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Coping With Loss of Control in the Practice of Medicine

Johanna Shapiro, PhD
John Astin, PhD
Shauna L. Shapiro, PhD
Daniel Robitshek, MD
Deane H. Shapiro, PhD

Although the quest for active control and mastery can be seen as a central thread that ties together important aspects of human experience, we are frequently confronted with the reality that much of what is encountered in life lies outside our active instrumental control. Control must involve finding healthy and life-affirming ways to exercise personal mastery, and identifying constructive ways to respond to the lack of control that pervades the human condition. In this article we explore a number of professional areas in which physicians may experience significant feelings of loss or lack of personal control–difficult encounters with patients, dealing with patient nonadherence, end-of-life care, confronting the uncertainty and ambiguity that are frequently a part of illness, as well as institutional and systemic factors that can result in loss of various forms of autonomy and control over decision-making. We then consider maladaptive ways in which physicians sometimes attempt to address such losses of control and suggest that personal stress and burnout and difficulty developing effective therapeutic relationships with patients may be the consequence, in part, of these efforts. Finally, we discuss an empirically derived, multidimensional theoretical model for better understanding control dynamics, and identifying more optimal strategies physicians can employ in their efforts to gain and regain a sense of control in caring for patients.

Keywords: control theory, physician loss of control, physician coping, physician wellbeing

Johanna Shapiro, PhD, Department of Family Medicine, University of California Irvine School of Medicine; John Astin, PhD, Research Institute, California Pacific Medical Center; Shauna L. Shapiro, PhD, Department of Counseling Psychology, Santa Clara University; Daniel Robitshek, MD, Hospitalist Program, Floyd Medical Center, Rome, Georgia; Deane H. Shapiro, PhD, Department of Psychiatry & Human Behavior, University of California Irvine School of Medicine.

Correspondence concerning this article should be addressed to Johanna Shapiro, PhD, Department of Family Medicine, University of California Irvine Medical Center, Route 81, Building 200, Suite 512, 101 City Drive South, Orange, CA 92868. E-mail: jfshapir@uci.edu

Psychological research has demonstrated that the desire for a "sense of control," which we define as "the ability (or perception that one has the ability) to cause an effect in the intended direction" (Shapiro & Astin, 1998), is a pervasive human experience (D. Shapiro, Astin, S. Shapiro, Soucar, & Santerre, 2010; Rodin, 1986). Although the precise nature of this need for control is influenced by factors such as self-efficacy (Bandura, 1977), culture (Burger & Cooper, 1979), and personal

variability (Evans, Shapiro, & Lewis, 1993), across domains and stages of life, the behaviors and cognitions of individuals can be understood, in part, as an expression of their perceived need to gain, maintain, and/or reestablish a sense of control (Shapiro & Astin, 1998; Shapiro, Schwartz, & Astin, 1996; Rodin, Schooler, & Schaie, 1990; Brehm, 1966). However, much of what we encounter in life is outside our active instrumental control–the weather, the stock market, illness and death. Thus, a healthy sense of control should include not only ways to exercise positive mastery, but also constructive acceptance of lack of control.

We suggest that examining issues of control, lack of control, and how to gain or regain a sense of control, is of particular relevance for physicians. Much of the training of physicians focuses on learning how to interact in ways best understood as taking control of problematic situations, for example, by removing a malignant tumor through surgery or reducing high blood pressure through medication. Yet one of the difficult realities physicians face is that, despite their knowledge, skill, and expertise, there remains much in medicine and patient care that they are unable to control through active, instrumental efforts. Below we highlight a number of professional areas where clinicians may experience significant feelings of loss of control and the maladaptive efforts they may sometimes employ to address or cope with such losses of control. Finally, we present an empirically validated, theoretical model for better understanding control dynamics and identifying more optimal strategies for gaining and regaining a sense of control that we think may be of relevance in clinical practice.

EXAMPLES OF ISSUES THAT MAY LEAD TO FEELINGS OF LACK OF CONTROL IN PHYSICIANS

It is often the unknown and unpredictable in life, both of which are very evident in dealing with health-related matters and the care of patients, that engender feelings of lack of control. As a result, physicians are frequently confronted with feelings of loss or lack of control in the course of their clinical practice. Below we highlight a number of areas that may be particularly likely to trigger such feelings.

Relationships With Patients

When we use the lens of "control," the ideal patient is one who agrees with the physician's diagnosis, accepts the physician's agenda, is willing to follow the physician's treatment plan, in general shares the physician's world view, and finally, is grateful for the physician's time and assistance (Khalil, 2009). Such patients support the physician's feelings of being "in control" of the encounter and the relationship. However, certain patient behaviors may be more likely to elicit feelings of loss or lack of control for physicians. These include: (a) demanding that doctors "fix" the problem, despite the problem not necessarily being "fixable," or insisting on inappropriate treatment (the "demanding" patient; Strous, Ulman, & Kotner, 2006); (b) becoming overly dependent or reliant upon the practitioner (the "needy" patient); (c) failing to take personal responsibility for their own health care choices; (d) communicating certain emotional states (e.g., anxiety, fear, anger, depression) that the provider is either personally uncomfortable with or finds difficult to address; and (e) having multiple coexisting psychological and medical problems, none of which is easily remediable (predictive of "difficult" clinical interactions) (Rosendal, Fink, Bro, & Olesen, 2005). Relationships with such patients tend to generate negative physician responses (e.g., anger, frustration, discomfort, blame, helplessness), which we relate to loss of control, responses that are likely to adversely affect patient care and create emotional distress in the physician.

Adherence

Patients frequently do not follow the therapeutic advice of their doctors, in many cases being either unable or unwill-

ing to change lifestyle/behavioral habits or adhere to treatment regimens (Vermeire et al., 2007). Although physicians are in many respects in a position of social power and influence with regard to their patients (e.g., patients do often willingly comply with physician suggestions), ultimately they are not in control of their patients' behavior and choices. Lack of behavioral change or adherence to drug regimens on the part of patients can therefore lead to pronounced feelings of powerlessness, helplessness, and frustration that are direct outgrowths of the physician's sense of lack of control. Such reactions can both erode the quality of physician-patient communication and diminish the quality of the physician's professional life.

End-of-Life Care

One of the most challenging issues faced by physicians is how best to communicate with and care for patients and their families in end-of-life situations. Difficulties relaying unfavorable diagnostic information are common (Trice & Prigerson, 2009; Winzelberg, Patrick, Rhodes, & Deyo, 2005). In an effort to preserve their sense of control and protect themselves from the fear of losing control, physicians can end up avoiding the emotionally difficult issues involved in end of life care, to the detriment of both their patients and themselves (Quill, 2000). Issues of control are also useful in explaining the complex decisions that surround the use of so-called heroic measures to prolong life. It could be argued that our sometimes excessive, inappropriate (and extraordinarily expensive) use of heroic measures reflects not only our culture's difficulties with surrendering control, but also physicians' fears that to cease medical intervention, even in the face of multisystem failure, will leave them and their patients feeling helpless and out of control.

Confronting Uncertainty

Despite the remarkable advances in biomedical science and our understanding of human health and illness, we frequently are unable to determine precisely why patients are not well and how best to help them (Evans & Trotter, 2009). Conditions such as chronic fatigue, fibromyalgia, and lower back pain are often only moderately responsive to treatment and bewilder both patients and doctors. Even when it is possible to make an accurate diagnosis in cases of chronic diseases, such as diabetes, hypertension, and coronary artery disease, restoring the patient to a "disease-free" state is often not possible. Medical conditions with uncertain etiologies or chronic prognoses are likely to produce feelings of loss of control (e.g., a sense of being powerless or helpless) in health care providers. These feelings may in turn interfere with the development of effective therapeutic relationships with patients.

Systemic Factors

Widespread and in some cases dramatic changes in the health care system, including how medical practices are organized and how health care is delivered and paid for in the past several decades have resulted in widespread physician dissatisfaction (Katerndahl, Parchman, & Wood, 2009; Linzer et al., 2009; Simoens, Scott, & Sibbald, 2002; Williams, Manwell, Konrad, & Linzer, 2007), in part stemming from feelings of lack or loss of control over their work (Gask, 2002). For example, in one study that examined predictors of physician well-being, it was found that "low perceived control," defined as lack of autonomy, reduced opportunities to participate in decision-making, lack of control over work schedules, and diminished ability to influence the work environment, was the single strongest predictor of dissatisfaction and poor psychological well-being among physicians (Freeborn, 2001).

The systemic uncertainty occurring in contemporary medicine as a result of ef-

forts to reform the health care system may be particularly difficult for physicians (Gundersen, 2001). Even the recent movement toward the Patient-Centered Medical Home (PCMH) (Kellerman & Kirk, 2007; Rogers, 2007) may pose control-related challenges for physicians not adequately prepared for this model. For example, PCMH assumes interprofessional team-based care and active patient participation in health care decision-making (Ferrante, Balasubramanian, Hudson, & Crabtree, 2010; Kellerman & Kirk, 2007). Both of these principles can threaten physicians sense of control when their relationships with patients are excessively authoritarian or paternalistic (Peters, 1994).

Many primary care physicians have not been trained to collaborate effectively and build relationships in real time with other health care workers such as nurses, interpreters, psychologists, social workers, and health educators. In contemporary health care teams are often organized to support the physician's hectic routines, and do not encourage shared roles and responsibilities (Chesluk & Holmboe, 2010). Similarly, patient-centered medicine assumes establishing common ground and building bridges between physician and patient agendas, the willingness to share power to promote patient wellbeing, and in particular to participate in shared decision-making (Frosch & Kaplan, 1999). Placing the patient at the center of care and emphasizing partnership concepts (Charles, Whelan, & Gafni, 1999) make a top-down, "doctor knows best" approach untenable, and are dependent on fluid models of control (Grol, 2001) that include recognizing multiple perspectives and negotiating mutually acceptable solutions (Montgomery & Fahey, 2001).

CONTROL AND THE BIOPSYCHOSOCIAL PERSPECTIVE

Despite decades of research that has lent strong support to Engel's (1997) notions regarding the fundamental importance of nonphysical factors in health (Astin, Shapiro, Eisenberg, & Forys, 2003; Novack, Cameron, & Epel, 2007; Salovey, Detweiler, & Steward, 2000), evidence suggests that medicine on the whole has not embraced the biopsychosocial model, either in research, clinical practice, or in how physicians are trained (Ghaemi, 2009; Levinson, Gorawara-Bhat, & Lamb, 2000; Shapiro & Freedman, 2001; Waldstein, Neumann, Drossman, & Novack, 2001). Studies demonstrate that psychosocial issues (including emotional problems identified by patients as significantly impacting their physical health) remain a frequently neglected aspect of communication within the medical encounter (Peters, Rogers, & Salmon, 2009; Suchman, Markakis, & Beckman, 1997).

Although the reasons underlying medicine's failure to move beyond the biomedical model are no doubt complex (e.g., curriculum that is already overloaded, lack of time and inadequate reimbursement, lack of knowledge of the evidence base supporting behavioral/mind-body interventions, strength of prior beliefs; Astin, Goddard, Forys, 2005), control-related issues may be of particular relevance in understanding barriers to integrating the biopsychosocial perspective. Suchman (2000) has suggested that medical culture in many ways prizes control over most other values. This is apparent in the emphasis medicine places on making accurate predictions and achieving desired outcomes, the hierarchical structure of relationships, and "cure" as the overriding criterion for clinical and personal success. Suchman (2000) further suggested that given such unrealistic personal and institutional expectations of control, it is understandable that physicians would be motivated to try and limit the "territory" for which they are responsible (e.g., "the body") and correspondingly less inclined to deal with other matters (e.g., emotions, thoughts) that they experience as less concrete, harder to observe and quantify, and more importantly less amenable or subject to control and prediction. In other words, to address the psychosocial (i.e., the interior)

aspects of patients' lives may require that physicians at times be willing to relinquish active control.

HOW PHYSICIANS RESPOND TO LACK OF CONTROL

Research suggests that people in general employ four basic strategies or "modes" (two positive and two negative) for gaining and regaining a sense of control (Shapiro & Astin, 1998; Shapiro, Schwartz, & Astin, 1996; see Figure 1). These modes have been reliably discriminated and empirically validated in both general and clinical populations (Shapiro et al., 1995; D. Shapiro, 1994; Shapiro, Potkin, Jin, Brown, & Carreon, 1993). The positive modes of control are represented by the terms *positive assertive* and *positive yielding*. Positive assertive involves active, assertive ways of gaining or regaining control. Positive yielding involves letting go of active control efforts. This mode is distinct from helplessness or passivity and represents the capacity to accept and respond effectively to potentially stressful, yet largely uncontrollable circumstances. The two negative modes of control are identified as *negative assertive* and *negative yielding*. Negative assertive or overcontrol involves inappropriate or excessive efforts to gain control, particularly in situations that are outside of one's personal control. Negative yielding, or helplessness, involves giving up and resigned passivity.

Historically, Western psychology has emphasized quadrants 1 (active control) and 4 (helplessness), arguing that humans' efforts to regain mastery and control exist on a continuum ranging from active, assertive efforts at change and mastery to helpless passivity. For example, as reflected in the frequently used Mental Adjustment to Cancer scale (Watson, Greer, & Young, 1988), patients are typically classified as either reacting to their disease with an attitude of "fighting spirit" (taking active steps to regain a sense of control, positive assertive control) or responding with feelings of helplessness-hopelessness (the negative yielding mode) (Watson, Haviland, Greer, Davidson, & Bliss, 1999). However, as we have pointed out in a series of publications (Astin, S.Shapiro, Schwartz, & D. Shapiro, 2001; Astin et al., 1999; Shapiro & Astin, 1998; Shapiro, Schwartz, & Astin, 1996), this view of control is both culture-bound and limited. Our research indicates that, in response to loss of control, people

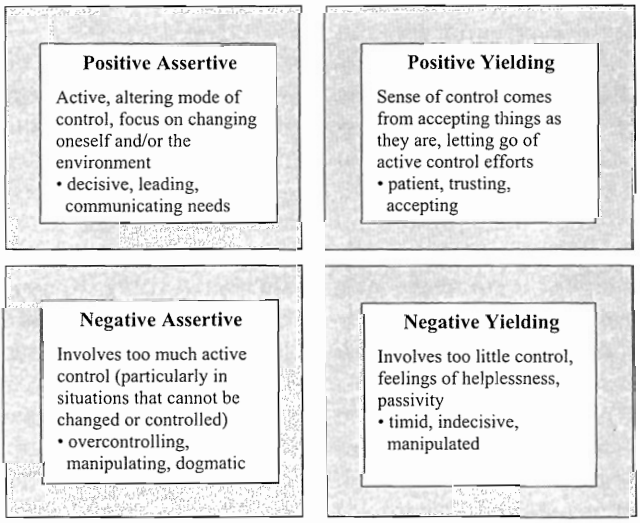

Figure 1. The four modes of control.

employ all four modes to regain a sense of control.

One way that physicians may respond to situations they perceive as less controllable is to avoid dealing with them, out of a sense of hopelessness and "giving up." We would call this a negative yielding response. Conversely, they may attempt resolution of such ambiguous or challenging aspects of health care through overcontrolling responses (e.g., becoming angry or coercive in difficult clinical encounters or in dealing with medical team conflict), which we term "negative assertive control." Loss of control and such maladaptive efforts to regain a sense of control can result in a failure to effectively deal with important patient care and health care system issues, and may in some cases be an important contributing factor to physician job stress, alcohol and substance abuse, and impaired mental health, all conditions in the general population that have been theoretically and/or empirically linked to lack of sense of control (Astin, S. Shapiro, Lee, & D. Shapiro, 1999).

IMPLICATIONS FOR PHYSICIAN TRAINING

How can physicians be prepared to deal with control-related issues in clinical practice? We suggest that physician training in medical school, residency, and beyond could address how to more reliably apply the two positive modes of control during stressful situations. Although physicians are currently most familiar with and most comfortable taking action, they could benefit from help in discriminating between appropriate assertive action and situations where they are behaving coercively and trying to overcontrol events that are not within their personal control (negative assertive mode). In terms of yielding skills, physicians need to learn when it is more beneficial to "do nothing," for instance simply sitting quietly and empathetically with a patient who has just received a terminal diagnosis. As part of their education, physicians could also be helped to realize when they are responding with feelings of powerlessness and hopelessness (negative yielding mode) to the sometimes seemingly overwhelming intellectual, emotional, and spiritual challenges of the practice of medicine, and learn to modulate these reactions in more positive ways.

Their training could prepare physicians to cultivate a flexible balance between the positive assertive and positive yielding modes of control. The most appropriate response to a given situation often involves combining positive and negative quadrants, that is, responses may have elements of both assertive action and yielding acceptance. It is critical that physicians know how to take charge of complex medical problems and how to obtain the latest evidence-based information about the clinical situation at hand (positive assertive mode of control). In the face of the many mysteries and uncertainties encountered in medicine, it is also crucial that physicians be able to accept themselves, the limits of their knowledge, and the lack of certainty (positive yielding mode of control). Learning to manage loss of control in healthy and effective ways could prove beneficial to their own and their patients' well-being.

STRENGTHENING POSITIVE MODES OF CONTROL IN PHYSICIANS

There are specific interventions that could help physicians cultivate the two positive modes of control. Controlled trials of mindfulness-based stress reduction have demonstrated increases in both positive assertive and positive yielding modes of control (Astin, 1997; Krasner et al., 2009; Shapiro, Schwartz, & Bonner, 1998; Shapiro & Carlson, 2009). Other approaches and strategies aimed at increasing a range of coping skills in physicians also may be relevant to improving the positive assertive and positive yielding quadrants, for example reflective practices such as writing critical incident reports (Branch, 2005) or en-

gaging in appreciative inquiry (Cottingham et al., 2008).

Strategies for strengthening positive modes of control derived from contemporary psychological theories, such as Control Therapy (Shapiro & Astin, 1998; D. Shapiro, Soucar, S. Shapiro & Astin, 2009), Dialectical Behavior Therapy (Dimeff, Koerner, & Linehan, 2007), Acceptance Commitment Therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006); Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002; Shapiro, Astin, Bishop, & Cordova, 2005;.Shapiro & Carlson, 2009) could also be profitably adapted to undergraduate, graduate, and continuing medical education contexts.

The application of control theory to physician training is at present in its formative stages. Although there is no set protocol for making physicians and physicians-in-training more aware of and more skillful in working with the four control quadrants, some specific dimensions have been identified as essential components of an educational experience. These have been piloted in an elective capstone Art of Doctoring course for fourth-year medical students at the University of California Irvine School of Medicine (Shapiro, Rucker, & Robitshek, 2006), now in its eighth year; and in single sessions taught over the course of several years as part of the behavioral science program in the University of California Irvine Family Medicine residency.

Self-Awareness and Reflective Capacity

To be able to consciously reduce behaviors and attitudes characteristic of quadrants 3 (overcontrolling, aggressive) and 4 (passive, resigned, hopeless) and increase those in quadrants 1 (active assertive) and 2 (accepting, letting go), the physician must first have awareness of herself and her own control-related tendencies (Wald, Davis, Reis, Monroe, & Borkan, 2009). Thus, activities that encourage self-introspection and a nonblaming willingness to recognize one's proclivities to be either overcontrolling or hopeless are valuable. For example, in the Art of Doctoring course, we use a variant of the Meyers–Briggs Personality Inventory to encourage students to become more familiar with their reflexive responses in stressful situations. A more specifically control-related inventory, the Shapiro Control Inventory (D. Shapiro, Soucar, S. Shapiro, & Astin, 1994), could also be incorporated into a class or even single session setting.

Mindful Emotion Regulation

In addition to self-knowledge, it is more likely that positive control quadrants will emerge from a calm, centered place. Mindful emotion regulation has been posited as a method that neither suppresses nor cognitively reframes emotions, but rather nonjudgmentally observes and investigates them (Chambers, Gullone, & Allen, 2009). This practice reduces emotional agitation and enables the individual to see the situation more clearly. Learning how to center oneself in the midst of the chronic pressures, time conflicts, and competing demands, often involving significant human suffering and sometimes questions of life and death that comprise the physician's daily world, is a critically important skill for physicians. It is also a trustworthy starting point from which to contemplate appropriately assertive action or an accepting/yielding response. This kind of centering can be promoted by spiritual practices such as prayer, meditation, reciting wisdom sayings; or something as simple as pausing and taking a breath. Again, many techniques are available for use with physicians (Epstein, 1999; Dobie, 2007).

Increasing Positive Control/Decreasing Negative Control

The basic approach in helping physicians work in more positive ways with their desire for control and fear of loss of control is to strengthen their ability to activate positive control modes, and resist the impulse to slide into negative modes. Through

self-awareness, physicians learn to recognize instances of all four modes. Through mindful emotion regulation, they learn to interrupt reflexive patterns, reactive patterning that favors negative control modes. They can then begin to recognize when they are trying to regain a sense of control by exercising control over a patient, to shame or intimidate a patient into compliance for example (quadrant 3); or when they allow themselves to succumb to the passive helplessness of burn-out, cynicism, and disillusionment (quadrant 4). They realize that they have some choice as to whether they wish to perpetuate these patterns, with all of the negative consequences they entail; or whether they wish to explore more constructive responses. In order to support a different choice, educational and training activities can emphasize practice of quadrant 1 and 2 attitudes and behaviors, or combinations thereof. Physicians learn that restoring either an active or an accepting mode of control, or some combination of both, is in part a skill that can be cultivated, just like learning to make a surgical incision or assess a skin lesion.

A Model for Promoting the Positive Assertive Mode and the Positive Yielding Mode in Difficult Situations

One model for encouraging the likelihood of quadrant 1 and 2 responses has been presented in medical student and resident educational contexts (the Six Noble Principles [6 NP]; see *Appendix*). This model consists of six steps. First, the physician needs to center herself (mindful emotion regulation), to increase the likelihood of identifying and then choosing the best response for a given situation. Next, she practices feeling grateful for something in the situation or something about the other person–even in situations of stress and conflict it is usually possible to find something to appreciate. Third, the physician assesses the problem, the other person, and herself as clearly as possible. Fourth, she sets a goal (what is she trying to accomplish?) and an intention (how does she want to achieve this goal?). In the fifth step, the physician generates possible options for action and considers whether this is a situation in which assertive action is possible and appropriate; whether it is most appropriate to accept and let go of something beyond her control; or some combination of the two. Once the appropriate response is chosen, the physician must implement this mode without regret. In Step 6, the physician evaluates the outcome of her action, and identifies insights and refinements for future similar situations.

EXAMPLES OF USING POSITIVE MODES OF CONTROL IN PROFESSIONAL CONTEXTS

Below we discuss possible control-enhancing responses to the five professional domains identified as being particularly likely to produce feelings of loss of control and being out of control in physicians.

Difficult Physician-Patient Relationships

Physicians often assume a therapeutic contract that includes acceptance of expertise, gratitude, and cooperation. When patients are "demanding," "needy," or otherwise "difficult," physicians may easily revert to quadrants 3 and 4 modes of trying to reestablish internal and external control. Preferable responses can be found in the domains of positive assertive or positive yielding. For example, once a physician has become centered, she may be able to let go of actively trying to control a difficult patient encounter (Bub, 2004), and instead choose to question the patient more closely about her behavior, and empathize with the root cause of the patient's anger, mistrust, or fear. In this case, a combination of being able to absorb and tolerate the patient's problematic attitudes and behavior (quadrant 2), while simultaneously being curious to understand better and address the reasons for the patient's behavior (quadrant

1), may yield the best possible outcome for both patient and physician.

Nonadherence

Physicians sometimes resort to either quadrant 3 or quadrant 4 in attempting to cope with a patient who apparently is resistant to following physician instructions and/or adherence to prescribed regimen. In quadrant 3, the physician will attempt to cope with her feelings of having lost control of the situation by exercising "power over" the patient to somehow force the patient into doing what the doctor wants. Alternatively, the physician may attempt to reduce feelings of loss of control by withdrawing emotional investment from the patient: "If my patient doesn't care about her own health, why should I?" This is essentially a quadrant 4, passive reaction.

A more effective way to regain a sense of control is to work out of either quadrants 1 or 2, or some combination of the two. Following the 6 NP model, the physician should first center and release her frustration with the patient. Then she should find something to be grateful for in the situation (perhaps that her patient is still coming to see her; or that the patient has told her she wants to improve her health for the sake of her children). At this point, the physician can explore various positive control strategies. On the active end of the continuum, she might contemplate creative ways of achieving patient buy-in to the proposed regimen. On the accepting end of the continuum, she might acknowledge that the patient is resistant to the treatment plan, and express nonjudgmental interest in why this is so.

End-of-Life Issues

It is understandable that physicians might on occasion attempt to deal with feelings of loss of control when faced with terminally ill patients and their families either by taking refuge in overcontrol or in resignation, withdrawal, or despair. Neither of these reactions, however, is helpful to the patient and family. After centering and reflecting, the physician should explore setting in motion positive quadrants to restore a sense of control. On the active end of the control continuum, there are still many "actions" that the physician can take (comfort care, arranging hospice, providing support and information to the patient and/or family). The physician can work to "accept" the inevitability of death in certain circumstances and the limits of medicine (and of herself). An attitude of courageous acceptance will allow the physician to overcome personal feelings of lack of control, and to be more present for patient and family.

Uncertainty

Lifelong learning and research breakthroughs advance individual knowledge. Yet the encounter between patient and doctor is often fraught with doubts and questions. When physicians pretend to a certainty they cannot guarantee, they are guilty of quadrant 3 (overcontrolling) behavior. Conversely, when they are paralyzed by fear, misgivings, and qualms, they have become lost in the passivity of quadrant 4. Paradoxically in these situations, the willingness to integrate uncertainty as a necessary part of clinical practice, the ability to admit the limits of knowing and prediction, can go a long way toward comforting both patient and physician.

Organizational Issues

Participating in the life of health care institutions requires patience and perseverance. Most health care organizations labor under a bewildering array of federal and state regulations, accept insurance plans that generate enormous paperwork and time on the telephone, and confront financial requirements that demand strenuous, sometimes mind-numbing workloads. Physicians do not always have the time, resources, or authority to care for their patients as they might wish. These circumstances can create reactions of over-

control or passivity. The likely changes in the health care systems that will result from national health care reform will continue to demand flexibility, adaptability, and persistence. Working to take full advantage of new opportunities offered by such models as the PCMH while resolving the problems that will inevitably arise requires both a centered frame of mind and the capacity to choose the best quadrant 1 and/or quadrant 2 responses that will sustain the physician with a positive sense of control. Working with health care teams and patients, in contrast to "ordering" them, requires flexible attitudes toward control that enable the physician to identify the most appropriate balance of positive assertive and positive yielding actions to accomplish desired goals in a given clinical situation.

CONCLUDING REMARKS

We believe that an important part of physicians' "calibrating" themselves (Novack et al., 1997) and becoming more self-aware "instruments of healing" should include attention in medical training and clinical practice to issues of control. This process would involve physicians and physicians-in-training becoming more aware of their own control dynamics and the ways in which such factors impact their relationships with patients, trainees, colleagues, and staff. It would entail a willingness to examine how they respond to feelings of loss of control (Suchman, 2000), and how they might better develop both positive assertive and positive yielding control strategies in their efforts to gain and regain a sense of control (J. Shapiro, Prislin, D. Shapiro, & Lie, 2000). Once physicians become cognizant of their own control-related issues, they may also begin to see how such issues affect their patients' responses and decisions in both positive and negative ways; and eventually learn to work with their patients to strengthen both their assertive and yielding modes of control. Focusing on issues of psychological control has important implications not only for improving the physician-patient relationship and the overall quality of patient care, but also in terms of developing more effective and respectful interprofessional team relationships and fostering greater health and well being for the deliverers of health care themselves.

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Appendix

THE SIX NOBLE PRINCIPLES (HANDOUT USED IN UC IRVINE SCHOOL OF MEDICINE 4TH YEAR ART OF DOCTORING)

Step One: Centering

At the simplest, we can just "*Take a breath.*" If the situation is not an emergency (and most situations aren't, even in medicine, although they might feel like it), it's always better to come from a centered, calm place.

Step Two: Gratitude

After centering, it is useful to create a context of gratefulness for your subsequent actions, including respecting your "enemy" even if, and especially when, you disagree with this person; or recognizing a common humanity with everyone, even those you dislike or find frustrating; or identifying something you appreciate, enjoy, or value about the other.

Step Three: Assessment/Exploration

From this calm, grateful place, it's easier to see "what is."

Situation/Concern

What is the nature and content of the situation of concern? How severe, acute, or important is it? Is it worth taking a conscious action, either an assertive or a yielding one?

(*Appendix continues*)

Other

If another person is involved, what do you know about that person's interactional style, needs, desires, fears, trustworthiness, and openness to honest feedback?

Self

What do you know about yourself and your own control dynamics? How do you generally respond to situations that feel out of control—with increased desire for control and assertive action? With feelings of helplessness?)

Step Four: Goal Setting/Intention

Goal

If everything goes perfectly, what would be the best possible outcome for this situation; that is, what is your goal? Be sure you know what your most "centered" goal is (wanting to increase patient compliance vs. wanting to express your frustrations toward the patient).

Intention

Further, what intention do you want to set for yourself in pursuing your goal?—(i.e., keeping calm, not insulting the other, standing your ground, being ready to compromise etc.).

Step Five: Intervention

Creating Options for the Response That Best Matches Your Goal

Once you have completed your exploration/ assessment, and have established a goal, what are different combinations of assertive and yielding modes that might help you achieve this goal? Which of the various response options feels most right to you in your situation?

Choosing an Option

From a centered place (Step One), based on your exploration and assessment of the situation (Step Two), and the goal and intention you have established (Step Three), select from the list of options you have generated the ones you think and feel will best help you achieve your goal. Choosing the optimal assertive/yielding mode for the particular situation involves recognizing our own personal dynamics, such as a fear of being too passive (quadrant four), or a fear of being overcontrolling and unkind (quadrant three).

Implement Your Choice Using Right Speech and Right Action

The principle of right speech and right action is to make sure that what you say and how you behave as part of your action are as clear and fair as possible. This means using speech and action that are no "stronger" than necessary to achieve your goals and intentions, and that seek to minimize hurt and harm to the other person—and to your self.

Step Six: Evaluation

Did you achieve your goal? If so, how does that feel? If not, what did you learn: for example, about the other person, yourself, the strategy you used? What changes might you make for next time, or in the next phase of the interaction?