Art of Doctoring
Can We "Teach" Relationship-Centered Medicine?

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Overview of session

- Apology: 3 presenters (and more importantly 3 viewpoints) morphed into one!
- What is Art of Doctoring?
- Why we started AoD
- What our goals are
- Overview of the course
- An experiential exercise
- Evaluation data and our interpretation
- Future directions
- Applications to your learning environments
  - Concepts and attitudes
  - Specific applications

What is Art of Doctoring? (AoD)

- 4th yr elective
- 2 wks credit
  - 16 2 hour sessions over 6 mo period
  - One half-day weekend session
  - Written assignments and final project
- Approved by Curriculum & Educational Policy committee
- Enrolls between ¼ and 1/3 of graduating class (25-35/100 students)
- Developed by psychologist, general internist, and hospitalist
- No additional support from Medical Education or School of Medicine
- Students must negotiate time to attend sessions with supervising residents

History

- My colleagues and I repeatedly observed frustration, burn-out, cynicism in 3rd yr ms
- Hypocrisy of injunctions to “hold onto values”
- Awareness that cultivating relationship takes skills of reflection, intention, centering, empathy, appreciation of other
- Relationship-centered medicine also takes practice
- Ethical obligation to create a learning environment that provided opportunity to explore relationship-centered aspects of clinical practice

Goals and Objectives in Designing AoD

- Make a connection between a theoretical model (Relationship-Centered Medicine) and daily practice
- Help medical students understand the usefulness of reflection and imaginative perspective in
  - cultivating self-awareness
  - enhancing compassion and empathy for patients, patients' family members, peers, attendings, residents, nurses, medical team
- Help medical students develop specific skills for empowering themselves as learners and as student-physicians
  - Be able to identify and assimilate relationship-centered attitudes and behaviors modeled by others
  - Know how to use re-centering techniques and compassionate curiosity in difficult and stressful situations
  - Be comfortable recognizing and working with relational "patterns"

Principles of Relationship-Centered Care

Mary Beach, Thomas Inui, Relationship-Centered Care Research Network

- Context:
  - Genuine relationships in healthcare are morally valuable
- Relationships depend on
  - Self-awareness and self-knowledge
  - Other awareness (empathy, understanding of the other)
- Personhood of both patient and doctor, as well as their roles, is always implicated in relationship
  - Patient is a human being, not a scientific object or passive recipient of care
  - Physician is also a human being, not merely an active instrument
  - Both physician and patient can suffer or benefit as a result of their encounter

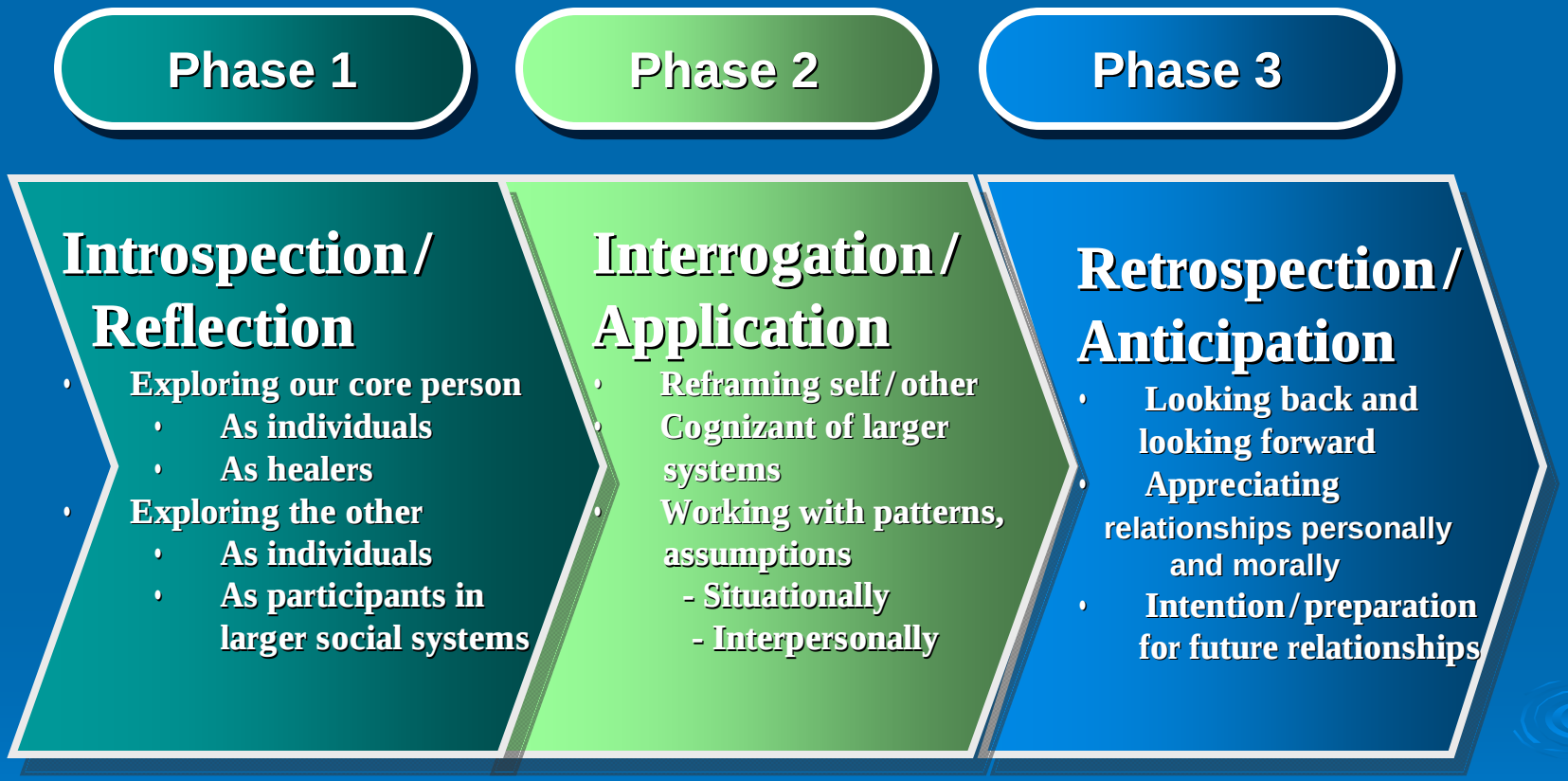
Principles of RCC

- Engagement and connection are cornerstones of relationship
  - Detachment and neutrality do not further relationship
- Communication is more than vertical information transmission
  - Communication and its influences are bidirectional and reciprocal
- Medical encounter is not completely predictable or controllable
  - Patterns of meaning and relation are constructed moment-by-moment
  - Without awareness and ability to recognize and work with patterns, they can rigidify in dysfunctional ways
- Patient-doctor relationships occur within a complex web
  - Societal, institutional, cultural, and familial relationships

RCC and Narrative Medicine
(Rita Charon)

- RCC is intimately connected to NM
- Relationships depend on storytelling
- Creating and sharing stories is how we connect with others
- Listening to stories is how we communicate concern, caring, and respect for others
- Sharing stories (“clinical anecdotes”) is the backbone of AoD

Process Diagram



Methods

- **Mini-lectures, small group discussions, student/faculty role playing and faculty role modeling**
  - Self-reflective techniques
  - Mindfulness, centeredness, and full presence with patients
  - Achieving emotional equilibrium: tenderness and steadiness
  - Maintain attitudes of thankfulness, gratitude, and self- and other-forgiveness
- **Written assignments**
  - Observational, self-assessment, self-awareness, etc
- **Problem-solving in a case-based format**
  - How to work most compassionately and effectively in situations involving time constraints, language barriers, and “difficult” or “demanding” attendings, residents, or patients
- **Readings by medical student and physician-authors**
  - Exploring their own efforts to cultivate and maintain compassion and empathy
- **Personal project**
  - Either an “N=1” self-change study or
  - A humanities/arts-based reflection
  - Purpose: to improve caring attitudes and behaviors in the clinical setting

Writing Assignments

- Meyer-Briggs type personal assessment
- Personal experience with loss and grief
- Compassion burn-out scales
  - current self-care
  - plans for addressing problems
- Cultivating positive emotions and attitudes
  - Kindness, patience, empathy, compassion
  - Altruism, service
- Critical incident report/creative representation of difficult encounter and possible alternatives
  - Resident/attending/nurse
  - Patient/family

Special Session – Healer's Art

- Healer's Art (Rachel Naomi Remen)
  - Half-day experience
  - developed by Rachel Naomi Remen, M.D.
  - to teach physician self-awareness and humanistic ideals.
- Seed Talks
  - Finding meaning in medicine
  - Medicine as service
- Sharing meaning object
- Writing/sharing personal Hippocratic Oath

Grading

- **HONORS/PASS/FAIL CRITERIA**
  - **Attendance 70%**
    - 16 regular sessions @ 4.375 points per session = **70 POINTS**
  - **Individual assignments 15%**
    - 3 essays @ 5 points per essay = **15 POINTS**
  - **Final project 15% - Mandatory**
    - **15 POINTS** [includes class presentation]
  - **Extra credit**
    - Barbecue at Dr. Robitshek's house = **3 POINTS**
    - Outside activity: Attendance (including a paragraph write-up) at an event of individual student's choosing (prior approval of instructor suggested) that you think contributes toward your being a better, more humane, and compassionate physician = **3 POINTS**
    - Participation in Healer's Art session = **6 POINTS**
  - **Honors: 90+ POINTS**
  - **Pass: 70-89 POINTS**

Introspection/Reflection: Self and Other

- **SESSION 1: INTRODUCTION**
  - Overview of the course
  - Housekeeping; faculty goals; student goals
  - Defining success as a physician
  - How you've changed since first year - large group discussion
  - Appreciative inquiry: stories that make you proud to be a doctor – mini-presentation

- **SESSION 2: APPRECIATIVE INQUIRY**
  - Small group exercise: story generation
  - Large group sharing: nominated stories presented by group member
  - Presentation on Kiersey/Meyer-Briggs Temperament Typology: mini-lecture

  Home Assignment [Handout]: Complete the Montgomery Inventory

- **SESSION 3: GETTING TO KNOW YOURSELF AND OTHERS**
  - Discussion of inventory results - large group discussion
  - Develop brief role-plays that magnify your own temperaments and show how they interact (may be humorous!)
  - Presentation and discussion of role-plays

Deep Introspection

- **SESSION 4: WORKING WITH DIFFICULT EMOTIONS/KEEPING AN EMOTIONAL CENTER**
  - Mini-presentation – managing fear, anger, shame; developing steadiness/tenderness
  - Small group discussions

  Required Assignment #1: Write about a personal encounter with loss and grief

  SESSION 5: LOSS, GRIEF, AND HEALING
  - Mini-presentation
  - Small group discussions

  Home Assignment [Handout]: Complete compassion fatigue/burn-out scales

- **SESSION 6:SELF-CARE: AVOIDING COMPASSION FATIGUE/BURN-OUT**
  - Mini-presentation - large group
  - Self-care strategies – small groups
  - Large group sharing

Example: Loss and Grief

Internal medicine was the first rotation of my 3rd year. Up until then, most of my clinical encounters had been with standardized patients… I remember that rotation to be extremely difficult, physically and emotionally. Moreover, I had to see very sick patients. Soon enough, though, my colleague Jack and I found ways to cheer each other up. We used to make up a bunch of inside jokes about our patients… One of his patients, with a diagnosis of cirrhosis and hepatic encephalopathy, was our favorite. Every time we would go into his room, we found something amusing, either in the patient's seldom speech, gestures, or just something in his room. Since I was not directly caring for this patient… I knew him as the "encephalopathy guy who says funny stuff once in a while." A month passed, and we moved to a different rotation. One day Jack and I remembered some of our inside jokes and decided to look up "encephalopathy guy" and see how he was dong. Jack opened his file and found his former patient to be deceased. I did not even consider myself "attached" to this patient and still felt horrible. A "real" patient was dead. I started having flashbacks of his face and his room and felt guilty that I just knew him as the "encephalopathy guy" and that my colleague and I would make occasional jokes about something "funny" that happened in his room. Most importantly, I had almost forgotten about him just like how I would forget about a standardized patient. I did not know whether all these feelings were okay or not; whether it was okay for me to forget about a patient and "move on" or to use humor in an adverse situation.

Application: Self in Relation to Others

- **SESSION 7: DEVELOPING EMPATHY; THE EMOTIONAL DETACHMENT/EMOTIONAL INVOLVEMENT RELATIONALCONTINUUM**
  - Definition of empathy – large group
  - Barriers to empathy; appropriate emotional connection – small group

- **SESSION 8: CULTIVATING POSITIVE ATTITUDES: KINDNESS, COMPASSION, ALTRUISM**
  - Mini-presentation: practices
  - Small groups: strategy generation
  - Large group sharing

  Required Assignment #2: Write a paragraph or two reflecting on how you personally encourage yourself in attitudes of kindness, patience, caring, humility, especially when you may be feeling the opposite.

- **SESSION 9: UNCERTAINTY, COMPLEXITY, AND MEDICAL MISTAKES**
  - Mini-presentation – common errors in medical thinking (cognitive/emotional patterns and their consequences)
  - Small group discussion – self and other forgiveness

Example: Cultivating Positive Attitudes

To encourage myself in attitudes of kindness, patience, caring, and humility, usually the first thing I do is to empathize and put myself in the patient's position. I imagine how I would feel if I was sick, in pain, alone in the hospital… If I were in his or her situation, I know how nice and helpful it would be if the physician or medical student was friendly, cheerful, honest, and caring. If I think of a person who is mean, impatient, arrogant, or condescending taking care of a patient, it helps me to be the opposite because I think of how unhappy that would make the patient and how non-therapeutic that would be. I also think of the possibility of the patient being someone I love, such as a family member or friend, which encourages more positive attitudes toward patients' and families as well.

Usually, when I become impatient with being in the hospital or working with different staff members, I think of my parents. I think of how spoiled I am complaining about waking up before the sun rises or spending more than 12 hours in the hospital because my parents used to do the same at my dad's donut shop when I was growing up, without the enormous reward that medicine provides. Thinking of my parents, who are immigrants, helps me be more caring and patient toward patients who don't understand everything the doctor is saying because of either language, cultural, or educational barriers.

Application: Relationships w/Others within Larger Systems

- **SESSION 10: "DIFFICULT" DOCTOR-PATIENT INTERACTIONS**
  - Mini-presentation: problem-solving skills; active and accepting
  - Small group discussion: additional problem-solving
  - Large group sharing

  Required Assignment #3: Describe in narrative or creative form one particularly troubling incident with a resident, attending, staff, patient, family member; and how you might handle it differently

- **SESSION 11: PROBLEM-SOLVING DIFFICULT INTERACTIONS**
  - Larger relational contexts (society, institution, culture etc.)
  - Clinical presentations, role-plays
    - Difficulties with attendings, residents
    - Morally disturbing incidents
    - Difficulties with patients, family members
  - Brainstorming alternative approaches

- **SESSION 12: STUDENT PROBLEM-SOLVING DIFFICULT SITUATIONS – SMALLGROUPS**

Example: Difficult Encounter

Our new patient was a young woman who had a broken intravenous heroin needle in her arm. In the ER, a surgery resident had tried unsuccessfully to dig the needle fragment out, and had signed off saying it might just stay indefinitely.

We stood around her bed: I , my classmate, three residents, and my porcelain-faced attending. We told her the news. The patient began to wail, “How can you not take it out?” Our attending turned to us, and with a grainy voice said, “She needs a psychiatry consult.” The patient, her eyes welling up with tears, exclaimed, “I’m not crazy! I just want the needle out, and I’m frustrated you can’t get it out. Aren’t you doctors?”

Our attending turned to us. “Let’s get an interventional radiology consult, a plastic surgery consult, and a dermatology consult. And make sure we get that psychiatry consult.”

We quickly whisked out of the room as if escaping a flood. I piped up, “But I don’t think she needs a psychiatry consult. She’s obviously upset because we haven’t been able to provide the care that she expected. It’s very understandable that she would be crying.”

We stepped into the elevator and the doors slid shut on us. I felt the mono-pressure-volume steeliness of my attending’s resolve: “She’s a heroin addict. She needs a psychiatry consult.”

Example: cont.

- My classmate and I went back to the patient's room later that afternoon and apologized for our team's callous behavior. She appreciated our concern, and disclosed that she had become addicted to pain medications prescribed by her doctors for ulcerative colitis, and then moved on to IV heroin.
- We did not end up getting all those consults. The patient left against medical advice and sought care at another hospital.
- This incident was particularly troubling to me because an attending whom I was supposed to look up to and learn from displayed an incredibly paucity of emotion, empathy, as well as aggression toward a defenseless patient. I feel my classmate and I acted appropriately on the patient's behalf, although we may have overstepped some bounds of hierarchy.

Integration/Summary

- **SESSION 13: APPRECIATIVE INQUIRY REVISITED – SMALL GROUPS**
- **SESSION 14: PRESENTATION OF FINAL PROJECTS (GROUP I)**
- **SESSION 15: PRESENTATION OF FINAL PROJECTS (GROUP II)**
- **SESSION 16: PRESENTATION OF FINAL PROJECTS (GROUP III)**
  - Course debriefing
  - Class discussion on suggested ways to improve course

Example of Two Mini-Lectures + Exercises

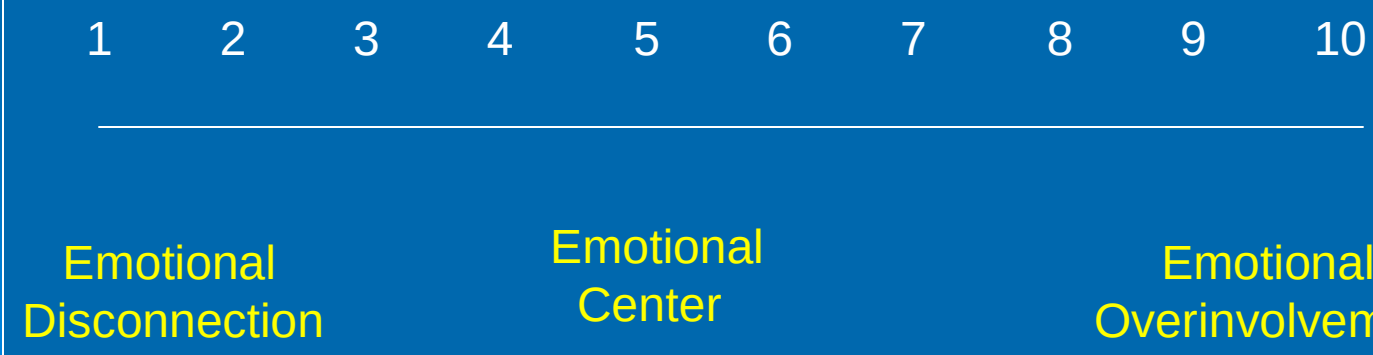
I. Find Your Emotional Equilibrium

Emotional equilibrium

- **Aequanimitas – Sir William Osler**
  - **“In the physician or surgeon, no quality takes rank with imperturbability…coolness and presence of mind, calmness amid storm, clearness of judgment in moments of grave peril…”**
  - **“The physician needs a clear head and a kind heart; his work is arduous and complex, requiring the exercise of the very highest faculties of the mind, while constantly appealing to the emotions and finer feelings.”**

Emotional Connection Continuum

- Where do you fall?
- Where would you *like* to fall?



Centering

- Found in both Christian and Buddhist contemplative traditions
- Can have a secular basis as well
- Groundedness
- Presence/mindfulness
- Calmness
  - Not detached
  - Loving, caring, compassionate

Coming back to Center

- Pause: Don’t just do something – stand there
- Take a breath
- Say a prayer, quote a wisdom saying
- Be curious, not furious
  - devastated, panicked, helpless etc.
- Soften your heart
- Broaden your perspective
  - When you look back from the perspective of tomorrow, what do you need to do to feel good about how you acted today?

Coming back to Center

- You are aware of your emotions BUT…
- You are not driven by your emotions
- Your emotions occur within a larger context of doing good for the other (your patient) and for yourself
- However you act
  - With firmness
  - With gentleness
  - Some combination of the two
- You have found a still, trustworthy center

II. Cultivating Positive Emotions/Attitudes in Patient Care

Some positive emotions/attitudes we need with patients/colleagues/family/friends (student-generated list)

- PATIENCE
- GENTLENESS
- ATTENTIVENESS
- RESPECT
- NONABANDONMENT
- SERVICE
- PERSEVERANCE
- STILLNESS
- STEADFASTNESS
- QUIETNESS
- CALMNESS
- PRESENCE
- FIDELITY
- DEVOTION
- TRUSTWORTHINESS
- PERSISTENCE
- COURAGE
- KINDNESS
- STRENGTH
- COMPASSION
- HUMILITY
- CURIOSITY
- TENDERNESS
- TOLERANCE
- STEADINESS
- CENTEREDNESS
- TENACITY
- CARING
- EMPATHY
- GENEROSITY
- MINDFULNESS

Cultivating Positive Emotions/Attitudes

- **Rachel Naomi Remen, M.D.:**
  - **"…*blessing life is about filling yourself up so that your blessings overflow onto others*."**
    (My Grandfather's Blessings, 2000)
  - **Compassion and caring should come from a brimming reservoir of joy and love, rather than scraping the bottom of our barrels to find the last remnants of these qualities**

Exercise

- Choose one of the qualities in the previous slide
- Take a few minutes to reflect on and then write down how you encourage the presence of that quality in your professional life
- Provide an example if possible

Some strategies for cultivating positive emotions/attitudes

- **Awareness of negative "leakage"**
  - **Accept your emotions without shame or blame**
  - **Interrupt the pattern**
  - **Decide how you'd like to be feeling**
- Practice gratitude
  - **Find something to appreciate in the situation/in the patient or other person**
  - **Keep a gratitude journal**

Cultivating positive emotions/attitudes

- Adopt the other's perspective
- Remember the other is someone's mother, father, sister, brother
- Change the story you tell about the other
- Practice commonalities
  - Look for what you share in common with the other, rather than what divides you
- Respect difference
  - Learn to be comfortable with differences: in values, behavior, priorities
- Try to see the divine in everyone you meet
- Mini-metta (lovingkindness) meditation

Cultivating positive emotions/attitudes

- **Remember something that makes you happy**
- Cue your core values
  - What would my role-model do in this situation?
- **Contemplate something in nature**
- **Go to newborn nursery**
- **Take care of yourself**

Outcomes and Evaluation:

What we've learned

Personal Projects

- Self-Change Projects
  - **2005 - 12; 2006 – 3; 2007 - 3; 2008 – 2; 2009 - 6**
- Representative topics
  - **Increasing patience; reducing interruptions**
  - **Decreasing negative judgment**
  - **Increasing respect**
  - **Fulfilling "promises" to pts**
  - **Decrease distancing humor**
  - **Improving listening/communication**
  - **Cultivating presence**
  - **Increasing empathy toward pts**
  - **Demonstrating caring toward pts**
  - **Improving team atmosphere**
  - **Personalizing work environment Speaking up on wards**
  - **Being less tense, more confident, more positive**
  - **Self-care, stress reduction, balance between personal/professional**
  - **Being a happier person**
  - **Smiling more**

- Creative Projects
  - **2005 -11; 2006 -15; 2007 - 23; 2008 - 27; 2009 - 14**
- Essays, poems, collages, skits, art, memory boxes, songs, photographs, multimedia slide shows
  - Personal/professional transformation/odyssey
  - Reflection on loss/growth: self-assessment
  - Recommitment to personal values
  - Self-care – balancing family and career
  - Tributes to family
  - Resolutions for future practice
  - Eulogies to pts
  - Communication issues
  - Importance of emotional connection w/pts

Example of Personal Project

(Excerpt from personal essay)

Shock and Awe

When I look back, I first remember my shock. From day one we began deconstructing the human being… learning in anatomy every muscle, nerve, artery by name… learning the biochemical pathways and each step name by name… we deconstructed the body down to the last molecule.

What I find so special wasn't in those first two years of intense and interesting deconstruction, but has rather been in the re-construction… as if we have built now a soul into that hollowed-out shell of knowledge we created. What I know is that those bodies that I thought I understood down to the very last molecule have been completely transformed yet again, to fuller, vibrant beings – full of intensities beyond their disease. I look back at my four years in awe… of all I have learned and the ways it has changed my view of the world in which we live and the people who inhabit that world and are my patients

Example of Faculty Comments

- Dear K

  Your project showed a lot of creativity and imagination. I appreciated your essay as well. All I can say is, I like your version of shock and awe a lot better than the original! I loved your metaphor of deconstruction/reconstruction. That gets it exactly right, I think. The sad thing is when the student isn't able to put all the pieces back together in a humane, holistic fashion. But you've obviously been able to reassemble things beautifully in a way that puts the patient's humanity, the soul of the patient, exactly where it should be – at the core and center. In particular, I valued your realization that everything is interconnected – that everything, including the patient and the physician, acts upon the body – and the soul – of the person for good or ill. It is inspiring to see how fully and compassionately you have integrated the totality of your learning on so many levels for the last four years. I am confident your learning will continue, through residency and over your lifetime.

AoD Course Evaluation

- 1. **This course**:
- Increased my empathy for patients, family members, and physicians
- b. . Improved my self-understanding
- c. Provided me with specific self-reflective practices to enhance my understanding of self and others
- d.. Allowed me to explore and work with difficult personal feelings evoked by problematic patient/resident/attending encounters
- e. Increased my ability to maintain emotional equilibrium when confronted with stressful or demanding patient care situations.
- f. Helped me examine and better deal with issues of loss and grief.
- g. Provided specific skills for avoiding compassion fatigue and burn-out.
- h. Helped me learn how to maintain positive attitudes of compassion and caring toward patients, patients' family members, peers, and self

AoD Course Evaluation cont.

- i. Helped me to come to terms with limitations and mistakes in medicine
- j. Enabled me to better accept uncertainty and complexity in medical practice.
- k. Helped me learn how to more effectively problem-solve difficult clinical and professional encounters
- l. Made me feel more appreciative and grateful for the opportunity to practice medicine
- m. Was well-organized
- n. Presented new knowledge and skills

- 2. **Reading materials**
- a. Quality of reading materials
- b. Quantity of reading materials

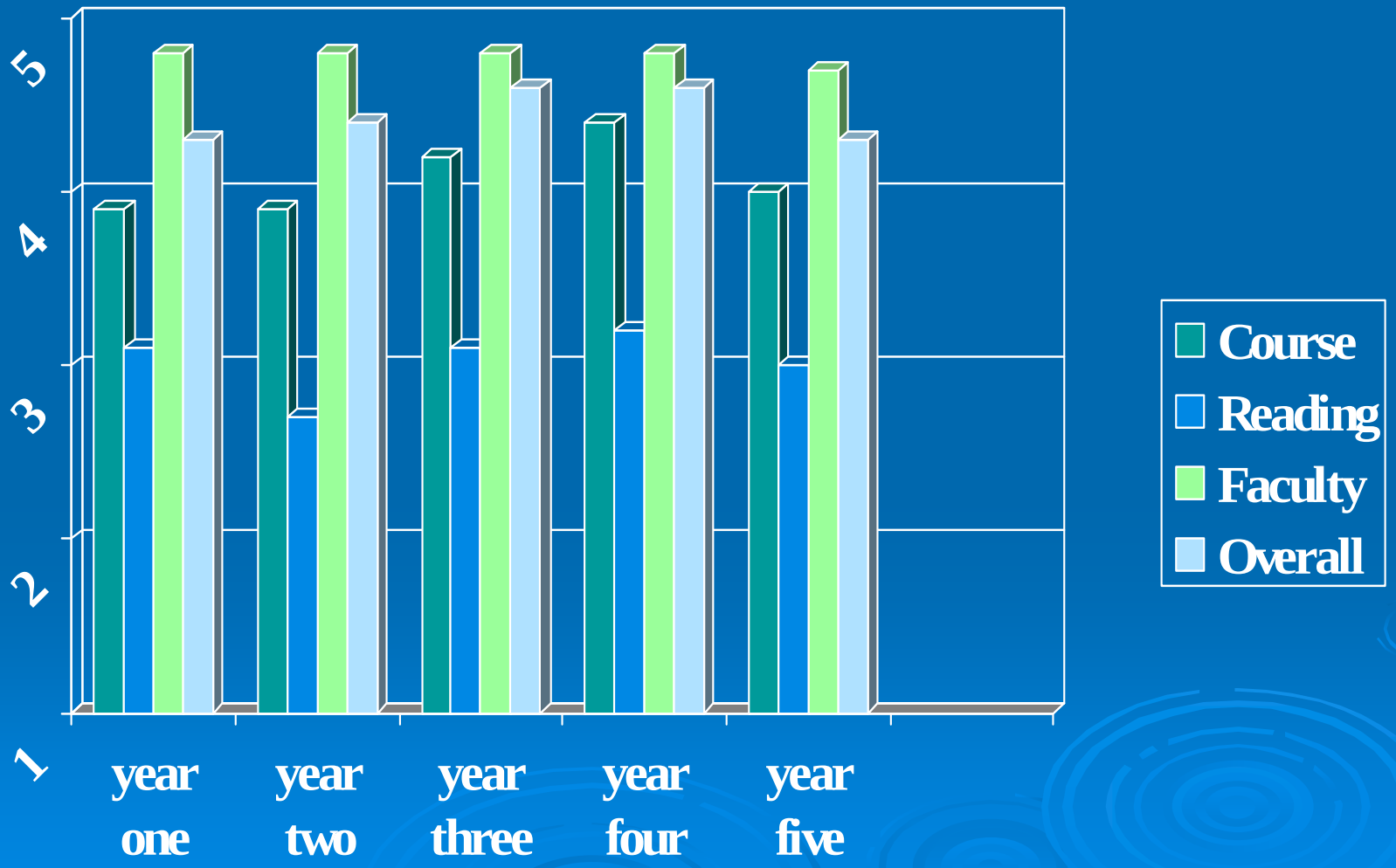
AoD Course Evaluation cont.

- 3.**Course Instructors**:

- a. Were well-prepared for each session
- b. Were insightful and stimulating
- c. Were knowledgeable about subject matter
- d. Appeared interested in my development as a physician
- e. Exhibited a sincere desire to help students learn
- f. Were responsive to student questions
- g. Encouraged student participation and discussion
- h. Encouraged critical thinking

- 4. I would be interested in taking a similar course in the future
- 5. I would recommend this course to other medical students

5 Year Course Evaluation



Positive Narrative Comments

- “This was a very unique class. It served as a perfect break from the normal training, it is a wonderful time of reflection. I enjoyed the opportunity to look back over the past four years, and assess if I have lost certain aspects of my humanism during this training. It allowed me to realize what areas I am prone to change in, and how to avoid them. This class has definitely helped to prepare me to be a well-rounded, humanistic physician.”
- This course should be required or at least strongly encouraged because all of us benefited greatly.
- This was such a refreshing and enlightening course.
- I have had difficulties in dealing with colleagues/peers. This course has through its processes helped me mediate these differences better

Positive Narrative Comments

- Overall a fantastic course that has allowed me to integrate myself and my individual components into a whole, well-rounded physician.
- Wonderful class and experience I will remember for the rest of my career.
- I am so glad that I was able to attend this course. I know that the things I learned will serve me well in my future career and in life in general.
- This was one of my favorite experiences at UCI. The way the course was designed to encourage self-exploration after going through med school was unbelievably helpful. I feel that every medical student would benefit from this course. We felt 100% comfortable sharing our true feelings/fears in a way we have never been able to in the past. Just being able to expose ourselves and realize that others were having similar issues and still be supported by faculty was amazing! Thank you so much for teaching me so much about myself, my peers, the world of medicine, how to be a better person!
- A wonderful course that comes at just the right time in medical education – it really helped me reflect on the experiences that I have had and to truly understand how to integrate the different parts of myself into my practice as a physician. I felt like a lot of effort was put into helping us grow and learn within the class and from each other's experiences and ideas. I think all students should be required to take this class.

Negative Narrative Comments

- “I felt that AoD dwelled on bad experiences too much and did not encourage us to think of positive patient encounters. I also felt there were too many colleagues in the class to truly express my feelings/thoughts, yet still be in a somewhat professional setting.”
- “Would be helpful to have more student discussion than lecture” “I’d say more student participation!” (2006, 2007, 2009)

Future Directions

- More small group work
- More student leadership
- Intersperse personal projects throughout the curriculum
- More involvement of physician faculty
- Required vs. elective?
- Institutional culture of caring