Teaching Humanistic and Psychosocial Aspects of Care:

Current Practices and Attitudes

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Objective: ***To assess current practices and attitudes toward teaching humanistic and psychosocial aspects of care in internal medicine residency programs.***

Design and participants: ***Survey questionnaires were sent to residency directors at all 434 internal medicine residency programs accredited in 1985–1986. Response rate for two mailings was 71%.***

Measurements and main results: ***78% of residency directors and 70% of department chairpersons had high or moderately high levels of commitment to teaching humanistic/psychosocial aspects of care, but only 44% of responding programs offered mandatory training, and only 18% offered elective training in these areas. Obstacles to expanded teaching of the humanistic/psychosocial aspects rated high or moderately high by residency directors included insufficient curriculum time (51%), lack of trained faculty (44%), and pressures to reduce both training costs (40%) and patient-care costs (37%).***

Conclusions: ***Most of the training that does occur in the humanistic/psychosocial aspects of care probably happens informally via mentoring and role modeling. Appeals to expand teaching in these areas raise questions regarding what to include in medical training and the proper scope of internal medicine. Sustainable change will depend on the politics of resource distribution and the influence of general internal medicine and primary care on traditional training.***

Key words: education; humanism; internal medicine; psychosocial; residency; training. J GEN INTERN MED 1990;5:34–41.

IN SPITE OF unparalleled achievements in health care, critics have described medical education as narrow, doctor-centered, technology-bound, and indifferent to both its overall mission and its changing context.[1-3] In internal medicine, many of these criticisms are based on the relatively recent trend toward subspecialization.[4] This, in turn, has helped foster the creation of new divisions of general internal medicine to emphasize primary care and has led to spirited appeals to increase training in the psychosocial and humanistic aspects of care in all internal medicine training programs.

Some educators emphasize the practical aspects of attending to patients' emotional problems. Studies have found, for example, that approximately 60% of all mental health care in the United States is provided by primary care physicians[5] who spend 20–50% of their time treating psychiatric and psychosocial problems.[6] Fifty to eighty percent of medical outpatients may have psychiatric disorders that complicate their medical care.[7] Nonetheless, 30–50% of significant psychiatric problems are unrecognized or inadequately treated by primary care physicians,[8] and audited outpatient medical charts frequently contain no psychosocial history or mental status data.[9] There are fiscal implications as well. Not only do patients with psychiatric disorders use more medical services,[10] but greater attention to the psychosocial aspects of care appears to be cost-effective, particularly over time.[11, 12]

Another theme among contemporary critics of medical education stresses the need to broaden the focus of medical practice from a traditional biomedical perspective to a more systems-based, "biopsychosocial" view.[13] As Engel and others (e.g., Thompson[6]) note, the traditional biomedical model is dualistic, reductionistic, and unable to incorporate psychological or social dimensions of health and illness. Furthermore, the biomedical model has become so fully assimilated into our culture that future doctors are indoctrinated with its nuances long before attending medical school.[3] Despite its obvious accomplishments, critics charge that this model loses sight of the centrality and integrity of medicine's principal subject matter—human beings.[3]

Some recent efforts to improve medical residents' skills in the humanistic/psychosocial aspects of care have reportedly been successful.[14, 15] Duke University and Stanford University have both established combined medical–psychiatric units where internists and psychiatrists train side by side.[16, 17] In spite of enthusiastic calls for rapprochement between psychiatry and medicine,[18] medical house officers may simply not be interested in learning more about the psychosocial aspects of care. In a study at Montefiore Medical Center, for example, researchers uncovered four widely held perceptions among medical residents: 1) the role of the internist is to care for medical, not psychosocial, problems; 2) internists have insufficient time to deal with social and psychological problems of patients; 3) talking about emotional stress can be overwhelming for the patient and is often best not done; 4) it is a waste of time to address psychosocial problems since it is beyond the internist's ability to solve them.[19]

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Developments that might augur curricular or attitudinal changes in medical training include the recent, rapid rise of divisions of general internal medicine in university medical centers,[20] the growing influence of the Society for General Internal Medicine, and the increased interest in primary care.[21] One survey of residency training directors concluded that primary care programs were significantly more committed to mental health training in ambulatory settings and more likely to evaluate that training than were traditional medical residencies.[22] Studies comparing residents in primary care tracks with residents in traditional training, however, have yet to demonstrate significant differences in how they actually treat patients.[23, 24]

Paralleling these developments, the American Board of Internal Medicine (ABIM) has become more concerned about residents' attitudes, values, and beliefs about medical care. After establishing a Committee on Evaluation in General Internal Medicine to specify the knowledge, skills, and attitudes expected of a board-eligible internist, the ABIM in 1979 published a report, "Clinical Competence in Internal Medicine",[25] which highlighted problem-solving abilities, interpersonal skills, and the importance of recognizing psychosocial influences on health and illness. In 1981, the ABIM appointed a Subcommittee on Evaluation of Humanistic Qualities in the Internist, whose final report in 1983 defined the essential humanistic qualities of the internist as integrity, respect, and compassion.[26] The report emphasized that the ability to affect attitudes, behavior patterns, and moral conduct in medical care should be recognized and utilized in residency training (Table 1).

The purpose of this study was to assess current practices and attitudes toward teaching the humanistic and psychosocial aspects of care in internal medicine residency programs. In view of the ABIM's assertion that "The commitment of the program director to the importance of humanism as an aspect of residency training is critical,"[26] surveys were sent to directors of all accredited internal medicine residency programs in the United States.

METHODS

Questionnaires were sent to all 434 accredited internal medicine residency programs in the United States listed in the *1985–1986 Directory of Residency Training Programs*.[27] The surveys were addressed to the directors of residency training and were accompanied by a letter explaining the purpose of the survey signed by the (then) Chairman of Internal Medicine at St. Louis University School of Medicine. The first mailing was sent in August 1985 and a second mailing to nonrespondents was sent in October 1985. All surveys received before January 1, 1986, were included in the analysis.

TABLE 1

Four Principles Regarding Humanistic Qualities of the Internist Adopted by the American Board of Internal Medicine in 1983*

Principle One: The essential humanistic qualities required of candidates seeking certification by the American Board of Internal Medicine are integrity, respect, and compassion.
Principle Two: Candidates for certification must meet high standards of humanistic behavior in their professional lives. The Board should not accept anything less. Moral behavior is an overriding professional consideration in caring for patients.
Principle Three: A major responsibility of those training residents in internal medicine is to stress the importance of the humanistic qualities in the patient-physician relationship throughout the residency. The certification process must assure that this responsibility has been undertaken.
Principle Four: The ability to affect attitudes, behavior patterns, and moral conduct in medical care should be recognized and utilized during the residency training—a unique experience that is not available at other times in medical education.

**Source:* Subcommittee on Evaluation of Humanistic Qualities in the Internist, American Board of Internal Medicine. Evaluation of humanistic qualities in the internist. Ann Intern Med. 1983;99:722.

The questionnaire was a four-page, typeset instrument. It began by soliciting basic descriptive information about the size, history, and affiliations of each program. Next, the four basic principles of humanistic behavior as defined by the Subcommittee on Evaluation of Humanistic Qualities in the Internist were provided, followed by a series of questions asking how well these principles were being met in each residency program. Additional questions asked respondents about other aspects of training in the humanistic/psychosocial aspects of care in their programs, e.g., number and training of participating faculty, resident interest and knowledge base, problems that might hinder an increase in teaching these subjects, levels of commitment of various administrators and faculty to further training, and the numbers of mandatory and elective training hours available to residents. Finally, participants were asked to indicate which of a list of 19 subjects commonly taught as part of the humanistic/psychosocial aspects of care were taught formally, informally, or not at all in their programs. The 19 subjects were chosen by the authors from among those that are often emphasized in internal medicine residency training programs.

All responses were coded for use with SPSS, a computer program designed for data analysis in the social sciences. A repeated-measures analysis of variance (ANOVA) was used to determine whether there were significant differences in levels of commitment to teaching humanistic/psychosocial aspects of care among department chairpersons, residency directors, senior faculty, junior faculty, and last graduating resident class. A Student Newman-Keuls test subsequently determined which specific groups differed from one another. Pearson product–moment correlations were

TABLE 2

Respondents' Ratings of Commitment to Teaching Humanistic/ Psychosocial Aspects of Care in Residency Training

Respondents	Level of Commitment No. Responding (% Positive Response) Low 1	2	Medium 3	4	High 5
Chairmen of departments	10(3)	16(5)	66(22)	102(34)	109(36)
Directors of residency training	8(3)	8(3)	50(17)	118(39)	115(39)
Senior faculty (≥7 years post-residency)	8(3)	49(16)	109(37)	96(32)	36(12)
Junior faculty (≤6 years post-residency)	10(3)	46(15)	123(41)	84(28)	39(13)
Last graduating class	7(2)	40(13)	150(50)	81(27)	21(7)

used to assess the relationship between resident interest in and knowledge of humanistic/psychosocial aspects of care and to determine the strength of any association between program size and rated severity of obstacles to increased humanistic/psychosocial training.

RESULTS

Response Rate

A total of 310 of 434 residency directors (71%) returned completed questionnaires. Two hundred thirty-six were returned after the first mailing and 74 were returned after the second mailing.

Characteristics of Responding Programs

Type of Program. As reported by the directors of residency training, 65% of the responding programs were university-affiliated, 23% were based in a university hospital, and 6% were based in a community hospital with no university affiliation. Six percent described their programs as "other," most of which were based in military hospitals.

Size of Program. The size of each program was determined from the total number of residents currently in training. Program sizes ranged from nine to 151 residents, with a mean of 44 (SD = 27).

Age of Program. The age of each program was determined by the first year in which it became accredited (range: 1914 to 1984). Fifteen percent of the programs were accredited before 1950, 16% during the 1950s, 29% during the 1960s, 31% during the 1970s, and 6% during the 1980s.

Percentage of Resident Time Allocated to Ambulatory Care. Respondents indicated that a mean of 16% (SD = 7%) of residency training time over three years was spent in ambulatory care settings, with a range of 4% to 53%.

Commitment to Teaching Humanistic/ Psychosocial Aspects of Care

Commitment was assessed by asking respondents to rate the levels of emphasis and integration of training in the humanistic/psychosocial aspects of care in their programs and to rate the levels of commitment of various persons in the programs. All ratings used a five-point Likert-type scale (1 = low, 5 = high).

When asked how well their programs were meeting the ABIM principle that it is "a major responsibility of those training residents in internal medicine to stress the importance of the humanistic qualities in the patient/physician relationship throughout the residency," 10% of the respondents indicated that they were meeting the responsibility very well, 50% indicated they were meeting the responsibility well, 35% said that they were meeting the responsibility somewhat, 3% said that they were meeting this responsibility slightly, and none indicated that they were not meeting this responsibility at all.

When asked how well integrated the teaching of humanistic/psychosocial aspects was with other components of their training program, 7% of the respondents said that these aspects were very well integrated, 37% said that they were well integrated, and 44% indicated that they were somewhat integrated. Eleven percent of respondents felt that these aspects were integrated only slightly or not at all.

When asked to rate how much emphasis their program gives to training in the humanistic/psychosocial aspects of care relative to other internal medicine residency programs, 40% of the residency directors reported that they emphasize these aspects more or much more than other programs, 46% responded that they emphasize these aspects about the same as other programs, and about 5% indicated that they emphasize these aspects less or much less than other residency programs.

Program directors also rated the levels of commitment of chairpersons of the departments, directors of residency training, senior faculty, junior faculty, and the last graduating class of residents to the teaching of the humanistic/psychosocial aspects of care as an integral part of the residency program. A five-point Likert-type scale (1 = low, 5 = high) was used (Table 2).

A repeated-measures ANOVA (reliability subprogram) determined that significant differences existed between the various groups rated ($F[4,284] = 93.72$, $p < 0.001$). Post-hoc analyses using a Student Newman-Keuls test showed that the chairpersons and the directors of residency training did not differ significantly from one another in levels of commitment, but had

TABLE 3

Residents' Knowledge of and Interest in Humanistic/Psychosocial Aspects of Care

	Much Less	Less	About the Same	More	Much More
	No. Responding (% Positive Response)				
Knowledge					
Compared with other areas of medicine	10(3)	123(40)	159(52)	11(4)	1(0.3)
Compared with residents in other programs	0(0)	5(2)	181(58)	86(28)	5(2)
Interest					
Compared with other areas of medicine	6(2)	119(39)	162(53)	18(6)	0(0)
Compared with residents in other programs	1(0.4)	9(3)	187(68)	72(26)	6(2)

significantly higher levels of commitment ($p<0.01$) than those attributed to the senior faculty, junior faculty, and last graduating class of residents.

Residents' Knowledge of and Interest in Humanistic/Psychosocial Aspects of Care

Respondents rated the residents' knowledge base in humanistic/psychosocial aspects of care compared with those in other areas of internal medicine, and with those of residents in other medicine training programs. They also rated residents' level of interest in these aspects of care compared with their interests in other areas of internal medicine, and with the interest levels of residents in other programs (Table 3).

Pearson product–moment correlation coefficients revealed that ratings of residents' knowledge in the humanistic/psychosocial aspects of care, when compared with their knowledge in other areas of internal medicine, were significantly correlated with ratings of their interests in these areas as compared with their interests in other areas of internal medicine ($r = 0.41$, $p<0.001$). Ratings of residents' levels of knowledge of these aspects of care as compared with those of residents in other programs were also significantly correlated with their interests in these areas compared with those of residents in other programs ($r = 0.65$, $p<0.001$).

Obstacles to Initiating or Expanding Teaching in Humanistic/Psychosocial Aspects of Care

Respondents rated the severities of ten potential obstacles that might be encountered in efforts to initiate or expand teaching in the humanistic/psychosocial aspects of care on a five-point Likert-type scale (1 = low, 5 = high) (Table 4). Problems frequently identified as high or somewhat high in severity included insufficient time in curriculum (51% of respondents), lack of trained faculty (44%), pressure to reduce training costs (40%), and pressure to reduce patient-care costs (37%).

To determine whether the perceived severities of those obstacles to initiating or expanding humanistic/psychosocial teaching were related to program size, Pearson product–moment correlations were performed between the total number of residents in each program and the severity ratings of individual problems. Only pressure to reduce training costs were significantly related to the size of the program ($r = 0.13$, $p<0.005$); thus, larger training programs were more likely to view pressure to lower training costs as an

TABLE 4

Respondents' Ratings of Potential Obstacles to Increasing Teaching of Humanistic/Psychosocial Aspects of Care

	Low 1	2	Medium 3	4	High 5
	Severity of Obstacle No. of Respondents (% Positive Response)				
Resident resistance	110(36)	95(31)	85(28)	14(5)	2(0.7)
Faculty resistance	86(28)	104(34)	81(27)	28(9)	5(2)
Director of residency training resistance	190(63)	79(26)	30(10)	3(1)	1(0.3)
Chief of medicine resistance	192(63)	74(24)	29(10)	7(2)	2(0.7)
Medical school/hospital administration resistance	168(57)	77(27)	41(14)	4(1)	2(0.7)
Patient resistance	181(62)	75(25)	34(11)	5(2)	0(0)
Lack of trained faculty	21(7)	46(15)	104(34)	95(31)	38(13)
Insufficient time in curriculum	16(6)	35(11)	99(33)	99(33)	54(18)
Pressure to reduce patient-care costs	67(22)	60(20)	64(21)	67(22)	44(15)
Pressure to reduce training costs	62(21)	57(19)	59(20)	41(23)	53(17)

TABLE 5

Faculty Who Devote at Least 25% of Their Time to Teaching Humanistic/Psychosocial Aspects of Care

	Frequency*	Percentage
Full-time physicians		
0	186	67
1	29	10
2	25	9
3	14	5
4	6	2
5	6	2
≥6	12	5
Part-time physicians		
0	221	80
1	23	8
2	12	4
3	5	2
≥4	17	6
Full-time psychologists		
0	248	89
1	18	6
≥2	13	5
Part-time psychologists		
0	259	92
1	20	7
≥2	4	1
Full-time social workers		
0	242	87
1	9	3
2	13	5
≥3	15	5
Part-time social workers		
0	268	95
1	8	3
≥2	5	2
Full-time nurses		
0	257	90
1	10	4
2	10	4
≥3	8	2
Part-time nurses		
0	277	97
≥1	8	3
Full-time other		
0	266	97
≥1	8	3
Part-time other		
0	269	98
≥1	5	2

*Not all respondents responded to all questions/categories.

obstacle to expanded teaching than were smaller programs.

Current Teaching and Research Activities

Program directors were asked to indicate how many faculty members (full-time and part-time) devoted 25% or more of their time to teaching humanistic/psychosocial aspects of care. The results showed that the majority of programs had no full-time or part-time faculty devoting 25% or more time to teaching in these areas (Table 5).

Respondents were also asked whether there were any faculty members who were actively involved in research with a major focus on the humanistic/psychosocial aspects of medicine. Results showed that 23% of the programs had at least one faculty member actively involved in such research.

In other questions, respondents indicated whether residents received formal training in humanistic/psychosocial aspects of care and the numbers of mandatory and elective hours of training offered (if any). With regard to formal instruction in humanistic/psychosocial aspects, 54% of respondents indicated that residents received formal training in PGY-1, 53% said that residents received formal training in PGY-2, and 50% said that residents received formal training in PGY-3. The mean numbers of hours of mandatory training were 13 for PGY-1 (SD = 40, range 0–329), 8.5 for PGY-2 (SD = 28, range 0–300), and 8 for PGY-3 (SD = 28, range 0–300). The mean numbers of hours of elective training were 4.8 for PGY-1 (SD = 21.5, range 0–160), 6.7 for PGY-2 (SD = 27, range 0–160), and 6.9 for PGY-3 (SD = 28, range 0–200). The frequency distribution of programs by number of hours of training in the humanistic/psychosocial aspects of care is shown in Table 6.

Finally, respondents were asked to rate whether each of 19 specific content areas was taught formally, informally, or not at all. Only two subjects, management of psychiatric conditions common in primary care and psychiatric diagnoses/disorders, were formally taught in over 50% of responding programs. Sixteen subjects, however, were taught informally in 50% or more of the responding programs (Table 7).

Faculty Support and Future Plans for Increasing Teaching in Humanistic/Psychosocial Aspects of Care

Respondents were asked to estimate the percentage of full-time faculty who would or would not support formal teaching of humanistic/psychosocial aspects of care. Results indicated that a mean of 50% of full-time faculty (SD = 28.8) would support formal

TABLE 6

Frequency Distribution of Programs by Number of Hours of Training in Humanistic/Psychosocial Aspects of Care

Hours of Training for 3-year Program	Programs with Mandatory Training No. (%)	Programs with Elective Training No. (%)
0	149 (56)	217 (82)
1–24	51 (19)	18 (7)
25–50	28 (10)	11 (4)
51–75	17 (6)	5 (2)
76–100	3 (1)	1 (0)
>100	19 (7)	13 (5)

TABLE 7

Frequency of Teaching of Humanistic/Psychosocial Subjects in Training Programs

Subject	Taught as Part of Formal Curriculum		Taught Informally		Not Taught	
	No. Responding	(% Positive Response)	No. Responding	(% Positive Response)	No. Responding	(% Positive Response)
Management of psychiatric conditions common in primary care	170	(56)	121	(40)	11	(4)
Psychiatric diagnoses and disorders	162	(54)	127	(42)	13	(4)
Medical ethics	130	(43)	159	(52)	14	(5)
Management of the dying patient	126	(41)	171	(57)	5	(2)
Management of difficult patients	120	(40)	177	(59)	4	(1)
Ability to recognize and treat psychosomatic disorders	118	(39)	177	(59)	6	(2)
Interviewing skills	108	(36)	176	(59)	13	(4)
Ability to recognize psychological, social, familial, and cultural influences on patients	100	(33)	191	(64)	9	(3)
Facilitating patient education and preventive health care	97	(33)	183	(61)	19	(6)
Interpersonal skills	85	(28)	197	(66)	17	(6)
Resident awareness of personal reactions to patients	79	(26)	205	(68)	17	(6)
Impact of stress on patient	77	(26)	193	(64)	31	(10)
Impact of stress on physician	75	(25)	175	(59)	49	(16)
Importance of empathy	71	(24)	216	(74)	7	(2)
Dimensions of doctor–patient relationship	59	(20)	208	(69)	34	(11)
Assessing and improving compliance	52	(17)	225	(75)	24	(8)
Office counseling	40	(13)	175	(58)	85	(28)
Sexual counseling	34	(11)	148	(50)	117	(39)
Human development and life cycle	25	(8)	146	(49)	129	(43)

teaching of these aspects of care and 21% of full-time faculty (SD = 23.3) would not support this formal teaching. Respondents were also asked whether they planned to increase humanistic/psychosocial training within the next one or two years. Fifty-five percent of respondents indicated they planned to do so within the next year and 53% planned to increase such training within the next two years. Forty-five percent indicated that they did not plan to increase this training within the next year, and 47% indicated they did not plan to increase it within the next two years.

DISCUSSION

The results of this survey of internal medicine residency directors suggest a high level of interest among faculty, residents, and administrators in teaching the humanistic/psychosocial aspects of care. Further, the majority of respondents thought their current training programs met the ABIM guidelines well or very well and that training in the humanistic/psychosocial aspects of care was well or somewhat well integrated into their residency programs. This enthusiasm, however, has not made the implementation of formal curricula easy. The majority of programs still do not require any training in the humanistic/psychosocial aspects of care. Furthermore, the total amount of curriculum time devoted to these subjects, when required, is meager.

Although survey responses may partially reflect the social desirability of supporting more attention to the humanistic/psychosocial aspects of care, there appear to be several commonly cited obstacles to any major changes in training. One problem is insufficient time in the curriculum. Many residency directors are wary of any activity that competes for time in an already overcrowded schedule. As one director noted, "The problem in introducing new areas of instruction is the limited time available. Each area's faculty already feels short-changed." Another commented: "House officers already have insufficient time. There is not enough time for patient care!" Other directors responded that residents should have been exposed to these topics earlier in their training: "Most of these subjects are addressed 'formally' during the second and third years of medical school. This is what medical school should be all about!" The time dilemma has no easy solution. In a recent evaluation of their own primary care training, a clear majority of resident respondents wanted more exposure to handling psychosocial problems, but less than 20% were willing to spend less time in other areas to get this training.[28]

Two other obstacles to change identified by the training directors are pressure to reduce training costs and pressure to reduce patient-care costs. One respondent asked, "Where does one get the funds to pay salaries for those who teach the psychosocial aspects of care?" Another commented, "Given present funding, we cannot afford the help we need for this kind of ongoing training." Current reimbursement practices exacerbate the problem. Talking with patients takes time—time that could potentially be used to do expensive, well-remunerated technical procedures.

Program development may also be hampered by lack of trained faculty. Most programs do not have physician faculty who specifically teach humanistic/psychosocial aspects of care, and programs have been reluctant to recruit non-medical professionals such as psychologists, social workers, or nurses to help teach residents. Even if there were sufficient faculty, however, there are few clear guidelines as to what subjects to include in a formal curriculum or how to teach and evaluate them. Only two subjects, management of psychiatric conditions common in primary care and psychiatric diagnoses and disorders, were formally taught in a majority of responding programs. Furthermore, teaching methods in ambulatory settings, where patient visits are brief and patients have more control over their care than inpatients, are still not yet well developed.[29]

The current interest in increasing training in the humanistic/psychosocial aspects of care has highlighted disagreements about ideology and educational philosophy. There is a long history of ambivalence towards teaching these subjects. As one residency director put it, "I have my doubts that such qualities as compassion, empathy, sensitivity, or humility can be taught to adults." Some directors question whether humanism can be taught at all. "A resident is either intrinsically humanistic or not," said one. Accordingly, some educators would concentrate efforts on recruiting more "humanistic" students into medicine rather than trying to modify current training practices to maximize these qualities throughout medical school and residency training.[30]

There is also continuing debate over the proper role and scope of internal medicine. Faculty tend to equate their own skills and preferences with the ideal goals of residency training.[31] Some faculty may fear that increased attention to humanism or a biopsychosocial model may lead medicine to lose its scientific rigor, technical efficiency, or objectivity.[32] The call for greater emphasis on the humanistic/psychosocial aspects of care raises a provocative question: What is — or is not — medical knowledge? Those who contend that medicine must guard its disease-oriented, hypothetico-deductive traditions are unlikely to support any endeavor that shifts precious resources away from traditional scientific training.

A final area that must be considered in any change in training emphasis involves the politics of redistributing such precious resources as curriculum time and faculty salaries. In this study, department chairpersons and residency directors felt a strong commitment to teaching the humanistic/psychosocial aspects of care, but this was not necessarily shared by other faculty or residents. Perhaps having risen to positions of leadership, chairpersons and residency directors have a broader perspective of internal medicine training as well as less need to confine themselves to traditional biomedical pursuits to advance their academic careers. The creation of new divisions of general internal medicine is an encouraging development, but the structure of academic medical centers may inhibit their success and performance.[33] Although many of these divisions have sought to create a core faculty dedicated to teaching, biopsychosocial medical training, and primary care, recent surveys have found that they are small, have high turnover rates, produce little research, sponsor few research fellowships, and face continuing problems meeting faculty promotion and tenure criteria.[20] So long as medicine continues to give richer rewards to high-tech specialists and traditional researchers, significant, sustainable changes in teaching hospitals or residency programs may be difficult to achieve.

The directors' overall high level of satisfaction with their training in the humanistic/psychosocial aspects of care is noteworthy in light of the scarcity of both curriculum time and trained faculty. This suggests a heavy reliance on informal teaching and role modeling. It may be that the most efficient efforts to increase resident knowledge and interest will be to increase faculty development efforts for current teachers and mentors.

It is too soon to predict the future of efforts to expand teaching in the humanistic/psychosocial aspects of care; the ABIM recommendations are still quite recent. Although there are mounting economic pressures to expedite service delivery and reduce costs, an increasingly competitive marketplace may counteract that trend by filling the practices of physicians who are perceived as compassionate or who are willing to take the time to talk to and understand their patients. It has been several years since these data were collected, and a follow-up survey would provide helpful information to assess any further changes. Future research efforts could expand the scope and validity of the present study by seeking information from sources other than residency directors, such as residents, chairpersons, administrators, and patients. It would also be instructive to study the informal interactions between attending physicians and housestaff to ascertain whether and how the humanistic/psychosocial aspects of care were somehow communicated and learned between the cracks of more formal residency requirements.

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