenge of preparing new physicians with the knowledge, technical skills, and professionalism necessary to meet the needs of patients and fulfill the promise of expertise and duty.<sup>5,6</sup>

Most medical educators have experience in teaching knowledge and skills-based material, and can proficiently delineate objectives, develop teaching strategies, and evaluate students' knowledge and skills. Professionalism, integrity in relationships, and other values-based material are more difficult to define and teach intentionally, so educators often rely on implicit modeling to transmit these competencies. Still, medical educators face a challenge as licensing and accrediting boards emphasize competency-based education and evaluation that includes teaching and assessing not only knowledge and skills, but also the values and ethics of the profession. How do we teach and evaluate professional competencies of altruism, dutifulness, and compassion? How do we define these qualities in behavioral descriptors and translate them into effective educational strategies?

One approach is to view these competencies and qualities through the eyes of experienced recipients of health care and tackle the educational challenges in collaboration with patients and families. These natural and important allies can help define competencies in a healthcare context, develop strategies for teaching, share their perspectives with students, and evaluate educational outcomes. This curriculum guide describes collaboration with experienced patients to pursue the aims of medical education. The approach involves writing behavioral descriptors based on the patients' perspective of good physicians and devising activities that allow a relationship to develop between real patients and students in which students can practice those behaviors. This provides opportunities within these relationships for students to experience their own growing capacity for compassion, altruism, dutifulness, and good communication within the context of health care. In such student-patient relationships, students begin to learn and demonstrate values-based competencies. This volume explains and provides examples of this process as applied to medical education.

## Where did this Idea Originate?

During the past twenty years, healthcare planners and administrators have increasingly turned to patients and families for their perspectives on health care and have tried to shape the delivery of health care to better address patients' needs and concerns. For example, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires patient feedback as one essential measure of quality necessary for accreditation of hospitals and other healthcare organizations. JCAHO involved healthcare consumers in the development of its core measures of quality, and JCAHO surveyors speak with patients and family members during accreditation visits in both inpatient and outpatient settings.<sup>7,8,9</sup> Other examples of quality measurement tools that rely heavily on responses from patients and families include those developed by the Foundation for Accountability (FACCT) and the Consumer Assessment of Health Plans (CAHPS) program of the Agency for Healthcare Research and Quality.<sup>10,11</sup> Several years ago, the Picker Institute administered a national survey to nearly 6500 recently-hospitalized patients and analyzed the results to build an understanding of patients' experiences of care and the implications for promoting patient-centered care.<sup>12</sup> The Picker Institute's book, *Through the Patient's Eyes*, translates patients' perspectives elicited through this survey into recommendations for increasing attention to individual patients' needs and increasing the support provided by healthcare environments.<sup>13</sup>

Consumer surveys such as these provide one way to gauge the healthcare needs of the public; patient and family participation in advisory groups provides another. At the local level, patients have participated on patient advisory boards in hospitals and clinics and in social service programs, particularly in settings that provide services for individuals with disabilities and chronic medical conditions. At the state and federal level, policy makers have been encouraged to incorporate the results of consumer surveys when planning changes in healthcare services and to provide opportunities for patients and families to influence healthcare policy and programs.<sup>14</sup> Some authors have suggested that the perspectives of the public should also influence the content of medical education.<sup>15</sup>

*"The future of the professions may increasingly hinge on how professionalism is understood and practiced. If the professions are to have a future, they may need to make their case on the basis of a social and moral rather than a wholly technical understanding of what it is that professionals are about."*

—William Sullivan, 2000, *Canadian Medical Association Journal*

*"There's an art to this. And I'm slowly learning that I'm going to spend the rest of my life figuring out what makes people tick, and it's not just how your heart sounds that day."*

—Jeffrey Lackey  
medical student

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*“Partnering also sets the stage for an atmosphere of mutual respect. Sometimes when a diagnosis is serious, there is very little that the patients/families can control. Mutual respect and open communication between the care provider and patient/families provides a sense of control and involvement that may otherwise be unattainable. It gives the patient/families a feeling of ownership; a right to decide what will or will not work best for them in union with the care providers involved. This ability to participate in one’s own care can be enough to bolster the strength and spirit of the patients/families. Partnering can have a positive impact on the journey and the outcome.”*

–Kathryn Vestermark, parent-advisor



In pediatrics, the importance of developing partnerships and incorporating the perspectives of patients and families has been reflected in the development of family-centered policies and approaches to care. For example, the Maternal Child Health Bureau, Health Resources and Services Administration, U. S. Department of Health and Human Services promotes family-centered care through guidance to Title V programs for children with special healthcare needs.<sup>16</sup> Several groups of healthcare providers have developed, implemented, and assessed approaches to pediatric care that convey respect for the needs and perspectives of parents and other family members.<sup>17,18,19,20,21</sup> Policy statements about family-centered care have emphasized the importance of listening to and learning from the reactions of families of children who receive care.<sup>22,23</sup> In health care for adults, patient-centered communication and physicians’ roles in helping patients negotiate increasingly complex healthcare systems have received heightened attention.<sup>24,25,26,27</sup> Researchers have studied patient/physician communication in detail over the past 30 years, and more current research has begun to investigate the links between patient/physician communication and healthcare outcomes, with findings that demonstrate that better communication leads to better outcomes in areas such as diabetes management and control of hypertension.<sup>28,29,30,31,32,33</sup> Recent work has also explored the quality of partnership occurring in the patient/physician relationship in differing situations, considering patient variables such as race, gender, age, education, marital status, and health status.<sup>34</sup> The combined influence of this research and shared concerns among healthcare providers and patients has led to responses at the national level, such as the inclusion of improved physician communication skills as a goal of Healthy People 2010.<sup>35</sup>

In addition to the emphasis on patient/physician communication, there has been a call for increased involvement of patients in their own health care.<sup>36,37</sup> Researchers have developed and studied the effect of decision aids for patients to promote their involvement in decisions about the treatment of their diseases. They have noted that such involvement is associated with health benefits such as less discomfort, greater alleviation of symptoms, and more improvement in general medical condition.<sup>38,39,40,41</sup> Recent research has begun to explore whether patients and physicians engage in shared decision-making and

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what approaches to communication facilitate shared decision-making.<sup>42,43,44</sup>

Credentialing bodies have responded to these developments in health care by incorporating competencies for communication, professionalism, and relationships with patients in medical education at both undergraduate and graduate levels. The Liaison Committee on Medical Education (LCME) of the Association of American Medical Colleges (AAMC) and the Committee on Accreditation of Canadian Medical Schools (CACMS), which accredit medical schools in the United States and Canada, have deemed communication “integral to the education and effective function of physicians.”<sup>45</sup> Report III of the Medical School Objectives Project is devoted to communication in medicine.<sup>46</sup> Two of the six areas of competency for resident education developed by the Accreditation Council on Graduate Medical Education (ACGME) are devoted to interpersonal and communication skills and professionalism. A third competency area encompasses systems-based practice, and includes a competency concerning advocating for patients in complex healthcare systems. Professional organizations such as The American Board of Internal Medicine (ABIM [Project Professionalism]), the Society for Teachers of Family Medicine (STFM [Future of Family Medicine Project]) and the American Board of Pediatrics (ABP) have also developed efforts to promote professionalism in medical education, underscoring physician qualities such as altruism, accountability to patients, guarding the patient/physician relationship, respect for others, and humanism.<sup>47,48,49</sup> Clearly, leaders in medical education have called for increased attention to the relationship between patients and physicians.

### **How have Medical Educators Responded to these Needs?**

What has been done to address these needs in medical education? How do physicians acquire the attitudes and skills needed to understand patients and families, communicate well, build relationships with patients, behave as professionals, and advocate for patients in complex healthcare systems? Traditionally, this learning has been relegated to the informal “hidden curriculum,” and measurement of results has been difficult.<sup>50,51,52,53</sup> Increasingly, though, contemporary medical educa-

*Educating Future Physicians for Ontario illustrates one way to honor the covenant between the profession of medicine and society.*

*“Medical interviewing justifiably reigns as the premier skill in medicine and is the vehicle for physician-patient interaction and exchange of information in almost all circumstances.”*

—Robert Smith, *et al.*,  
1998, *Annals of Internal Medicine*

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*Project DOCC has involved parents in home visits, interviews, and grand rounds presentations for residents. Bellevue Hospital Center in New York developed an educational experience in a 4-week ambulatory clinic clerkship for third-year students, involving HIV-positive people in group discussions and in providing one-to-one feedback to students after interviews.*

tors are devising ways to integrate content about attitudes, communication, and relationships in the explicit medical school curriculum. Efforts to teach medical students and residents skills for patient/physician communication have emerged and multiplied over recent decades.<sup>54,55</sup>

Medical educators have developed varied approaches to teaching professionalism, communication, and relationships between patients and physicians. Branch uses small group teaching to support moral development and build values among medical students.<sup>56,57,58</sup> Branch and his colleagues also gathered recommendations from educators about teaching methods integrated into the clinical environment, and summarized them in three categories (taking advantage of seminal events, role modeling, and using active learning skills).<sup>59</sup> Other educators have presented recommendations for personal awareness activities for physicians but acknowledged that few such activities occur during medical school or residency.<sup>60,61</sup> Others have integrated narrative into the medical school curriculum by encouraging medical students to both read stories of patients' experiences with illness and write reflections about their observations of patients and their interactions with physicians.<sup>62,63,64</sup>

One response that is receiving increasing attention among medical educators has been to find ways to include additional experiences with patients and families in undergraduate medical education. Some medical schools have provided opportunities for students to spend time with patients and families in home and community settings, where they engage in detailed conversations about life, health, and medical care, thus seeing people live life in their own environments with various health or developmental challenges.<sup>65,66,67,68</sup> A few medical education programs have involved patients and families in teaching roles.<sup>69</sup> Delbanco *et al.* have included patients as presenters and discussants about their own clinical cases and have developed a video series showing patients and their physicians discussing clinical situations.<sup>70</sup> Project DOCC (Delivery of Chronic Care) has involved parents in home visits, interviews, and grand rounds presentations for residents.<sup>71,72</sup> Bellevue Hospital Center in New York developed an educational experience in a 4-week ambulatory clinic clerkship for third-year students, involving HIV-positive patients in group discussions and in providing one-to-one feedback to students after interviews.<sup>73</sup> Elderly patients have partici-

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pated in dialogs with residents about practical challenges of health care, and mothers have been trained to observe medical students' interviews and provide feedback.<sup>74,75</sup> Other roles for patients and families include sharing personal stories, performing skits for residents, including medical students and residents as companions and observers during health-care visits, instructing alongside faculty, and providing opportunities for these learners to offer respite care for families.<sup>76,77</sup>

Recently a few medical educators have elicited and integrated the perspectives of the public about medical education. In 1998, the AAMC conducted a survey regarding the public's expectations of medical education.<sup>78</sup> A more extensive effort not only gathered public perceptions but also implemented a series of changes in medical education at five medical schools throughout the decade of the 1990's in Ontario, Canada. This project, Educating Future Physicians for Ontario (EFPO), solicited the views of the people of Ontario through surveys, interviews, and focus groups, identified eight physician roles, and developed and implemented curricular strategies to equip medical students to fill these roles.<sup>79,80,81</sup> The Royal College of Physicians and Surgeons of Canada's Council also convened a societal needs working group to develop the CanMEDS 2000 project. This project applies the eight physician roles of EFPO to education for physician specialists.<sup>82</sup> These examples illustrate one way to honor the covenant between medicine and society—by actively seeking the perspective of those who receive medical care and developing ways to modify medical education with their contributions and engagement.

Still, overall, there has been limited involvement of patients and families in the development of content for medical education or in teaching at medical schools. An approach that advances a partnership between medical educators, patients and families, and medical students from concept to implementation could prepare physicians to understand and better respond to the needs of patients and families and thus to meet the expectations of society. Medical educators together with patients and families, through joint planning and ongoing conversation, could discover content and approaches to teaching and learning that might otherwise be missed.

*“The greatest challenge in improving the teaching of professionalism is to modify the internal culture of the academic health center so that it better reinforces the values that medical educators wish to impart.”*

—Kenneth Ludmerer, 1999, *Journal of the American Medical Association*

*“While there is growing consensus that a collaborative approach humanizes the service delivery system, improves outcomes for children, and results in greater satisfaction for both providers and families, the partnership paradigm is radically different from the client/provider relationships in which most professionals were schooled.”*

—Elizabeth Jeppson and Josie Thomas, 1995, *Essential Allies: Families as Advisors*

## **How can a Partnership Between Patients and Medical Educators Advance?**

Ideally, medical educators, medical students, and practicing physicians would identify and incorporate the values and perspectives of patients and families into the practice and teaching of medicine. They would identify their own attitudes about patients and families and their attitudes about the nature of relationships between physicians, patients, and families. Building on this foundation, they would develop communication skills that enable them to understand the needs of patients and families and of patients' goals and priorities. Such an approach may better prepare physicians to respond to patient cues during each healthcare encounter and to fill their role as an advocate for patients and families within the healthcare system. In this way, the covenant between the profession and society could be honored through educational experience.

Medical students could learn with patients and families as partners in medical education. Medical educators could develop competencies for medical education with advisory input from patients and families, develop strategies for teaching collaboratively with patients and families, and teach competencies about communication and patient/physician relationships jointly with patients and families. Such an approach would provide a model of collaboration throughout the years of medical school and across the medical school curriculum. It would set the stage for continuing collaborative relationships between future patients and practicing physicians.

### **One Approach to Advancing the Partnership**

What would such an approach look like in practice? One approach would be to develop an advisory group of patients and families to share their perspectives about medical care and patient/physician interactions and then participate in developing and teaching educational experiences across the curriculum. Over the past few years in the F. Edward Hébert School of Medicine at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, we have begun to integrate activities into the existing medical school curriculum, involving students



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in all four years of medical school in educational activities with patients and families.<sup>83</sup> In their role as advisors, patients and families have helped to define content, develop plans for educational activities, co-teach, and participate in evaluation. These patient and family advisors have been involved not just in administrative planning, but in interactions with medical students and faculty in the context of courses and clerkships and in evaluating the results of their efforts.

In the pages that follow, we describe a process for working with patient and family advisors in this way, with examples of curriculum activities that have been developed collaboratively. At another medical school, the particular needs of patients in the community surrounding that school may be somewhat different, and the details of the curricular applications may vary. Nevertheless, we aim to provide enough detail about the program developed at the Uniformed Services University to make the process clear and replicable and to motivate and equip others to launch similar efforts at other medical schools.

*“When parents of special needs children interact with medical students, something very special happens. Myriads of insightful experiences and teachable examples unravel before the students. The power of common sense, simplicity of understanding, and the approach of partnership become reasonable goals rather than the exception. Uninhibited by professors and free to question without intimidation, medical students benefit from real-life testimonials of experienced parents. In turn, parents are buoyed by offering their pearls of wisdom to the next generation of physicians during the short but strategic window of influence in medical school.”*

—Colleen O’Brien, parent-advisor

*“What is being done with this project at [The Uniformed Services University] is one of the best things happening in medical education in the US today.”*

—Sue Fisk, parent-advisor



## References

1. Ludmerer KM. Instilling professionalism in medical education. *JAMA*. 1999;282:881-2.
2. Crawshaw R, Rogers DE, Pellegrino ED, et al. Patient-Physician Covenant. *JAMA*. 1995;273:1553.
3. Sullivan WM. Medicine under threat: Professionalism and professional identity. *Can Med Assoc J*. 2000;162:673-5.
4. Cruess SR, Cruess RL. Professionalism: A contract between medicine and society. *Can Med Assoc J*. 2000;162:668-9.
5. Pellegrino ED. Toward a virtue-based normative ethics for the health professions. *Kennedy Institute of Ethics Journal*. 1995;5(3):253-77.
6. Pellegrino ED. *Humanism and the Physician*. Knoxville, TN: University of Tennessee Press; 1979. p. 224.
7. Joint Commission on Accreditation on Healthcare Organizations. A comprehensive review of development and testing of a national implementation of hospital care measures. Available at [http://www.jcaho.org/pms/core+measures/cr\\_hos\\_cm.htm](http://www.jcaho.org/pms/core+measures/cr_hos_cm.htm). Accessed November 23, 2003.
8. Joint Commission on Accreditation on Healthcare Organizations. Accreditation Process for Ambulatory Care. Available at <http://www.jcaho.org/accredited+organizations/ambulatory+care/survey+process/index.htm>. Accessed September 15, 2005.
9. Joint Commission on Accreditation on Healthcare Organizations. Accreditation Process for Hospitals. Available at <http://www.jcaho.org/accredited+organizations/hospitals/survey+process/index.htm>. Accessed September 15, 2005.
10. Foundation for Accountability: Quality Measures. Available at <http://www.facct.org/facct/site/facct/facct/Measures>. Accessed November 25, 2003.
11. Agency for Healthcare Research and Quality. Available at <http://www.ahrq.gov/qual/cahps/depti.htm>. Accessed November 25, 2003.
12. Cleary PD, Edgman-Levitan S, Roberts M, Moloney TW, McMullen W, Walker JD, Delbanco TL. Patients evaluate their hospital care: A national survey. *Health Affairs*. 1991;10:254-67.
13. Gerteis M, Edgman-Levitan S, Daley J, Delbanco TL. *Through the Patient's Eyes. Understanding and Promoting Patient-Centered Care*. San Francisco, CA: Jossey Bass; 1993.

## 1. Advancing a Partnership: Patients, Families and Medical Educators

14. Jeppson ES, Thomas J. *Essential Allies: Families as Advisors*. Washington, DC: Institute for Family-Centered Care; 1995.
15. Evans JR. The “Health of the Public” approach to medical education. *Acad Med*. 1992;67:719-23.
16. McPherson M, Weissman G, Strickland BB, van Dyck PC, Blumberg SJ, Newacheck PW. Implementing community-based systems of services for children and youths with special health care needs: How well are we doing? *Pediatrics*. 2004;113:1538-44.
17. Hanson JL, Randall VF. Evaluating and improving the practice of family-centered care. *Pediatr Nurs*. 1999;25:445-9.
18. Medalie JH, Zyzanski SJ, Langa D, Stange KC. The family in family practice: Is it a reality? *J Fam Pract*. 1998;46:390-6.
19. Moore KAC, Coker K, DuBuisson AB, Swett B, Edwards WH. Implementing potentially better practices for improving family-centered care in neonatal intensive care units: Successes and challenges. *Pediatrics*. 2003;111:450-60
20. Saunder RP, Abraham MR, Crosby MJ, Thomas K, Edwards WH. Evaluation and development of potentially better practices for improving family-centered care in neonatal intensive care units. *Pediatrics*. 2003;111:437-49.
21. Garwick AW, Kohrman C, Wolman C, Blum RW. Families’ recommendation for improving services for children with chronic conditions. *Arch Pediatr Adolesc Med*. 1998;152:440-8.
22. Schor EL, Billingsley MM, Golden AL, et al. Family pediatrics: Report of the Task Force on the Family. *Pediatrics*. 2003;111:1541-71.
23. American Academy of Pediatrics Committee on Hospital Care and Institute for Family Centered Care. Family-centered care and the pediatrician’s role. *Pediatrics*. 2003;112:691-6.
24. Daley J. A 58 year-old woman dissatisfied with her care. *JAMA*. 2001;285:2629-35.
25. Sams WM II. The corroding of our core. *J Am Acad Dermatol*. 1998;38:983-6.
26. Rusnak CH. Am I still proud to be a surgeon? *Am J Surg*. 2002;183:493-8.
27. Beaudoin C, Maheux B, Cote L. Clinical teachers as humanistic caregivers and educators: Perceptions of senior clerks and second-year residents. *Can Med Assoc J*. 1998;159:765-8.

“Once the students realize it’s not just about medicine, but about compassion and common sense, they realize how important it is to administer total care to people.”

–Carolyn Jordan-Alexander,  
parent- and patient-advisor

“The scientific successes of modern medicine, with new life-sustaining treatment and the potential for genetic manipulation, highlight the need for effective communication and respectful collaboration with patients and families.”

–Barbara Blaylock, 2000,  
*Families, Systems and Health*

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“Despite rhetoric about increasing partnership in the consultation, shared decision making (SDM) is not necessarily happening in practice.”

—Fiona Stevenson, 2003, *Patient Education and Counseling*

“Patients and physicians face new opportunities and challenges as they work together to make healthcare decisions. Efforts to make care more patient-centered coincide with an emphasis on evidence-based decision-making and greater access to healthcare information of variable quality.”

—Karen Sepucha and Albert Mulley, 2003, *Patient Education and Counseling*

28. Smith RC, Lyles JS, Mettler JA, et al.: A strategy for improving patient satisfaction by the intensive training of residents in psychosocial medicine: A controlled, randomized study. *Acad Med.* 1995;70:729-32.
29. Lipkin M Jr., Putnam SM, Lazare A. *The Medical Interview. Clinical Care, Education, and Research.* New York, NY: Springer-Verlag; 1995.
30. Stewart MA. Effective physician-patient communication and health outcomes: A review. *Can Med Assoc J.* 1995;152:1423-33.
31. Stewart M, Meredith L, Brown JB, Galajda J. Communication between older patients and their physicians. *Clinic Geriatr Med.* 2000;16:25-36.
32. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. *Journal of Family Practice.* 2000;49:796-804.
33. Di Blasi A, Harkness E, Ernst E, Georgiou A, Kleijnen J. Influence of context effects on health outcomes: A systematic review. *Lancet.* 2001;357:757-62.
34. Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. *JAMA.* 1999;282: 583-9.
35. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Communicating Health: Priorities and Strategies for Progress. Action Plans to Achieve the Health Communication Objectives in Health People 2010.* Washington, DC: U.S. Department of Health and Human Services; 2003.
36. Hughes TE, Larson LN. Patient involvement in healthcare: A procedural justice viewpoint. *Med Care.* 1991;29:297-303.
37. Drossman DA. Psychosocial sound bites: Exercises in the patient-doctor relationship. *Am J of Gastroenterol.* 1997; 92:1418-23.
38. O'Connor AM, Rostom A, Fiset V, et al. Decision aids for patients facing health treatment or screening decisions: Systemic review. *Br Med J.* 1999;319:731-4.
39. Sepucha KR, Mulley AG. Extending decision support: Preparation and implementation. *Patient Educ Couns.* 2003;50:269-71.
40. Graham ID, Logan J, O'Connor A, et al. A qualitative study of physicians' perceptions of three decision aids. *Patient Educ Couns.* 2003;50:279-83.
41. Brody DS, Miller SM, Lerman CE, Smith DG, Caputo GC. Patient perception of involvement in medical care: Relationship to illness attitudes and outcomes. *J Gen Intern Med.* 1989;4:507-11.

## 1. Advancing a Partnership: Patients, Families and Medical Educators

42. Wills CE, Homes-Rovner M. Patient comprehension of information for shared treatment decision making: State of the art and future directions. *Patient Educ Couns.* 2003;30:285-90.
43. Stevenson FA. General practitioners' views on shared decision making: A qualitative analysis. *Patient Educ Couns.* 2003;50:291-3.
44. Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. *Br Med J.* 1999;319:766-9.
45. Barkun H. Integrating communication skills in medical education. *Can Med Assoc J.* 1995; 153:739-40.
46. Association of American Medical Colleges. *Report III: Contemporary Issues in Medicine: Communication in Medicine.* Washington, DC: Association of American Medical Colleges; 1999.
47. American Board of Internal Medicine. Project Professionalism. Available at <http://www.abim.org/pubs/profess.pdf>. Accessed November 23, 2003.
48. Kahn NB. The future of Family Medicine: A collaborative project of the Family Medicine community. *Ann Fam Med.* 2004;2:S3-S32.
49. American Board of Pediatrics. *Professionalism and Vignettes on Professionalism.* <http://www.abp.org/resident/profguid.htm> and <http://www.abp.org/resident/profvign.htm>. Accessed October 7, 2004.
50. Hundert EM. Characteristics of the informal curriculum and trainees' ethical choices. *Acad Med.* 1996;71:624-33.
51. Wear D. On white coats and professional development: The formal and the hidden curricula. *Ann Intern Med.* 1998;129:734-7.
52. Hafferty FW. Beyond curriculum reform: Confronting medicine's hidden curriculum. *Acad Med.* 1998;73:403-7.
53. Hundert EM, Hafferty F, Christakis D. Characteristics of the informal curriculum and trainees' ethical choices. *Acad Med.* 1996;71:624-42.
54. Aspegren K. BEME Guide No.2: Teaching and learning communication skills in medicine: A review. *Med Teach.* 1999;21:563-71.
55. Smith RC, Lyles JS, Mettler JA, Stoffelmayr BE, VanEgeren L, Marshall AA, Gardiner JC, Maduschke KM, Stanley JM, Osborn GG, Shebroe V, Greenbaum RB. The effectiveness of intensive training for residents in interviewing: A randomized controlled study. *Ann Intern Med.* 1998;128(2):118-26.

*“Competence as an internist comprises not only medical knowledge, clinical judgment, and clinical skills including proficiency in performing certain procedures, but also the professional attitudes and behavior which are the foundation for success as a physician.”*

—American Board of Internal Medicine, 1995, *Project Professionalism*

*“The practice of medicine combines the life sciences with humanism. 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.”*

—William Branch III et al., 2001, *Journal of the American Medical Association*

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“Physicians personal characteristics, their past experiences, values, attitudes, and biases can have important effects on communication with patients; being aware of these characteristics can enhance communication.”

—Dennis Novack et al., 1997,  
*Journal of the American Medical Association*

“A heightened awareness of the role of family dynamics allows a more compassionate and understanding approach to all patients and families affected by chronic illness.”

—Cheryl Conaster and Hilary Babcock, 1993, *Cancer Practice*

56. Branch WT II. Supporting the moral development of medical students. *J Gen Intern Med.* 2000;15:503-8.
57. Branch WT II. Small-group teaching emphasizing reflection can positively influence medical students' values. *Acad Med.* 2001;76:1171-3.
58. Branch WT II. The ethics of caring and medical education. *Acad Med.* 2000;75:127-32.
59. Branch WT II, Kern D, Haidet P, et al.. Teaching the human dimension of care in clinical settings. *JAMA.* 2001;286:1067-74.
60. Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C. Calibrating the physician: Personal awareness and effective patient care. *JAMA.* 1997;278:502-9.
61. Novack DH, Epstein RM, Paulsen RH. Toward creating physician-healers: Fostering medical students' self-awareness, personal growth and well-being. *Acad Med.* 1999;74:516-20.
62. Charon R. Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA.* 2001;286:1897-1902.
63. Charon R. Narrative medicine: Form, function, and ethics. *Ann Intern Med.* 2001;134: 83-7.
64. Branch W, Pels RJ, Lawrence RS, Arky R. Becoming a doctor—critical-incident reports from third-year medical students. *N Engl J Med.* 1993;329:1130-2.
65. Andrew NR, Siegel BS, Politch L, Coulter D. Teaching medical students about children with developmental disabilities. *Ambulatory Child Health.* 1998;4:307-16.
66. Widrick G, Whaley C, DiVenere N, Vecchione E, Swartz D, Stiffler D. The medical education project: An example of collaboration between parents and professionals. *Children's Health Council.* 1991;20:93-100.
67. Schaechter JL, Canning EH. 'Pals' : A medical student public service program. *West J Med.* 1994;161:390-2.
68. Conatser C, Babcock HM. Children with cancer and medical students teach each other. *Cancer Practice.* 1993;1:110-5.
69. The Pickering Institute. “Clinical Crossroads:” A new road for patients in medical education. *The Picker Report.* 1995; 9.
70. Delbanco TL, Daley J, Walzer J, Winker MA. Clinical crossroads: An invitation. *JAMA.* 1995;274:76-7.

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71. United Hospital Fund. Project DOCC. Available at [http://www.uhfnyc.org/pubsstories3220/pubs-stories\\_list.htm?attrib\\_id=7687](http://www.uhfnyc.org/pubsstories3220/pubs-stories_list.htm?attrib_id=7687). Accessed December 15, 2003.
72. United Hospital Fund. Fund teams up with family experts to improve quality of care. *Blueprint*. 2003;Summer: 1-2.
73. Vail R, Mahon-Salazar C, Morrison A, Kalet A. Patients as teachers: An integrated approach to teaching medical students about the ambulatory care of HIV infected patients. *Patient Educ Couns*. 1996;27:95-101.
74. Katz AM, Conant L, Jr., Inui TS, Baron D, Bor D. A council of elders: Creating a multi-voiced dialogue in community of care. *Soc Sci Med*. 2000;50: 851-60.
75. Stillman PL, Sabers DL, Redfield DL. Use of trained mothers to teach interviewing skills to first-year medical students: A follow-up study. *Pediatrics*. 1977;60:165-9.
76. Blaylock BL. Patients and families as teachers: Inspiring an empathic connection. *Families, Systems and Health*. 2000;18:161-75.
77. Hanson JL, Randall VF, Colston SS. Parent advisors: Enhancing services for young children with special needs. *Infants and Young Children*. 1999;21:17-25.
78. Neely SK. *What Americans Say About the Nation's Medical Schools and Teaching Hospitals. Report on Public Opinion Research Part II*. Washington, DC: Association of American Medical Colleges; 1998.
79. Neufeld VR, Maudsley RF, Pickering RJ, et al. Demand-side medical education: Educating future physicians for Ontario. *Can Med Assoc J*. 1993;148:1471-7.
80. Neufeld VR, Maudsley RF, Pickering RJ, et al. Educating future physicians for Ontario. *Acad Med*. 1998;73:1133-48.
81. Maudsley RF, Wilson DR, Neufeld VR, et al. Educating future physicians for Ontario. *Acad Med*. 2000;75:113-26.
82. The Royal College of Physicians and Surgeons of Canada. Skills for the new millennium: Report of the societal needs working group. *CanMEDS 2000 Project*. Available at <http://rcpsc.medical.org/canmeds/index.php>. Accessed November 23, 2003.
83. Randall VF, Hanson JL. The family competency project. *Acad Med*. 2000;75:529-30.

*“As medical practice moves in the direction of balancing technological imperatives with a renewed focus on the interpersonal aspects of clinical care, patients and families offer valuable resources for the education of health professionals.”*

—Barbara Blaylock, 2000,  
*Families, Systems and Health*

*“In an era of ‘medical care delivery systems,’ there is an increasing need for the patient’s voice to be heard, for it to be invited, listened to, and taken seriously.”*

—Arlene Katz et al., 2000,  
*Social Science and Medicine*

