organ system or use of procedures.[3,4] The ideal academic medical center is a community-based network engaged actively in primary care outcomes research.[5]

Examples of why a relationship-centered educational process would be beneficial are easy to find once one is willing to grasp the essential challenge. Consider, as one example, a recent, cogent analysis of medical error.[6] At one level, the analysis urges medicine to adopt some of the proven methods, long used in industry, to assure higher levels of safety; and in so doing, medicine must inevitably come to view errors only in part as a matter of individual responsibility and much more as a function of systems design. Thus, if we want to do something serious about preventing errors that harm our patients, we must start to think much more in systems terms — which is to say, the network of relationships among ourselves, our patients, and our fellow providers. Moreover, we need to get much more in touch with the *human* aspects of these relationships, as well as to reflect much more thoughtfully upon our own humanness. We will never effectively reduce medical error so long as we imagine that physicians are potentially perfectible, so that each commission of a mistake is a trigger for denial, self-blame, and withdrawal into anguished isolation. As other industries have learned, we must instead realize that all humans make mistakes and then ask how we can design systems that best allow us to learn from our mistakes and minimize their tragic consequences.

The call for relationship-centered education also coheres well with some recent criticisms of how medical ethics has been taught. The focus on rules and principles, however useful they might be in resolving ethical dilemmas, suggests in the end that human relationships are somehow irrelevant to ethical analysis. We are being challenged today to develop new views of ethics in which caring, relationships, and the human life context are taken much more seriously.[3,7]

While we do a much better job of relationship-centered teaching than do most other medical specialties, the Pew-Fetzer report challenges us to improve upon our record. For one thing, we certainly need to do a much better job at the level of our national organizations in forging a partnership with the nursing profession, as daunting as that task might be politically. For another, we need to assure that time and space for thoughtful reflection are built-in features of both the medical school and the residency experience. Finally, especially as managed care comes to dominate the medical marketplace, we must attend much more carefully to the human as well as the technical dimensions of the relationships between primary care physicians and subspecialist consultants and make the formation of positive, mutually respectful relationships an explicit part of our educational programs.

I strongly encourage family medicine educators first to study the Pew-Fetzer report and next to circulate it as widely as possible within their institutions. I believe it provides a very effective framework for the next wave of educational reform, which we must promote if our health care system is ever to be truly healthy.

Howard Brody, MD, PhD
Michigan State University
East Lansing, MI

References

1. Brody H. A policy imperative for primary care: reflections on Keystone II. Fam Med 1990; 22:42-5.
2. Health professions education and relationship-centered care. San Francisco: Pew Health Professions Commission, 1994.
3. Brody H. The healer's power. New Haven: Yale University Press, 1992.
4. *Idem*. My story is broken, can you help me fix it? Medical ethics and the joint construction of narrative. Lit Med 1994; 13:79-92.
5. Brody H, Sparks HV, Abbett WS, Wood DL, Woodland WC, Smith RC. The mammalian medical center for the 21st century. JAMA 1993; 270:1097-100.
6. Leape LL. Error in medicine. JAMA 1994; 272:1851-7.
7. Nelson JL. Taking families seriously. Hastings Cent Rep 1992; 22(4):6-12.

Happy Residents, Happy People, Or Both?

The author Robert Coles produced a lifetime of work, beginning with *Children of Crisis: A Study of Courage and Fear*,[1] describing the strength of chil-

Submitted 26 June 1995.

From the Department of Family Medicine, University of Wisconsin, Madison. Address reprint requests to John J. Frey III, MD, Department of Family Medicine, University of Wisconsin, 777 S. Mills Street, Madison, WI 53715-1896.

J Am Board Fam Pract: first published as 10.3122/jabfm.8.5.418 on 1 September 1995. Downloaded from http://www.jabfm.org/ on 10 February 2025 by guest. Protected by copyright.

dren in the face of adversity and danger. Coles focused on the redeeming aspects of childrens' lives rather than on "vulture research," as I once heard him refer to it, which analyzes failure. While we should learn from failure, we have a great need to learn from those who overcome obstacles.

This issue of the *Journal* includes an article that, using some of the same methods as those employed by Coles, looks at the strengths and strategies that residents use to make their experiences ones of growth and learning. Any faculty member understands the burdens of time, emotional pressure, and content that must be endured in residency education. It is refreshing, then, to read a study that helps us understand the strengths of residents' lives.[2]

Manusov and his colleagues build on a pilot study that described positive forces in residents' experiences to carry out a broader study of resident personal and professional adaptation. Their research methods are fine examples of the meticulous preparation and process that help get beneath the Likert scales and questionnaires that too often mark these types of studies. Manusov and site collaborators from four residency programs carried out structured interviews with 59 residents from all 3 years of training. While gathering resident estimates of the most stressful factors in their lives at the time of the interview, the interviewer also elicited aspects of residents' lives that they enjoyed, that helped them persist through the difficulties of training, and helped them, as the study also showed, feel on the whole positive and even enthusiastic about themselves.

While using the awkward term *happiers* to define categories of positive aspects of residents' lives, Manusov and colleagues have outlined some interesting, not altogether surprising but nevertheless important, information for educators.

The study notes four major categories, described by all residents in the study, which were contributors to a sense of well-being: positive relationships, goals and achievements, accentuating the positive, and building a balanced lifestyle. Three minor categories, religion or religious commitment, feedback, and a sense of control or autonomy, were noted by more than 50 percent of interviewees.

Family medicine is a discipline, as McWhinney[3] noted 20 years ago, in which the person takes priority over technology, and so it seems logical and quite reaffirming that residents see relationships — with family, children, colleagues, and patients — as a source of happiness and satisfaction in their lives. If that sense of enjoyment of people underlies their time as residents, then there is great hope for their future lives as family physicians. In many ways, Manusov and colleagues have provided empirical support for Carmichael's relational model, proposed as a theoretical basis of family practice 13 years ago.[4]

The second and third categories that residents describe as helping them feel happy — goals and achievements and accentuating the positive — seem more connected to the experience of formal education than to the work of doctoring. The completion of residency education marks the end of what has been a very long, often arduous period of life for young physicians. There is no questioning the satisfaction of successfully learning from and in many cases triumphing over the adversity of graduate medical education. In this study, interviewers talked with individuals in the midst of one of the most challenging times of their lives. The next step into the world of practice, however, is one with fewer clear and measurable goals and with no graduation to mark transition. Finding their way successfully and happily in a life that is not prescribed but rather is theirs to choose will offer a different series of challenges to happiness. One contribution of this study that should be helpful in that transition is to remind young physicians that the qualities and perceptions which have helped them be happy with their lives to this point must anchor their future careers also.

It is entirely possible that what the investigators call minor factors in happiness for residents — religious or spiritual meaning, positive feedback from teachers and patients, and autonomy — could in the next stages of their lives be the most compelling factors in a satisfying professional life. Living one's own life and exercising individual judgment and choice are a strong part of physician satisfaction. Much anguish for physicians regarding the changes in health care in the past 10 years has been the threat of the loss of autonomy in their professional lives. Any system that ignores the need for emotional ownership of one's work will diminish not only the professional satisfaction but perhaps also the quality of the work itself.

Being appreciated by patients and colleagues is an important referent for a service profession such as medicine. Engaging in a deeper search for meaning and purpose is the central work for all adults and might represent a challenge rather than happiness as it is defined in this study.

This study begs to be repeated with residents from other disciplines and with physicians at different periods of their careers. In a time of the ascendancy of primary care, family practice residents face a future that should encourage them to act on their most deeply held beliefs about service, community, and a balanced life. Other disciplines facing more trying times might find a very different set of values and a higher level of anxiety about the future.

Most importantly, Manusov and his colleagues could help all of us by following their subjects over time and describing changes in personal and professional happiness as these physicians grow in their work. Whether the qualities that residents describe in this study are qualities that they brought with them to medicine and whether these qualities will persist over a lifetime are the next and most important questions to address with this research.

John J. Frey III, MD
University of Wisconsin
Madison, WI

References

1. Coles R. Children of crisis: a study of courage and fear. Boston: Little, Brown, 1964.
2. Manusov EG, Carr R, Powane M, Beatty LA, Nadeau MT. Dimensions of happiness: a qualitative study of family practice residents. J Am Board Fam Pract 1995; 5:367-75.
3. McWhinney I. Family medicine in perspective. N Engl J Med 1975; 293:176-81.
4. Carmichael LP. The relational model in family practice. Marr Fam Rev 1981; 4:123-33.