R-E-S-P-E-C-T: Even More Difficult to Teach than to Define

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"Respect" is a word like "empathy", "love", and "compassion", that everyone agrees connotes a positive attribute; however, there are innumerable ideas about what respect means. Perhaps the reason it is so difficult to define is because it can mean different things to different people, depending on whether it is being used as a verb or as a noun, on the person's cultural background, and the context in which it is being discussed. For instance, when a parent tells a teenager "to show some respect" the meaning is somewhat different than when philosophers talk about "respect for persons". Aretha[1] put it very simply: "R-E-S-P-E-C-T, find out what it means to ME!"

Still, it is useful to examine why and how a physician can show respect to patients. After all, the American Board of Internal Medicine's *Medical Professionalism in the New Millennium: A Physician Charter* mentions "respect for patient autonomy" as a core principle and the *Project Professionalism* states that "Respect for others (patients and their families, other physicians, and professional colleagues such as nurses, medical students, residents, and subspecialty fellows) is the essence of humanism, and humanism is both central to professionalism and fundamental to enhancing collegiality among physicians."[2,3] In this issue of JGIM, Beach et al attempt to define the object of physicians' respect and what respect requires[4]. They believe autonomy is too limited as the object of our respect because it seems to make respect conditional on whether we admire a patient's values, and because it limits our obligation to those patients who lack autonomy. They propose that it is a physician's moral duty to respect all patients equally as persons, as a professional extension of one's universal duty to respect all people because of their "unconditional intrinsic value as human beings." They go on to describe this respect as bidimensional; that is, the concept of respect is both an attitude and a set of behaviors that one *ought to have* as a physician. Both dimensions, they argue, are morally required of physicians.

This article is likely to be widely read and discussed. Whereas philosophers may argue about whether their concept of autonomy is biased, we agree that respect should not be contingent on a patient's lifestyle or health decisions. For medical educators who are charged with training respectful physicians for the future, the article raises questions about the barriers to respect, how to teach respect, whether a focus on behavior is sufficient, and what behaviors constitute respect. We will focus our attention on these issues.

PROFESSIONAL RESPECT IS NOT INNATE

It is important to point out that in everyday life, it is common to hear one say "In order to have my respect, you have to earn it." In common vernacular, respect and admiration are synonyms. Respect is not unconditional regardless of one's personal characteristics, behaviors, or intentions. We see examples of this on TV and the Internet, in the grocery store, and even among our own family members. If you ask people on the street who they respect, they may name someone famous, someone whom they aspire to be like or who is accomplished in their field, or perhaps someone who is altruistic or who has "done good." Rarely will they tell you that they respect "everyone."

So perhaps the first factor that we must recognize as educators is that we cannot expect trainees to both think and act respectfully from the start of their training as physicians, simply because they *ought to* as professionals. Similar to the other duties a physician has, such as the mastery of a large amount of medical information and the honing of physical examination skills, the duties of professionalism, including respect for patients, require learning, constant practice, reinforcement, and improvement.

Inherent in this acknowledgment is the necessity for educators to voice their awareness of how hard it can be to respect patients, particularly those from whom they are different. Learning to be a doctor involves becoming an expert—acquiring massive amounts of knowledge and then learning to apply it to promote a patient's health. After all that hard work, it may feel frustrating or demeaning to trainees when patients do not follow their advice, or even worse, contradict their professional or personal values. Learning to respect patients who do not "respect" you is difficult. It becomes doubly difficult when you are sleep-deprived, overworked, and feel you will never know enough to be a competent physician[5–7].

TEACHING RESPECT

How can one teach respect given the reality of medical education? First, we can role model respect in our behavior *toward the students*. If we believe that patients are worthy of our respect because of their "unconditional intrinsic value as human beings," so are trainees[8,9]. Trainees are unfortunately

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quite attentive to the values (or lack thereof) taught by their superiors as part of the hidden curriculum[6,7,9,10]. In this context, the flurry of articles on student abuse is particularly disturbing, as they suggest that while we tell trainees that they should respect their patients, their teachers do not respect their trainees[11–16]. Second, educators need to attend to the effect of the environment on trainees' behavior[9]. Every parent knows that a child is less likely to exhibit a "desired behavior" when s/he is tired, hungry, or stressed. Similarly, if we want trainees to show respect in difficult situations, we need to make sure the environment attends to their basic needs. Third, it may be useful to explicitly explore with trainees the reasons it may be difficult to respect patients. Safe forums such as support groups, Balint groups, or individual or group self-reflection exercises can encourage introspection and may serve as appropriate venues for exploring barriers to respect[17,18]. By inquiring about, acknowledging, and helping to eliminate the barriers to respect, educators can create a learning environment that promotes respectful behaviors.

Branch[17] argues that teaching respect requires "an ongoing synergy ... whereby active learning and practicing the skills of respectful interacting with patients alternates with reflection..." He suggests the use of: 1) formal clinical exercises in which students practice eliciting and appreciating the patient's story; 2) bedside role modeling and identifying respectful behavior; and 3) critical reflection away from the clinical setting. Other proposed mechanisms for teaching respect include the use of appreciative inquiry, self-disclosure, video review, seminars, or role-playing,[18,19]. A training program that incorporates a combination of such methods has been shown to improve patient-centered interviewing skills[20], but no similar studies of respect exist.

BEHAVIOR AND ATTITUDES—WHERE DOES ONE BEGIN?

Beach et al argue that physicians must both behave and think respectfully. In fact, they speak disparagingly about behaving respectfully without the proper attitude. In an ideal world, both respectful attitudes and respectful behaviors would come naturally to physicians or would at least be learnable simultaneously. But as educators, we worry that focusing on attitudes may come across as moralistic or "preachy" to trainees. Furthermore, the literature on attitudes suggests rather than being "formally taught", attitudes are acquired through enculturation and reflection[5,9,18]. We also wonder how one could ever tell if a learner had a truly "genuine" attitude of respect.

We are not saying that attitudes are unimportant. Nor do we deny that physicians should ideally display respectful behaviors *as well as* have a respectful attitude toward their patients. In fact, possessing positive attitudes may make it more likely that physicians will automatically engage in behaviors consistent with such attitudes[21,22]. However, because attitudes are more difficult to teach and measure than are behaviors, we propose that a better way to approach teaching respect is to focus first on the development of behaviors or skills. This approach seems to be consistent with those used to teach other aspects of medicine. In teaching medical interviewing, for example, we focus on the observable behaviors that display compassion or empathy, rather than on the trainee's attitudes toward such qualities. In fact, we often explicitly acknowledge that one does not have to feel compassion to act compassionately[22,23].

A behavior-first focus may be particularly important for those trainees whose attitudes of respect are incongruent with what is expected. For example, when a trainee shows frustration in caring for a patient with unhealthy behaviors, or is blatantly disrespectful, it is a wonderful time to discuss what a doctor's role is, what our ethical obligations toward patients are, and what these things mean in terms of behavior[9,24]. The large body of literature on the theory of cognitive dissonance supports this approach and is consistent with our thought that through continued practice, reflection, and reinforcement of respectful behaviors, respectful attitudes will follow[25].

MORE RESEARCH IS NEEDED

Whereas the work by Beach et al provides an excellent basis for discussion, there is a great deal of theoretical and empirical work that needs to be done to flesh out what is meant by respect, what it entails, and how to teach it. What does it mean to have an attitude that values a "patient as a person?" How is this concept of respect different from kindness, dignity, patient-centeredness, or politeness? In assessing whether a behavior is respectful, are there objective criteria, or is a subjective patient standard primary? Whereas Beach et al give a deontological argument for being respectful, data on the patient and physician consequences of being respectful would be important to have. Finally, as educators, we are interested in what methods and learning environments most effectively promote respect.

SUMMARY

Beach et al's paper is a useful reminder of the important role respect has in professionalism and will hopefully lead to renewed scholarship on the concept. However, we believe that learning is a complex process influenced by and sometimes inhibited by many factors, and that the concept of "respect for patients as persons" cannot be adopted by trainees simply by telling them it is something they *ought to have*. We propose that to help trainees develop and sustain this duty, educators must: 1) acknowledge and explore personal and systems factors that may serve as barriers to the respect of patients as persons; 2) provide a supportive and respectful environment for trainees to learn and reflect upon the difficult task of respecting patients; and 3) identify behaviors that display respect for patients and develop effective ways to teach and measure such behaviors. Ensuring that physicians give "a little respect" to their patients is going to take a lot more of our work.

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REFERENCES

1. Lyrics to RESPECT (Song). LYRICS007. Available at: http://www.lyrics007.com/Aretha%20Franklin%20Lyrics/Respect%20Lyrics.html. Accessed February 15, 2007.

2. ABIM Foundation. American Board of Internal Medicine. Medical professionalism in the new millennium: a physician charter. Ann Intern Med. 2002;136:243–6.
3. American Board of Internal Medicine. Project Professionalism. Available at: http://www.abim.org/resources/publications/professionalism.pdf. Accessed February 15, 2007.
4. **Beach MC, Duggan PS, Cassel CK, Geller G.** What does "respect" mean? Exploring the moral obligation of health professionals to respect patients. J Gen Intern Med. 2007, in press. DOI:10.1007/s11606-006-0054-7.
5. **Hilton SR, Slotnick HB.** Proto-professionalism: how professionalisation occurs across the continuum of medical education. Med Ed. 2005;39:58–65.
6. **Hafferty FW, Franks R.** The hidden curriculum, ethics teaching, and the structure of medical education. Acad Med. 1994;69:861–71.
7. **Haidet P, Stein HF.** The role of the student–teacher relationship in the formation of physicians: the hidden curriculum as process. J Gen Intern Med. 2006;21:S16–20.
8. **Reiser SJ.** The ethics of learning and teaching. Acad Med. 1994;69:872–6.
9. **Branch WT, Kern D, Haidet P, et al.** Teaching the human dimensions of care in clinical settings. JAMA. 2001;286:1067–74.
10. **Lempp H, Seale C.** The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. BMJ. 2004;329:770–3.
11. **Sheehan KH, Sheehan DV, White K, Leibowitz A, Baldwin DC.** A pilot study of medical student "abuse": student perceptions of mistreatment and misconduct in medical school. JAMA. 1990;263:533–7.
12. **Baldwin DC, Daugherty SR, Eckenfels EJ.** Student perceptions of mistreatment and harassment during medical school: a survey of ten United States schools. West J Med. 1991;155:140–5.
13. **Van Ineveld CH, Cook DJ, Kane SC, King DB.** Discrimination and abuse in internal medicine residency. J Gen Intern Med. 1996;11:401–5.
14. **Lubitz RM, Nguyen DD.** Medical student abuse during third-year clerkships. JAMA. 1996;275:414–6.
15. **Elnicki MD, Linger B, Asch E, et al.** Patterns of medical student abuse during the internal medicine clerkship: perspectives of students at 11 medical schools. Acad Med. 1999;74:S99–101.
16. **Frank E, Carrera JS, Stratton T, Bickel J, Nora LM.** Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey. BMJ. 2006;333:682–4.
17. **Branch WT.** Teaching respect for patients. Acad Med. 2006;81:463–7.
18. **Inui TS, Frankel RM.** Hello, stranger: building a healing narrative that includes everyone. Acad Med. 2006;81:415–8.
19. **Toledo-Pereyra LH.** Respect. J Invest Surg. 2005;18:281–4.
20. **Smith RC, Lyles JS, Mettler J, et al.** The effectiveness of intensive training for residents in interviewing: a randomized, controlled study. Ann Intern Med. 1998;128:118–26.
21. **Olson JM, Zanna MP.** Attitudes and attitude change. Annu Rev Psychol. 1993;44:117–54.
22. **Larson EB, Yao X.** Clinical empathy as emotional labor in the physician–patient relationship. JAMA. 2005;293:1100–6.
23. **Finestone HM, Conter DB.** Acting in medical practice. Lancet. 1994;344:801–2.
24. **Burack JH, Irby DM, Carline JD, Root RK, Larson EB.** Teaching compassion and respect: attending physicians' responses to problematic behaviors. J Gen Intern Med. 1999;14:49–55.
25. **Cooper J, Mirabile R, Scher SJ.** Actions and attitudes: the theory of cognitive dissonance. In: Brock TC and Green MC, editors. Persuasion: Psychological Insights and Perspectives. 2nd ed. Thousand Oaks, CA: Sage Publications, Inc.; 2005. p. 63–79.