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### Family Perspectives

## How physicians draw satisfaction and overcome barriers in their practices: “It sustains me”

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### ABSTRACT

**Objective:** Major reorganizations of medical practice today challenge physicians' ability to deliver compassionate care. We sought to understand how physicians who completed an intensive faculty development program in medical humanism sustain their humanistic practices.

**Methods:** Program completers from 8 U.S. medical schools wrote reflections in answer to two open-ended questions addressing their personal motivations and the barriers that impeded their humanistic practice and teaching. Reflections were qualitatively analyzed using the constant comparative method.

**Results:** Sixty-eight physicians (74% response rate) submitted reflections. Motivating factors included: 1) identification with humanistic values; 2) providing care that they or their family would want; 3) connecting to patients; 4) passing on values through role modelling; 5) being in the moment. Inhibiting factors included: 1) time, 2) stress, 3) culture, and 4) episodic burnout.

**Conclusions:** Determination to live by one's values, embedded within a strong professional identity, allowed study participants to alleviate, but not resolve, the barriers. Collaborative action to address organizational impediments was endorsed but found to be lacking.

**Practice implications:** Fostering fully mature professional development among physicians will require new skills and opportunities that reinforce time-honored values while simultaneously partnering with others to nurture, sustain and improve patient care by addressing system issues.

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### 1. Introduction

Major reorganizations in medical practice today create unique stressors, including physicians' experiencing loss of control of their practices, inadequate time with patients, bureaucratic administrative requirements that diminish face-time with patients, and epidemic levels of burnout affecting physicians and other care-

providers [1–14]. Aspirationally, medicine is a moral enterprise guided by standards that require sacrifice and emotional energy to achieve the respectful, compassionate, culturally sensitive humanistic relationships that are therapeutic for patients, families, and others [15–21].

To help physicians approach these professional standards, it is important to understand factors that sustain and impede them. For example, burnout, reflecting stress in the practice, has become epidemic among physicians [11]. Bodenheimer and Sinsky proposed that improving the work life of physicians and other healthcare providers should join population-based health, patient experience and cost control as a fourth aim of the health care

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system [22]. A central component of coping with stress is finding meaning in one's practice, which enhances resilience and resistance to burnout [23,24]. Our study analyzes the central issue of meaning versus frustration in medical practice by addressing the sustaining and impeding factors to humanistic practice as a source of meaning [18]. We explored these factors in a group of faculty who had completed a multi-institutional faculty development program in humanism [25–27]. We studied these physicians because as humanistic exemplars, we expected their reactions would amplify our understanding of how stress in practice affects physicians' abilities to navigate change, to practice humanistically and thereby find meaning. This information should enable us to suggest strategies to enhance medical humanism [17,19].

Conceptually, we adopted the perspective of professional identity formation, ways of being and relating professionally that occur during the life course of physicians: how they develop their mature values and social identities over time [28–35]. We utilized Kegan's model where, at the highest level, self-internalized values, principles and standards guide mature physicians, who have become well adapted and socialized into their community of practice [28,29]. Kegan's theoretic and empirically studied model provides an ideal framework for studying humanistic physicians' responses to today's stressful practice environment.

Although medical humanism or its lack in medical students and residents has been explored previously, the focus has generally been on the negative side [36–38]. Only one other study identified motivating factors to embody humanism in medical school faculty members [39]. Chou interviewed 16 “highly humanistic” faculty members at a single institution [39]. However, no studies have examined this issue using larger samples across institutions or have used more open-ended questions to elicit humanistic physicians' perceptions.

We asked study participants to write reflectively about what motivated them to practice humanistically, and the barriers that limited them. We employed qualitative thematic analysis of their responses to elucidate impediments, and having done so, to shed light on a key question for medical practice: what factors and strategies enable faculty physicians to provide humanistic care despite impediments?

## 2. Methods

### 2.1. Subjects and settings

Study participants at eight medical schools had completed a one-year small group faculty development program designed to enhance their humanistic teaching and role modeling [25,26]. Site leaders/facilitators at each school (the investigators) identified and enrolled in the small groups, eight to twelve physician faculty members who were recognized as promising and respected clinical teachers and practitioners in their respective fields, were recommended by their department chairs, and often held leadership roles in educational and clinical programs (Table 1).

Our faculty development program employed twice-monthly, 90 min, small-group sessions over one year to enhance humanistic teaching and role modeling by following a curriculum described in our previous publications [25–27]. The curriculum employed a combination of experiential learning, critical reflection, and supportive group-process [27]. Previously published evaluations showed that completers of the program were judged by their learners to be superior to matched controls on the validated humanistic teaching and practice evaluation questionnaire (HTPE) [25,26,40].

Table 1 shows that most study participants were female, were Instructors or Assistant Professors, were less than 45 years of age,

**Table 1**  
Characteristics of the Study Physicians and their Reflective Responses.

Institutions	Female/ Male	Ages years	Ranks	Held Leadership Role <sup>a</sup>	Word Count Reflections Motivators	Word Count Reflections Barriers
#1	6/5	<45: 72% ≥45: 28%	Assistant/Instructor	100% 91%	Range: 15–154 Mean: 54 Median: 53	14–124 60 69
#2	7/3	<45: 60% ≥45: 40%	Assistant/Instructor	100% 50%	Range: 7–528 Mean: 135 Median: 74	2–196 76 57
#3	10/5	<45: 71% ≥45: 39%	Assistant/Instructor (1 Fellow) 86% Associate/Professor 14%	71%	Range: 32–205 Mean: 71 Median: 67	30–169 79 58
#4	3/7	<45: 70% ≥45: 30%	Assistant/Instructor (1 Resident) 60% Associate/Professor: 40%	80%	Range: 29–181 Mean: 127 Median: 114	35–273 126 106
#5	8/2	<45: 88% ≥45: 12%	Assistant/Instructor: 88% Associate/Professor: 12%	90%	Range: 15–221 Mean: 99 Median: 88	35–236 117 108
#6	1/1	<45: 0% ≥45: 100%	Assistant/instructor: 100%	100%	Range: 95–197 Mean: 146 Median: N/A	83–227 180 N/A
#7	1/2	<45: 100% ≥45: 0%	Assistant/Instructor 66% Associate/Professor 33%	66%	Range: 77–165 Mean: 119 Median: 115	224–127 66 47
#8	4/3	<45: 43% ≥45: 57%	Assistant/Instructor 57% Associate/Professor 43%	57%	Range: 60–229 Mean: 99 Median: 105	45–175 87 110
Totals	40 (59%) /28 (41%)	<45: 69% ≥45: 31%	Assistant/Instructor 85% Associate/Professor 15%	71%	Range: 7–528 Mean 93 Median: 95	2–273 87 91

<sup>a</sup> Examples: Assistant/Associate Dean, Assistant/Associate/Full Program Director or Clerkship Director.

and held leadership roles in their teaching programs. About one half of the study participants was primary care providers (general internists, pediatricians, or family physicians) and the remainder was from medical specialty practices.

## 2.2. Data collection

Using the Arnold P. Gold (a Foundation dedicated to the promotion and study of medical humanism) definition to provide a commonly shared, working description of medical humanism, participating faculty at the eight schools were provided with these instructions by the site leaders for their privately written reflective responses: “ ‘Humanism in health care is characterized by a respectful and compassionate relationship among physicians, their patients, and other members of the health care team. It flourishes within a humanistic culture. A humanistic health care professional demonstrates integrity, excellence, compassion, altruism, respect, empathy, and service [19].’ Please answer from your personal experience in the boxes below. Consider your hopes, goals, motivations and rewards. Your answers should be at least a paragraph in length and could be a longer essay.”

The two prompts were: 1. “What motivates you to practice and teach humanistically?” and 2. “What are the barriers that limit your ability to be humanistic?” The returned responses were given unique identifiers to maintain anonymity. The study was either exempted or approved by the Institutional Review Boards of all participating institutions.

Sixty-eight of 92 participating faculty, who had completed our course between 2013 and 2015 at the eight schools, submitted responses to the invitation (74% response rate). These included 11/16 from school #1, 10/10 from #2, 15/17 from #3, 10/10 from #4, 10/12 from #5, 2/17 from #6, 3/3 from #7, and 7/7 from #8 (Table 1). Our method of collecting demographic information and written reflective responses by emailed questionnaire was preceded by verbal instructions from the local facilitator. We adopted the method to capture the essence of their thinking from our large number of participants without sacrificing detail. A rapid reading of the responses revealed that the data collected in this way was quite rich and warranted further analysis. The word counts of their responses generally conformed with instructions (Table 1).

call on six occasions and compared themes and insights from ten to twelve subjects’ reflections on each call. After several calls, investigators reached general agreement on their coding of responses. Investigators were not assigned responses from their own schools, but all participated in the discussions. Themes and their illustrative phrases were identified by consensus, recorded, and iteratively revised on subsequent calls as new sets of responses were compared with the previous ones that had been coded. We did not limit the number of themes that could be coded from a single reflective response. Coding in writing, using a spread sheet, allowed us to see all themes including those embedded in long responses that expressed several themes. By the fifth conference call, we reached thematic saturation where no additional themes were identified. To check the trustworthiness of the coding, another author (JPH) reviewed the data and analysis on an additional conference call [43]. Complete agreement was attained with no additional themes identified.

## 3. Results

### 3.1. Motivating factors

#### 3.1.1. Themes (Table 2)

Five themes were identified by consensus of the investigators. The first theme was mentioned by far most frequently; remaining themes were ranked by their perceived connectivity to the first theme: 1. identification with humanistic values: *It is who I am*; 2. providing the same care that I or my family would want; 3. connection to patients; 4. passing on my values through role modeling; and 5. being present in the moment. Themes were often linked and reinforced one another. We present the most cogent illustrative quotes below with additional quotes supporting our analysis listed in Table 2.

#### 3.1.2. Identification with humanistic values

*It is who I am*: Almost all study-participants believed that their humanistic values were bedrocks of their professional identities.

The following extract expresses the thought processes of a study participant striving to be humanistic. In the long quote, key phrases corresponding to themes are outlined in grey. This participant described “the kind of physician she aspires to be”, which she linked to her family background. A related theme linked to her identity as a humanistic physician was her personal role models:

Narrative	Coding
<i>I am motivated by a desire to be the kind of physician that I thought I would be when I applied to medical school...in my daydreams, I saw myself as the kind of doctor who cared for patients, brought comfort to them, and was contributing to the good of world. I also feel the influence of all the people who supported and encouraged me...I am deeply sincere when I say that the times when I felt most humanistic as a physician were also the times I know I would have made my mother most proud...</i>	Who I am (Values)  Personal role models

## 2.3. Data analysis

We employed the constant comparative method for thematic analysis of the 68 study participants’ reflective responses [41–43]. Four investigators (WTB, AW, MAG and DKL) met by conference

#### 3.1.3. Providing the same care that I or my family would want

This quote captured the essence of the theme:

*I cannot imagine treating anyone different than I would want myself or a loved one to be treated.*

**Table 2**  
Motivation for Humanistic Practice: Illustrative Themes and Quotes.

Theme	Illustrative Quotes
Identification with humanistic values	<ul style="list-style-type: none"> <li>• <i>It is who I am.</i></li> <li>• <i>I saw myself as the kind of doctor who was contributing to the good of the world.</i></li> <li>• <i>Truly at the core of who I am.</i></li> <li>• <i>I was raised to do the right thing.</i></li> <li>• <i>I wanted my children to see me as a good person.</i></li> <li>• <i>(I want my) patients to notice compassion and concern.</i></li> <li>• <i>(Humanism) enables healing to occur.</i></li> <li>• <i>Patients deserve full effort to address concerns.</i></li> </ul>
Providing the same care that I or my family would want <sup>a</sup>	<ul style="list-style-type: none"> <li>• <i>Lying on a gurney traversing the very halls I had walked for decades was eye-opening. . (allowing me) to feel firsthand what it is like to be vulnerable and scared.</i></li> <li>• <i>To do (for my patients) what I or my family would want</i></li> <li>• <i>To treat others as you'd like to be treated</i></li> </ul>
Connection to patients	<ul style="list-style-type: none"> <li>• <i>Connection leads to satisfaction and rewards of doctoring.</i></li> <li>• <i>Leads to highest quality care, leads to best teaching</i></li> <li>• <i>Patients are fearful and vulnerable and in pain and want to feel connected.</i></li> <li>• <i>Without the connection we will fall short.</i></li> <li>• <i>Respected patients are happier</i></li> <li>• <i>(T)he joy of connections.</i></li> </ul>
Passing on (my) values by role modeling	<ul style="list-style-type: none"> <li>• <i>To serve as a role model motivates me to teach humanistically. This pushes me to show (humanism) to my trainees no matter how stressful or how busy things are.</i></li> <li>• <i>It is of great importance to incorporate humanism into my daily practice and to enable it to be passed on to generations of future doctors so that patients are cared for optimally and physicians become better people and practitioners.</i></li> <li>• <i>(T)o pass on to generations</i></li> <li>• <i>(S)howing the importance of teaching others about families and social background</i></li> </ul>
Being in the moment	<ul style="list-style-type: none"> <li>• <i>(E)xternal issues go to the background and patients are treated with one's full attention and the respect that they deserve.</i></li> <li>• <i>Calm, thoughtful, achieves more, less uncomfortable</i></li> <li>• <i>There are no barriers because I focus on the moment.</i></li> </ul>

<sup>a</sup> A personal experience of illness was a potent motivating factor for providing patients with the same care one would want for oneself or one's family.

### 3.1.4. Connection to patients

Many physicians expressed the belief that close, rewarding relationships with patients provided protection against burnout: *It (my relationship with patients) fills me up instead of emptying me out; it sustains me.*

### 3.1.5. Role modeling

Passing on my values through role modeling was mentioned by many study participants as motivating them to sustain humanism. One participant harkened back to the role modeling he received from his teachers but also developed his thoughts about role modeling for others, passing his values to learners:

Narrative	Coding
<p><i>I value those whose practice affects me and those who taught me humanistically. The memory of my best teachers and care providers is vivid amongst the many experiences I have had... I hope to provide that to others and perpetuate a culture where that is the norm for interactions - both in healthcare and in teaching.</i></p>	<p>Personal role models</p> <p>Passing on values</p>

### 3.1.6. Being present in the moment

As described in their reflections, presence was a sustaining factor for humanism in that it diminished stress; hence, some study participants cultivated presence and calmness to remain humanistic:

Narrative	Coding
<i>...demands on one's time can be high...I try to give the patient and family as much time as they need to understand a diagnosis, the rationale for treatment, and future steps. If one believes that clinical care is of utmost importance, as I do, then external issues go to the background and patients are treated with one's full attention and the respect that they deserve.</i>	Being present

### 3.2.2. Stress

Stress, fatigue and feelings of inadequacy interfered with study participants' desire to learn about their patients including social, family, and cultural issues:

*Pressures leave me stressed and not feeling the human being I want to be.*

### 3.1.7. To summarize

One study participant's reflections interwove four themes while describing joy in her practice. This participant had been afflicted with a debilitating chronic condition in childhood and thus had been exposed to the medical care system during her formative years:

*(Given) limited resources . . . (I) avoid bringing up topics . . . (such as) financial hardship.*

*I often lose heart because their psychosocial problems are so far reaching that it is tempting to focus on little physical symptoms I can fix.*

Some admitted to delivering suboptimal care at times under these conditions and felt “drained” when encountering complex patients:

Narrative	Coding
<i>...I was a child diagnosed with (deleted). Very shortly after my initial diagnosis at age 7...When doctors treated me with respect and compassion, I ...wanted to emulate it...I was always interested in how physicians spoke to me...my role models were those doctors who treated patients humanistically and I became very interested in working with children whose medical and developmental issues made it harder for people to recognize their humanity. Practicing humanistically means forging a connection with each patient and family as a human being... As I work with students, residents, fellows, and other faculty, it is important to me to share the joy of making those connections...It is through modeling and discussion that I try to help students.</i>	Experience of illness Role models Who I am (values) Connection Role modeling

## 3.2. Barriers to humanism

Four themes in order of frequency emerged as impediments to humanistic practice (Table 3): 1. time, 2. stress, 3. culture, and 4. episodic burnout.

### 3.2.1. Time

Time was ubiquitously cited by the study participants as a limiting factor. For example, when asked to identify the most important barrier, one said:

*Time, time, time!*

Others identified a host of logistical barriers as related and contributing to insufficient time:

*... distractions, personal issues that intrude on work, rushing, paperwork, phone calls, and the electronic record.*

*I think that the biggest barrier is time and frustration within the medical system. The amount of work and pace that we have to function at along with the pressures that being a primary care physician put on us creates an environment that fosters cynicism and anger.*

*A difficult patient at the end of a busy day can be a burden.*

### 3.2.3. Culture

Study participants' comments typified frustrations related to the prevailing culture of the medical practice. Culture functioned like a hidden curriculum embedded in the practice:

*This comes through in jargon (e.g., “noncompliant”), in how we treat each other as professionals, in how people are compensated for their work, and in the silent judgments we make about certain patients.*

*...I want to reveal the poisonous hidden curriculum in order to better counter it.*

A cultural clash between business values and the study participants' humanistic values highlighted a perceived organizational barrier, constituting a kind of hidden bureaucratic curriculum of the practice:

*I feel judged by administrators, pressure to accomplish as much as possible, have to hit the mark, others are not humanistic and have different expectations.*



**Table 3**  
Barriers to Humanistic Practice: Illustrative Themes and Quotes.

Themes	Illustrative Quotes
Time	<ul style="list-style-type: none"> <li>• (Given) limited resources. . (I) avoided bringing up (issues)</li> <li>• Rushing</li> <li>• Time, resources, insurance, paperwork</li> <li>• The electronic record, paperwork, phone calls</li> <li>• Mundane phone calls</li> <li>• Intrusions: computers, checklists, meaningful use</li> <li>• The system (time)</li> </ul>
Stress	<ul style="list-style-type: none"> <li>• Distractions, stress, anxiety</li> <li>• Fatigue, feeling demoralized</li> <li>• Personal issues that intruded on work</li> <li>• Demoralized by busy work</li> <li>• Fatigue and time pressure</li> <li>• Frustrated when fatigued,</li> <li>• Topics (such as patients') financial hardship</li> <li>• Resources, insurance, dictating) messes them up</li> <li>• Patients are (sometimes) sad, angry or ungrateful.</li> <li>• A difficult patient at the end of a busy day can be a burden.</li> <li>• Drained by heartbreaking situations</li> <li>• Overwhelming to care for a very sick patient population</li> <li>• Emotionally taxing experiences</li> <li>• Psychosocial problems too difficult</li> </ul>
Culture	<ul style="list-style-type: none"> <li>• Aggressive Socratic questioning, not compatible with humanism, difficult to break culture</li> <li>• Perverse culture fosters cynicism and anger</li> <li>• Learners don't get it (i.e., humanistic practice).</li> <li>• (L)earners – don't see it as a priority, not enough buy-in</li> <li>• (W)hen staff are negatively stereotyping</li> </ul>
Episodic burnout and discouragement	<ul style="list-style-type: none"> <li>• Burnout during weeks that are stressful/overbooked.</li> <li>• ... defensive, protect themselves</li> <li>• Surrounded by colleagues who are burned out. I have also been burned out.</li> <li>• Physical and mental fatigue lead to burnout, not taking time to prioritize</li> <li>• Stress and personal issues.</li> <li>• Burnout makes practitioners not practice humanistically.</li> <li>• Fatigue and burnout</li> </ul>

Some expressed a determination to practice and teach humanistically but viewed themselves as swimming upstream against the dominant culture:

*Most have suboptimal role models. I want to be the opposite role model.*

The following longer quote expressed the complex interrelationships between the many stressful physical, emotional, and cultural barriers:

#### 3.2.4. Episodic burnout

Participants used the word “burnout” to describe feelings transiently associated with times that “are stressful and overbooked” (see Table 3).

Feeling intermittently burned out was alleviated in some study participants by being present or centered and finding meaning through role modeling humanism:

Narrative	Coding
The barriers that limit my ability to be humanistic are varied. There are the physical ones – if I am overly fatigued or hungry or have caught one of the pediatric bugs in the hospital and don't feel well, it becomes more challenging to attend to the needs of a child and family. There are emotional barriers in that same vein as well – if I am feeling stressed or worried about something else that can spill into my ability to be humanistic...time can be a barrier as can discontinuity and other issues in the system (it may be a good visit with me but then the family has trouble reaching me after a visit, etc.). A culture that seems to value research and clinical “productivity” over humanistic care can be a barrier as well.	Physical stress Emotional stress Time Culture

Narrative	Coding
<i>When I am most in touch with the meaning of my work, I am less likely to feel burned out, and more likely to feel centered and present in daily interactions. It also enables me to do my best work when I am truly thinking about the importance of what I am doing—even for the most mundane tasks. One of my contributions to society and the future is helping to foster a sense of humanism and meaning in those that I train. Teaching them and modeling for them is what makes this profession special and worthy of the amount of commitment...</i>	Being present  Role modeling

### 3.2.5. To summarize

The following quote expressed the inverse relationship between time, stress, bureaucratic culture, and the ability to be humanistic:

of control over their workload and practices, which has been linked to physician career satisfaction [8].

Several study participants wrote about feeling “drained” by complex patients, who might have benefited most from having therapeutic relationships; other physicians used the word

Narrative	Coding
<i>Honestly, personal fatigue, feeling drained of my own spirit at times and just not feeling like I have anything to give. Being judged by hospital administrators by crude metrics such as parking costs, wait times in the lab, quality of hospital food), etc., and even the patient driven measures seem to not pick up on any humanism. Satisfaction surveys pick up dissatisfiers (sic) that have nothing to do with me and my care in the encounter. Waiting times, and surgical outcomes count, but less so my acts of compassion or care. I am scored by the pressure to hit these marks, which qualify me as good or bad. This can fuel a need to be technically perfect more so than compassionate and empathetic. This might mean I spend less time with patients, and feel rushed with learners...</i>	Stress  Bureaucratic culture     Bureaucratic culture  Time

## 4. Discussion

### 4.1. Observations of the study participants

Study participants voiced their commitment to being humanistic despite facing multiple barriers. They seemed committed to humanistic practice because it “sustained” them, suggesting that humanism provided meaning and was core to their professional identities as physicians, “It is who I am” [27–32].

Humanistic care was often at odds with policies designed to improve efficiency and productivity. These policies created a bureaucratic culture filled with frustration and dissatisfaction for the physicians. The tensions created in a bureaucratic culture that did not include or value humanistic precepts constituted a hidden curriculum, experienced by the subjects as antithetical to the traditions of the profession and a commitment to humane care [15–21,44–48]. Barriers included inadequate time to build relationships with patients and attention taken away from patients by required paperwork, logistics and the electronic medical record. In their reflections, the study participants never indicated any sense

“burnout”. They seemed to be describing episodic stress and fatigue. Only one study participant mentioned ongoing burnout as defined in the literature [7,10–13]. This low prevalence of chronic burnout suggests the possibility that strongly held humanistic values provided meaning to their work, a source of resilience [23,24]. This and other tools for dealing with stress could be usefully employed as preventative measures to help cope with the day to day stresses and strains of practice and avoid the more debilitating effects of chronic stress on performance [13].

Sustaining factors included a deep sense of responsibility to be role models, expressed as an unselfish, perhaps altruistic, desire “to pass their humanistic values and the rewards of humanistic practice to their students”, and to teach the benefits of therapeutic physician/patient connections and relationships [49]. These physicians had been taught to forge strongly therapeutic connections with their patients by communicating empathy, compassion and respect [19,50–55].

Study participants sustained their humanism and coped with the stress and the pace of practice by “being present in the moment”. Mindfulness programs are reported to lower the incidence of burnout and stress [56,57]. However, the study participants

reported a kind of “*presence*” unrelated to formal training in meditation and most likely self-taught. Further studies of this approach as a strategy for maintaining humanism in practice should prove useful to practitioners.

We felt it important to communicate the effort, commitment, and passion of the study participants. Humanistic practice required a huge effort by the physicians to live by their values. To convey this, we employed longer quotes in our Results section than are usual in qualitative research papers to provide more of the context, emotion and thought processes of the physicians.

This passion for maintaining humanism is one of two overarching observations that emerged from the data. We observed that humanistic professional values were deeply integrated into the physicians’ professional identities enabling them to maintain their commitments to humanistic practice [28–35]. Our previously published studies suggest that completing the Humanistic Faculty Development Course likely contributed to study participants’ strongly embedded values and professional identities, making them humanistic exemplars, e.g., “It is who I am” [25–27,48]. We can interpret this observation from the viewpoint of Kegan’s stages of professional identity formation [28,29,34,35].

Table 4 shows Kegan’s highest three stages of identity formation as reflected in his and others’ most recent writings [28,29,34,35]. We view these stages chiefly through two lenses: developing personal values and social role formation. We examined the data in relation to Kegan’s work and observed that many study physicians had reached Kegan’s highest stages of internalizing the values of the profession and acting on principle [28,29,34,35]. The study physicians applied their self-chosen standards and values to govern their relationships with patients.

Although the motivators and sustaining factors helped alleviate stress and frustration, our findings show that they did not eliminate the stressors. In their social roles as professionals, the study participants described turmoil and dissatisfaction as opposed to the confident ability to seek and solve problems, lead while appreciating others’ viewpoints, and negotiate conflicts that is indicative of Kegan’s highest stages of social role formation outlined in Table 4 [28,29,34,35]. Whereas the study physicians mentioned administrators and some colleagues negatively (see Results, Table 3), we found no mention of collaborative relationships or negotiations between study physicians, other professionals, and administrators to address the barriers to humanistic practice. This is our second overarching observation. Study physicians portrayed themselves as isolated individuals heroically placing their fingers in the dike and hoping that their individual humanism would save the day. In a time of disruptive change, many study physicians seemed to function at Stage 3 in the component of professional identity related to assuming the social role of physician within their community of practice. We speculate that they were prepared by their training for social roles within certain older parameters of practice, but were ill-prepared to cope with the rapid changes documented in today’s practice environments [2–14]. Kegan and others have postulated that the ability to adapt one’s role to new circumstances, to negotiate and problem-solve in collaboration with others while maintaining one’s core identity and values may be necessary in today’s environment if one wishes to achieve a rewarding career and optimal patient care [29]. Given of the implications of these findings, how individual physicians address organizational and cultural barriers is an important area for further research.

We recommend that physicians along with other professional caregivers channel their advocacy for benefiting their patients into

**Table 4**  
Kegan’s Stages of Professional Identity Formation.

Stage 3 The Socialized Mind	<p>Social Role:</p> <ul style="list-style-type: none"> <li>• Team Player who takes others’ views into account</li> <li>• Reliant, but own needs and emotions may predominate</li> </ul> <p>Values, Principles and Standards:</p> <ul style="list-style-type: none"> <li>• Faithful follower who obeys the rules and seeks direction.</li> <li>• Not self-reflective.</li> </ul>
Stage 4 The Self-Authoring Mind	<p>Social Role:</p> <ul style="list-style-type: none"> <li>• Leader who learns to lead by problem-solving, sharing obligations with others, and subordinating self-interest</li> <li>• Creates and directs an agenda or strategy</li> <li>• Can subordinate emotions to do the right thing</li> </ul> <p>Values, Principles and Standards:</p> <ul style="list-style-type: none"> <li>• Chooses principles and values to live by</li> <li>• Identity with the profession and its values incorporated into the self</li> <li>• Independent but may put the interests of others before the self</li> <li>• Idealistic and self-reflective</li> </ul>
Stage 5 The Self-transforming mind	<p>Social Role:</p> <ul style="list-style-type: none"> <li>• Can step back and consider alternative points of view and strategies, can hold and consider contradictions</li> <li>• Assesses relationships in terms of personal values but considers different viewpoints</li> <li>• Understands different values and expectations in relationships</li> <li>• Leader leads to learn and is problem-finding</li> <li>• Reason controls emotions</li> </ul> <p>Values, Principles and Standards:</p> <ul style="list-style-type: none"> <li>• Values of the profession are internalized but open to values of others, has a more fluid self-identity</li> <li>• Can place the interests of society above self-interests</li> </ul>

Adapted from: Kegan R. The Evolving Self. Problem and Process in Human Development. Harvard Univ Press, Cambridge, MA and London, England, 1982. Kegan R and Lahey LL, Immunity to Change: How to Overcome it and Unlock the potential in Yourself and Your Organization, Leadership for the Common Good, Center for Public Leadership, John F. Kennedy School of Government, Harvard Business Press, 2009. Cruess RL, Cruess SR, Boudreau D, Snell L, Steinert Y, A schematic representation of professional identity formation and socialization of medical students and residents: Guide for medical educators, Acad Med. 2015;90:718–725.



**Table 5**  
Recommendations for Fostering Humanism in Healthcare and Enhancing Motivators for Humanism.

Identification with humanistic values:		
Strategy	Explanation	Rationale
Re-connecting physicians with “who they are” and why they chose medicine	Capturing stories that exemplify the positive professional identity (who we are when we are at our best), using these stories in teaching with reflective learning (appreciative inquiry narratives) or by opening faculty meetings by asking for a brief story of something that went well in your work (called “appreciative check-in”)	Most physicians have a strong sense of identity and purpose when they enter the profession. But as the profession changes, physicians may struggle to maintain that sense of purpose that first brought them to the profession. These core values, the “who we are” in our work, ground our behaviors. Keeping that identity front and center is how we choose our actions.
Providing the same care that I or my family would want:		
Connection with patients:		
Foster connection with patients: Cultivate the value of treating patients like family.	Using the lens of treating patients like family (rather than as customers) can help physicians to rediscover the joy of doctoring, and refocus the way we approach patient care, the language we use, and the way we portray our work.	Physicians talk about patient care differently than business people talk about customers. The examples of “treating people like family” recognizes the shared vulnerability and fear we all have as humans, which is amplified when we become patients.
Passing on values through role modeling:		
Creating opportunities for role modeling and passing on values	Faculty may want to brainstorm creative ways to teach and model humanism in the current environment. Error disclosure, peer support, providing avenues for addressing critical incidents for students and faculty, capturing stories of humanism, are some examples.	Physicians describe teaching and modeling humanistic behaviors as also re-kindling humanism for themselves. Physicians must remember, they are always role modeling. Physicians also need to intentionally and explicitly model humanism. We teach this active role modeling by role play with coaching and feedback.
Being in the moment:		
Study and teach self-awareness and mindful and reflective practice along with communication skills. We recommend experiential learning using role play, feedback, coaching and reflection in the context of facilitated faculty development groups.	Faculty enrolled in longitudinal small-group learning such as our study participants have been shown to perform superiorly as humanistic role models and teachers. Self-awareness and mindful practice can be learned.	Stress is diminished by mindful, reflective practice. These skills and habits once learned become powerful tools for teachers to model for learners.
<b>Addressing Barriers to Humanism in Healthcare</b>		
Time, logistics, and structural limitations of practice, creating stress, fatigue, and feelings of inadequacy:		
Redouble efforts to make patients the center of care prioritizing time with patients as an individual and organizational goal. Partner with administrators and other health care providers to realize this goal.	Healthcare institutions may need to restructure work to allow clinicians greater time (and more flexibility of time) with patients. The previously accepted 15–20 min standard visit template may need to be changed if we want to foster humanistic care.	Time with patients has been reduced perhaps beyond the tolerable by business forces. This minimization may now be backfiring, resulting in reduced physician and patient satisfaction with care. Physicians feel that a major barrier to humanism is lack of time. That time pressure creates an environment that fosters cynicism and anger. Without addressing this fundamental issue, behavioral training will likely fail.
Partner with administrators and other health care providers to maximize “face” time with patients and minimize distractions e.g., interruptions, excessive use of the EMR and computer screen	As the number of administrative tasks physicians are required to complete has increased along with pressures for through-put the sanctity of the physician patient relationship has been eroded. One way to maximize time is to remove any distractions from the face to face time, tasks that others on the healthcare team can be empowered to complete.	Limited time is exacerbated by multiple conflicting tasks that erode the face to face time: phone, EMR, paperwork. Evidence suggests that multi-tasking is potentially harmful to the doctor- patient relationship and may be associated with physician burnout.
Maximize complementary team function Teach the skills of teamwork	Doctors cannot solve every problem. A high functioning multidisciplinary team can use multiple professions to address difficult socioeconomic, psychosocial problems that impact patient's health and medical challenges.	Recognizing the impact that social factors have on medical and health issues, physicians feel great frustration at not being able to adequately address these social, economic and psychological issues. Sharing this work on high functioning teams can achieve better outcomes for patients.
Culture antithetical to humanism:		
Complement the prevailing business culture with a focus on meaning and purpose Work with administrators and other professionals to adopt this goal for the practice	Add meaningful outcomes that reflect the deeper purpose of health care to metrics that measure profit and volume.	Prioritizing volume and profit alone undermines humanistic behavior and demoralizes professionals who are motivated by a deeper purpose.
Feeling drained by patients:		
Give physicians tools for coping with difficult patient encounters	Habits of reflective practice, mindfulness and motivational interviewing are examples of relational tools important for dealing with difficult encounters.	Humanistic behavior is often lacking in situations where the physician feels helpless, and lacks the tools to deal with the challenges effectively.
Burnout and discouragement:		
Address burnout directly with a variety of interventions: participation in a supportive group, mindfulness (formal training or sharing tools), fostering positive emotion, fostering meaning.	Literature on burnout suggests that interventions like mindfulness, focusing on meaning, restructuring work, and enhancing positive emotion, can reduce burnout. Leaders can promote these.	Burnout among physicians is at critically high levels. Addressing burnout through a variety of mechanisms could be critical in fostering humanistic behaviors. This may then create a “virtuous cycle” where humanistic behaviors then lead to a reduction in burnout.

working with institutional leaders to make their practices more humanistic as others have also suggested [1,58–60]. This calls for high level social and professional development, indeed. Few people in the general population, mostly in middle age, are said to reach Kegan's stage 5. [29]. Consequently, we plan to strengthen the teamwork and social role development components of our faculty development program. Table 5 summarizes our consensus recommendations, organized along the lines of this study's findings and reflecting our experience as faculty developers, for collaborative means of sustaining humanism and reforming practice organizations.

#### 4.1.1. Limitations of the study

Our sample of study participants may inadequately reflect the attitudes of nonacademic physicians or faculty members who did not join a humanistic faculty development program. However, our study is relatively large and multi-institutional so provides a good picture of motivators and barriers to humanism as seen by physicians of this caliber. Learning about the motivations and limitations of study physicians who are exemplars of humanism can identify the best practices for inculcating and maintaining humanistic attitudes, and can also identify the issues, even in highly motivated physicians, that need to be addressed. This is an important point, because our goal was to study these exemplars as a means to identify issues and suggest improvements that are likely to help sustain humanism generally in medicine.

Our cross-sectional study design prohibited follow-up to elaborate on the data. Chou had identified habits of humanism in her study that partially overlapped with those we identified [39]. However, Chou used a semi-structured protocol that probed preselected factors such as self-reflection and work-life balance, while in our study a larger number of subjects responded to open-ended questions, which did not limit their reflections to specific avenues of inquiry. Our faculty development program likely influenced the study participants' responses. Nevertheless, although interference between our curriculum and study participants' identified motivations may exist, incorporation of humanistic values into professional identity, which emerged most strongly as the source of meaning and sustainer of medical humanism, is an aspiration not unique to our curriculum.

#### 4.2. Conclusions

Our study suggests two important conclusions: 1. we provide data to support the central role of professional identity formation in humanistic practice and teaching by physicians (others have advocated this [28–35], but providing well-analyzed data is important); and 2. we show that even highly developed humanistic physicians may not see the big picture regarding collaborative leadership in their social roles, even though expressing dissatisfaction with their practice organization. One image that comes to mind from the responses we received is that these highly humanistic physicians are somewhat like the main character, Smith, in Alan Sillitoe's novel, "The Loneliness of the Long Distance Runner" [61]. Smith derives strength, expertise and power through perseverance, hard work and remaining true to his value of being incorruptible. At the end of an important race, in which he is leading, he stops just short of the finish line and lets his competitors win to demonstrate that he alone holds the key to his success. In contrast to Smith, and as gleaned from our study participants' reflections, to optimally function in the clinical and social role of a physician today requires more than individual skill and effort. Patient care today is a team sport that includes other physicians, healthcare professionals and administrators, without relinquishing humanistic values. Reflecting on the comments

provided by our study participants convinces us that these are pressing clinical issues affecting patient care.

#### 4.3. Practice implications

Fostering fully mature professional development among physicians will require new skills and opportunities that reinforce time-honored values, while simultaneously developing partnerships with others to nurture, sustain and improve patient care by addressing system issues.

#### Conflicts of interest

None.

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#### IRB approval or exemption

Yes.

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