Hi [redacted]. Thanks for getting in touch, and for sharing your ideas. I just sent out a memo asking everyone to do this, so you're ahead of the curve. You're off to a great start. Your "area" is perfect - active listening, a much-needed skill. And you've also "operationalized" it - "less" interrupting (or "more" allowing the patient to finish her sentence); and not writing while listening to the patient. Since you're not going to be interrupting and you're not going to be writing, are there any positive, proactive things you could do to demonstrate active listening? (more eye contact, more uh-huhs, more paraphrasing or clarification?).

So your first two steps are excellent. Now try to monitor each behavior for a couple of days. How often did you interrupt your patients? How often did you write while listening? This is just to get a sense of where you are.

The next step is to think about what you can do to increase the likelihood that you won't interrupt or won't write and listen. A cue card? Setting an intention before each patient encounter? Try some interventions for a week and see what happens. Maybe you'll decide, for example, that you NEED to write and listen, so you might modify your goal to writing respectfully, and demonstrate this by explaining to the patient why you're writing ("If you don't mind, Senora Garcia, I'm going to write down a couple of things as you talk because I don't want to forget anything important") and by setting down your pen at key moments of the interview. These are just hypotheticals, but hopefully they'll give you a sense of how to do this project.

The final step is to pay attention to your own and your patients' reactions while you're working with these behaviors. Are you a better doctor in any way when you interrupt less/pay more attention? Do you feel more relaxed, more respectful? Do your patients respond any differently?

This is a long answer to some excellent, focused questions. I hope it gives you a concrete way of translating the project into your life. Thanks again for the inquiry and for bringing such good intention and focus to this assignment. See you on the 23rd. Regards, Dr. Shapiro

-----Original Message-----
[redacted]
Sent: Wednesday, March 03, 2004 8:20 PM
To: Shapiro, Johanna
Subject: RE: Art of Doctoring homework assignment

Hi Dr. Shapiro,

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, March 24, 2004 11:03 AM
To: [redacted]
Subject: RE: Self-change project

[redacted] this looks great. Your general area of focus is to be "more of a patient advocate." The ways you intend to accomplish this goal are to: 1) See patients outside of rounds (you might even try to pin this down further - half of your patients, once after rounding) 2) Give the team more input (again, you might decide to try to provide at least one comment to the team about each patient you've seen). You'll encourage yourself to do these things by a) observing positive role-models and b) paying attention. The way you'll assess the larger impact of this project on your doctoring skills will be to see whether you a) become more confident, b) are more in touch with patient feelings, and c) are better able to formulate treatment plans.

As Dr. [redacted]r points out, the best way to figure out whether you're making progress is to make a little chart in which you record on a daily basis:
1) "Extra" non-rounding visit to patient a, b, c etc. (yes/no)
2) Input to team about patient a,b,c(0,1,2, 3+ comments)
3) Feelings of confidence (maybe rate once daily on a scale 1-10)
4) Awareness of patient a,b,c feelings (maybe rate once daily 1-10)
5) Improvement in contributions to plan of care patient a,b,c (rate once daily).

These are just ideas, you can come up with your own approach, but the important thing is to pay attention by monitoring your behavior.

This is a very worthwhile project, and the way your operationalized advocacy makes a lot of sense. Thanks for sharing, Dr. Shapiro

-----Original Message-----
[redacted]
Cc: Shapiro, Johanna
Sent: 3/23/2004 4:01 PM
Subject: Self-change project

[redacted]
the team.

Nice work, [redacted]. Talking about uncomfortable subjects is a crucial issue in medicine, and you've probably already discovered that you're not the only one who struggles with it. Many, although of course by no means the majority, physicians also "shy away," and treat these topics callously, judgmentally, or superficially. So you've made a great choice! You've also done a great job of identifying the "antecedent behavior," i.e., the initial avoidance impulse that precedes the topic, and are using this as a cue to attempt a different, more engaged response.

My only thought is that you might want to play around with how you "force yourself" to interact with patients around such topics. In my own life, I've discovered that when I "force myself," I can generally achieve the desired behavior for awhile, but it disappears pretty quickly, because it's painful to use force on anyone, even ourselves. I've tried to learn how to "soften" into behaviors that are personally difficult for me, like the ones you describe, by pausing before I panic (:-)), taking a breath, finding something to be thankful for in the situation ("I'm glad I can be here to tell this man he has metastatic lung cancer, even though it's going to be tough, because he needs someone with him), and setting an intention ("I want to make this about him and not me"). Then, while acknowledging the tough parts ("I wanted to cry along with him," "I felt so helpless because there was nothing we could offer"), it can be important to pay attention to some of the positive outcomes of your effort ("Gee, the patient seemed really grateful I took the time to answer his questions"). This approach may help you attain your objectives in this area more easily.

However, regardless of how you develop your intervention, it sounds as though it has already been effective and you've begun to notice some beneficial results. It's an excellent observation on your part that you're starting to come up with "certain qualifying phrases" that make these discussions go more smoothly. As you continue to practice, and make refinements and modifications in your technique, you'll notice what is effective, what is comforting, and what is less so. And of course your own comfort level should increase as well.

Thanks for sharing this interesting project. Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Tuesday, April 13, 2004 2:52 PM
To: Shapiro, Johanna
[redacted]
Subject: self change project

Hi Drs. Shapiro [redacted]

[redacted]

Shapiro, Johanna

From: [redacted]
Sent: Wednesday, April 14, 2004 1:11 PM
To: Shapiro, Johanna; [redacted]
Subject: RE: personal project

This is really what we had in mind. Stories like these are very gratifying.

LR

[redacted]

-----Original Message-----
From: Shapiro, Johanna
Sent: Wednesday, April 14, 2004 12:26 PM
[redacted]
Subject: personal project

[redacted], thank you very much for taking the time to share what you've been dong with your personal project. I'm really impressed. You've done really good work in operationalizing how to find out more about patient problems through the mechanism of an "extra visit." (It's time expended that you probably don't exactly have, but I hope the reward of gratitude and a hug made it worthwhile!). It also sounds as though you're making excellent progress with your second goal of providing more input to the team. Paying attention to what's being discussed is an important strategy (surprising how much our minds wander – *why aren't I saying anything? I wonder if I can take 10 minutes to grab lunch? That guy is so self-important* – and we lose sight of the ostensible purpose of the discussion, ie., the patient. And, as you've discovered, your goals are interrelated: the more you know about the patient, the more you're well-positioned to fill in the team's gaps. Finally, I'm delighted to hear your confidence is increasing, you are becoming more aware of patient feelings, and you feel you are providing whole-person, patient-centered care. You sound like you're becoming a real doctor! ☺. Thanks for the update, Dr. Shapiro

Shapiro, Johanna

From: [redacted]
Sent: Friday, February 27, 2004 11:41 AM
To: Shapiro, Johanna
Subject: RE: art of doctoring essay

[redacted]

-----Original Message-----
From: Shapiro, Johanna
To: [redacted]
Sent: 2/25/2004 4:54 PM
Subject: art of doctoring essay

[redacted], thank you so much for sharing this work. I'm impressed with how seriously you took this assignment, and the obvious care and thoughtful honesty you put into it. I think your assessment of the medical school environment shows evidence of acute observation, and unfortunately I couldn't agree more with your conclusions. Although I know none of this is really humorous, I did have to smile at your comments equating being seen with being perceived as in the way - too often, how true!

Your suggestions for changing the system are quite excellent, and made me particularly glad that you'd given a copy of this to Dr. [redacted], who is in a better position to change the system than I am. The idea of a teaching session for residents is outstanding. I don't know if you were aware of the BEST program that Dr. Morrison ran the last three years, but it actually did something quite similar to what you propose. Dr. Morrison worked with (a select number of) IM and FM residents on a set of teaching skills, including how they interacted with medical students. Although this program is essentially in abeyance at the moment (because it ran out of funding - another systemic problem!), with your permission I'd like to pass along your suggestions to Dr. [redacted] for possible incorporation when she is able to revive this program. Your point about involving attendings in an oversight capacity is also extremely well-taken.

I appreciated your honesty about struggling with what you can do personally about these problems. In a way, it's not fair to ask you (or any student) to do personal work when none of this is your fault, it's a systems problem. I do see this, agree with your analysis, and fully support any program, any intervention, any anything that can positively influence resident and attending behavior. My only point in asking you all to think about what you can do personally is to a) reduce the feelings of helplessness, by focusing on a domain that is more under your control than the actions and attitudes of others b) help you develop the skills to cope when you find yourself in a bad situation, so that no matter how others behave, you know that you are hanging on to your own integrity and values. My personal belief is that by doing so, you are less likely to morph into one of those thoughtless, exploitive residents! In fact, you came up with some wonderful ideas, which I think will make your learning experience more enjoyable and make you "visible" (at least to yourself) in a way you can feel proud about.

Finally, underneath the problem-solving, I hear your pain and frustration at having to pursue what is probably a lifelong dream (ie., becoming a physician) in such an inhumane, judgmental, harsh environment. It is with an eye toward reducing this suffering - and the suffering of your fellow students, because I think your feelings are widespread - that I'm encouraging you to develop personal strategies for handling these difficulties in a way that empowers you and helps you grow as a person.

Thanks again [redacted] It does get better, I promise you that. Dr. Shapiro

Art of Doctoring
Group 1 Assignment 2

Hi, everybody. Great group! Thank you for being so participatory and open. I think we are going to work very well together.

Our next meeting is not until Nov 11 (sorry for the gap, blame it on scheduling). So it's important that you remain focused on your *intention* for participating in this elective, which is to keep compassionate and empathic attitudes and behaviors toward patients, and toward others generally, in the forefront. One way you can do that is by *acting* like a group, even when we are not all physically together. In fact, we are a kind of "intentional community," coming together for the purpose of trying to become (just a tiny bit!) better people. So don't hesitate to remind each other that you are "part of a community," when you are on the same rotation, or pass each other in the corridors. Also consider using email to share an inspirational quote, ask a question, or make a suggestion. We can all learn from each other – really!

The second way you can keep focused is by *actually completing the writing assignments below.* Unless your initials are RP, you do not have to complete every aspect of the assignments with total precision and absolute comprehensiveness (just kidding, [redacted]. But please do make a whole-hearted effort. If there is one part of the assignment that you don't find helpful (e.g., you don't like jotting down the numbers), discontinue it. If you really want to concentrate on one part, and deemphasize others, feel free to do so. The main point is that we've learned over the years that people usually get a lot more out of something when they put sustained, systematic, and focused effort into it, rather than simply "thinking about it" on the fly. As Dr. [redacted] observed, doing the writing is less a matter of time than of intention (ahh, any parallels between this and patients whom we "don't have time" to interact with empathically?!). Make a commitment, as an experiment, to write for 5 minutes every day – or 7 minutes twice a week – or whatever you want. Even if this doesn't make sense to you, do it as a kind of discipline, and then in November you can tell us how much you hated it ☺. To encourage this effort, we hope/expect that you will all bring your journals to our next session. We won't be collecting them (!), but we hope you will have identified an interesting passage or two that you will be willing to share.

Now as to the specific assignments:

1) Same old, same old: Particularly for those of you who did not write anything down this time, or who were confused about what you were supposed to write down, or who loved writing this stuff down so much that you want to continue…
    a) Daily numerical rating (1-10) on "how good a job did you do at work today" from the perspective of acting in a kind, compassionate, empathic, and caring way toward your patients.
    b) Daily numerical rating (1-10) on "how you felt about yourself today."

c) Example of one "good" thing you did (professional OR personal) that made a positive difference in someone's life in the sense of that person feeling cared about, valued, understood, respected etc.
d) Example of one situation which, looking back, you wish you had handled differently, in the sense of being more understanding, patient, kindly, compassionate, etc.

2) Emotional equilibrium scale and commentary:
Make a scale that looks something like this, or one of your own devising:

Complete emotional detachment/objectivity (patient could be a slug or a paramecium for all you care)	Emotional equilibrium Osler's aequanimitas combination of steadiness/tenderness	Complete emotional "overwhelm," meltdown (patient needs to put *you* back together)

Write down each day where you think you fell (either overall, or based on a single clinical interaction); then comment how you felt about that (pleased or disappointed), and why you think you acted as you did. Jack Coulehan, a professor of internal medicine at SUNY and an accomplished poet, has written a wonderful essay on emotional steadiness and tenderness. He defines steadiness (which he prefers to the more emotionally vacant terms of distance or detachment) as the ability to keep a calm and even emotional keel when all around you is emotional chaos and turbulence (an attitude that says, "Ah, this too" and that communicates "Don't worry. I can handle this situation emotionally. I can contain this grief, this fury, this helplessness." Tenderness, on the other hand, is the ability to care about the people/patients lost in all this emotional turmoil, to be moved by their suffering.

3) Below is a partial summary of some of the ideas/concepts that emerged from our group discussion. Choose one that you will commit to as a "practice," and then write each day briefly about how you did, how you felt, and what you noticed.
   a) Relax/center physically, emotionally, and spiritually as part of each transition (before interviewing patient, presenting to attending, eating lunch, going home)
   b) Set a daily intention ("I'm going to focus on being compassionate, grateful joyful, kind, loving, attentive, alert etc. etc. in all situations today")
   c) Be "present" (attentive, aware, focused) in each moment
   d) Be aware of and labeling your emotional state ("I'm feeling... annoyed, panicked, angry, guilty, fearful, anxious, worried, exhausted, incompetent, idiotic, disgusted/ joyful, grateful, happy, proud, enthusiastic, etc.)
   e) Try to understand how every person/situation you encounter is your teacher

f) Pay attention to how you can bring your most important values into your daily life
g) Practice compassionate curiosity toward patients (and others)
h) Practice "deep listening" toward patients (and others)
i) Share more of yourself with patients (and others)*
j) Spend five minutes thinking creatively and compassionately about patients (and others) when you don't have to

- "Sharing more of yourself" does not necessarily mean telling people your life story but learning to be more "authentic" with them, filtering the unique essence of who you are through the shell of professionalism.

Remember, we want you to take this assignment seriously and ***write about stuff!*** But don't hesitate to tailor the assignment to your needs and interests. Maybe you would like to stick with #1 for the next 6 weeks. Maybe you'd like to spend a week on each, and see which one you like best. Maybe you want to modify the assignment to make it more "your own." Be creative, be bold, but be committed.

The sloppy, angry, inconvenient, hurried, and difficult Buddhas around us can teach us steadiness, equanimity, and compassion.
- Jack Kornfield

SUMMARY NOTES ART OF DOCTORING GROUP 1 SESSION 3 11/25/03

began by asking members to engage in a thankfulness exercise, by expressing thankfulness for one professional and one personal aspect of their life. She explained that expressing thankfulness does not mean ignoring or repressing more negative emotions of frustration, annoyance, anger, resentfulness, exhaustion. Rather, it is an attempt to develop a larger context as a way of containing such emotions. Some students acknowledged not feeling much gratitude or thankfulness. modeled thankfulness statements, then all participants mentioned relevant items. Most personal items had to do with family. Professional items ranged from gratitude toward patients to finishing call or switching from in-patient to outpatient. also shared research study that people high in altruistic qualities of listening, caring for others have higher mental health than those who do not; and distributed an article by an older physician expressing gratitude toward teachers and patients

then asked students to list something that was really "pissing them off." expressed frustration at students leaving a lecture she was giving. mentioned institutional resistance to admitting patients with no insurance. mentioned a patient who wanted a natural childbirth, but ended up being "consented" for use of forceps only so that ob residents could "practice." noted the competitive environment, which caused many residents to make disparaging remarks about students or even each other. JS elaborated on this point as an example of "third party communications," and invited students to engage in "right speech" for a week. and stated they had nothing they were pissed off about. mentioned the anger she feels and bad language she uses while driving that results from her levels of stress and tension on in-patient. made a statement about medical school being an "E-ticket ride" overall, although there were many aspects that frustrated and angered him. and both mentioned the constant pressures of being graded and the entire evaluation process, which resulted in feelings of helplessness. and additionally noted their own feelings of futility in protesting poor treatment of patients, or other systemic inadequacies. They felt that "nothing ever changed" as a result of such acts, yet they often resulted in negative consequences for the student. There was some discussion of how power inequities in the hierarchy of medical education disadvantaged students in terms of full participation in the system in which they are supposedly stakeholders.

raised the question of why "good" medical students turn into "bad" (mean, abusive, disrespectful) residents. Students hastened to point out that many of their resident role-models are outstanding and take the time to do extra teaching and mentoring. Students seemed to agree that "goodness" and "badness" are innate qualities, such that "good" students somehow survive medical education to become "good" doctors; while "bad" people's qualities are exacerbated by the training process and turns them into "mean" residents and "uncaring, insensitive" physicians. suggested the possibility that it is not so much "badness" as exhaustion, lack of awareness, thoughtlessness, and systemic failures into which residents are socialized.

A long discussion of grading ensued. [redacted] observed that evaluation has much to teach us and should not be summarily dismissed. He suggested a middle ground, in which attention was paid to others' opinions, but one also develops one's own standards and a trust in oneself. [redacted] suggested that stringent criticism, even from people one does not agree with or perhaps even respect, was valuable as an opportunity to learn to work with difficult people. [redacted] elaborated on this thought, pointing out that it was an act of cognitive reframing, and encouraging students to think about such people as giving them a unique "gift" that the most supportive and perceptive teacher could not give them.

Students gave examples of how the evaluation process could be made more constructive. [redacted] pointed out that specific, detailed feedback was more helpful than general injunctions to "do better." [redacted] described a situation in which he had used tact and a "help me understand" strategy to create more of a dialogue about evaluation with his R2. [redacted] shared a situation in which she and her supervising residents talked openly and non-defensively about times when medical students were a burden and times when they were helpful. [redacted] elaborated that mutuality, communication, and safety are important dimensions of useful evaluation.

There was additional discussion of right speech. [redacted] noted that gossip and disparaging speech is not the sole province of residents; in fact, students engage in bad-mouthing residents and attendings as well. [redacted] mentioned "medical hexing" ([redacted]), in the sense that unskillful, thoughtless language on the part of the physician may do great psychological, emotional, and spiritual damage to the patient.

[redacted] gave students the assignment to 1) identify and describe 3-4 recurrent and significant problems associated with their medical education experience 2) make a) systemic and b) personal suggestion that might have a positive impact on changing the current system and culture of medical education.

SUMMARY NOTES ART OF DOCTORING SESSION 1 RUCKER 9/30/03

[redacted] introduced session (11 out of 15 participants; 3 had emailed inability to attend; 1 new student)

- Transitions and how to cope with them
  - Take a breath
  - Take another breath, this time releasing all stress, strain, worries, and thoughts from previous activities
  - Setting an intention
    - Rather than stumble mindlessly into transition, use it as a cue for setting an intention
    - Example of gratitude for this space to pause and reflect

  * [redacted] made the point that another way to think about this is to focus in the moment; business example of giving complete attention to the task-at-hand, and let the big picture take care of itself (JS commented on influence of Buddhist/Taoist philosophy on B-schools; convergence of similar principles)

[redacted] asks for feedback on assignment

- MD comments how difficult environment (Pediatrics – dd kids "like missiles") negatively influences her to be more anxious, less organized – notes coping strategy of detachment, objectivity, focusing on clinical symptoms; "parents don't want a doctor who's overwhelmed by their child's problem"
- [redacted] comments that his experience with demented Alzheimer's patients made it easier to cope with his grandmother in a nursing home (post-stroke?)
  - Discussion as to why this helped: symptoms more familiar, less frightening; [redacted] felt he had better ways of interacting with grandmother that he'd learned on Psych
  - [redacted] asked if [redacted] felt better from a professional perspective toward grandmother, but perhaps had lost something personally; this question not directly answered
- [redacted] comments on two preceptors, one emphasizes talking/connecting with patients, other emphasizes efficiency
  - Notes her difficulty with "efficient" preceptor; not her "personal style"
  - Discussion of acceptance of all kinds of teachers
  - Importance of recognizing own values
  - ML picks up on last point, reiterates that being true to your values is important regardless of environment or situation; it's what will make you satisfied in your work at the end of the day

* [redacted] comments that when he's struggling with a clinical situation, it helps to demonstrate what we agreed to call "compassionate curiosity," i.e., coming from a place of compassion and caring, to try to understand more deeply what's happening

  * "Tell me more;" "Help me understand"

* Notes this calms him down

* Discussion of how to respond when negative surprises occur (student thinks is doing a good job, getting the appropriate information, then patient bursts into tears, or says something that doesn't fit)

* First, explored the feelings that arise (panic, anxiety, fear, guilt) and noted that these feelings are all focused on self, not patient

* Discussion of how to work with these feelings

* Reconnect with one's center: calm down, take a breath, remind oneself of one's values

* Change focus from self to patient, through compassionate curiosity

[redacted]– go around the group, sharing "one good thing," "one thing that student would like to do differently"

- [redacted]– listened well; wasn't sure exactly what this meant; thought it had something to do with not having too high expectations for the patient
- [redacted] – gave example of not using power-over with a patient to coerce a history, but negotiated a flexible interaction that restored some of patient's sense of control
- [redacted] and [redacted] both talked about being present, staying focused in the moment as a way of improving their interactions with patients; some discussion about the difficulty of staying in the present, tendency of mind to wander, and the importance of practice
- A couple of students ([redacted]) mentioned that "feeling good about themselves" or "doing a good job" was closely correlated to positive feedback from attendings or residents, performing well, doing a good case presentation
- [redacted]oted that detachment and objectivity "didn't work" for him, and that when he was having trouble with a patient he sometimes made a personal disclosure, sharing something of himself
- [redacted]commented that she sometimes reflected on her patients outside of work, thinking about better questions to ask them
- [redacted]ommented on possible confusion of the assignment: clarified that our intention was to get students to think about when they did a "good job" in terms of acting in a compassionate, empathic manner

[redacted] shifts discussion: asks people to describe whether they actually did the assignments in written form. [redacted] comments that he followed the assignment to the letter, noting a numerical score for both "work" and "feeling" each day, as well as identifying both a "positive" and "negative" experience. He found the numbers helpful in pro viding an orienting point. MD had also used the numbers and found them helpful. [redacted] had done fairly consistent journaling, and had found it extremely helpful. [redacted] commented that he'd "thought about" scores for himself each day, but usually while driving home. Other students commented similarly.

[redacted] commented on her own difficulty in journaling, but added that it had superior value to "thinking about" an issue because it was less ruminative, clearer, more focused, and brought one closer to the issue. [redacted] emphasized the value of actually doing the writing, and stressed that to get the most out of the elective, students should engage in writing. He recommended that students continue the assignment in between now and the next group meeting.

[redacted] encouraged students to pay attention to, and write about, where they found themselves on the continuum between emotional detachment/objectivity and emotional "overwhelm."

[redacted] summarized key points of the session, and invited students to think about the ones they found most interesting or potentially useful, and to try them out between now and the next session. [redacted] commented that students should have the last word because this was really their group. [redacted] reiterated [redacted]'s earlier point about choosing supportive environments, and pointed out that by participating in this elective, the students were doing precisely that. [redacted] encouraged students to act as a "virtual" group in between actual sessions, and give each other a smile, a hug when needed. [redacted] also encouraged students to use email to communicate thoughts, ideas, feelings with each other and with faculty facilitators if desired. Students did have the last word ([redacted] bit her tongue).

SUMMARY ART OF DOCTORING GROUP 1 12/16/03

Group was in a festive mood [redacted] contributed gingerbread people, and [redacted] contributed a pirate joke (!). [redacted] briefly presented a proposed model for dealing with difficult or challenging situations, either between students and supervisors or between student-physicians and patients. There was limited discussion, but we did discuss the feasibility of the model due to time constraints. [redacted] noted that practicing the steps made the process more automatic, and therefore swifter. Students presented various clinical problematic clinical scenarios.

[redacted] described a situation in which an older attending chose to rely on his own experience, which was in conflict with the latest EBM recommendations, in when and how to remove a breathing tube. The chief resident protested, but the attending went ahead with his plan. The student said nothing, but was concerned and felt this type of event occurred with some regularity on the wards. We discussed possible goals for patient, attending, and student (intention). Some goals mentioned for patient were 1) to have a good outcome 2) to receive standard of care; for attending 1) to become more knowledgeable 3) to become more comfortable with EBM guidelines. No goals for students were mentioned, but indirectly there was some discussion of how powerless the student was (since the chief resident had no success), and how vulnerable the student would be if he/she did express concerns. [redacted] gave an alternative example of an attending who also did not regularly practice EBM, but was more open to feedback from learners (including students), and requested articles that expressed a different perspective from his own. We concluded that a third goal for the attending (and the system of medical education) was to feel safe teaching using more horizontal power distribution, such that students would be encouraged to share the knowledge they had, and the attending would be more enthusiastic about considering alternatives. There was also some discussion of how comfortable it was to be wrong, or not to know the answers, or ask for help, or admit mistakes. Students claimed they were fairly comfortable with limits of knowledge, but felt the case was different for residents and attendings. [redacted] pointed out that students are reluctant to question attendings precisely because they often don't know what the right thing to do might be in any given clinical situation.

[redacted] described a situation in surgery where the surgeon seemed to be out of depth in performing an operation. The result was the surgery took much longer than expected, and the surgeon became angry, "blaming everything and everyone but himself." Again, students did not know what to do, and only talked among themselves about what had happened. Patient was then "kept in a coma for 10 days because the staff hated him." We discussed the line where negative feelings cross over into negligence or incompetence. [redacted] noted that such behavior is reportable, and LR mentioned anonymous reporting. Again, physician arrogance, inability to admit limits, and failure to acknowledge mistakes were implicated. Student vulnerability and limited knowledge were offered as the main reasons why they would not intervene. [redacted] raised the question as to what happens to the students' own integrity and moral code when they remain silent in such situations. We also noted when it becomes normative in a system to engage in unprofessional behavior (i.e., the drug-induced coma), widespread support for the action is generated.

The final example came from [redacted], and addressed the issue of residents and staff "making fun of" and "laughing at" patients, either behind their backs or in their presence. Students all could think of examples of this behavior that they had personally witnessed, and most students agreed they had engaged in such behavior themselves. We discussed the importance of group identity, and how patients do not belong to the doctor's group, thus running the risk of being perceived as "the other." Reasons offered for participating in this behavior were 1) catharsis – letting off stream, dealing with difficult emotions such as frustration, dislike, and anger 2) blaming the patient for one's own helplessness or the limitations of the system 3) exhaustion, and a loosening of value-based "screens" or surveillance mechanisms 4) desire to join with and solidify one's relationship to the group. We discussed whether such humor (laughing at rather than with the patient) was dehumanizing to both patient and doctor, and generally agreed that it was. However, [redacted] expressed an alternative view that blunt speaking and humor were influenced by cultural and familial norms, and what might be offensive in one context might be acceptable in another. [redacted] stated that "poking fun" was "just human nature," and several students agreed. We explored the implications of this statement, and whether it meant that nothing could be done to change what was human nature. [redacted] identified a continuum of good-bad behavior, and said that everyone fell somewhere along it. There was some group discussion as to whether "good" people would stay good, and "bad" people would stay bad, regardless of external circumstances. The group agreed that behavior is a result of the interaction of personality (individual goodness/badness) and the values and norms of the society/institution/social system. We decided that the doctoring elective, consisting of course of "good" people, was useful in helping these good people to stay good.

[redacted] closed the session with a personal example in which he realized he had discussed a patient anonymously in a social setting for the entertainment value provided. This incident caused him to make a commitment never to discuss his patients again outside of appropriate professional contexts. [redacted] questioned whether physicians should be held to a higher standard because of the uniqueness of their profession, as [redacted] implied. [redacted] reminded students that the purpose of the elective was not to promote special values for physicians, but to help students who wanted to become "better" people, in accordance with the values and ethical standards they had set for themselves, and in the process become "better" doctors as well.

The session ended with mutual good wishes for the holidays.

ART OF DOCTORING GROUP 1 Session 5 1/27/04

A large group, with several Group 2 students attending
Discussion commenced with reading of "How To Be Good" excerpt and commentary
[redacted] tried to determine whether article reflected students' experience – some misunderstanding on part of students
[redacted] presented the point more clearly, ie., that people often assume your "goodness" when they discover you're studying to be a doctor; and after awhile, it becomes easy to believe you are good because of what you do
Other students perceived this to varying degrees
[redacted] made the point that intention to be good, such as is described in the excerpt, is insufficient – importance of practice; tried to link concept of practice back to self-observation and self-reflection exercises
Several problematic situations were presented
One student presented situation of problem patient who was noncompliant with diabetic medication for a reason that seemed superficial to the student, i.e., didn't like bruises on thigh resulting from insulin shots; student took time to pause and consider goals for interview; also took a different perspective on the patient, thinking about her in her roles of wife and mother, and how important it was to "keep her around" for a long time; went back into patient's room and spent a long time educating her about diabetes, including clearing up misconceptions about how to handle hypoglycemic episodes and the value of drinking water; student felt her efforts were undermined when the patient asked her doctor about water, and he encouraged her to drink; still persisted in continuing efforts to educate and enlist patient
Discussion focused on the value of being aware of your negative emotions; setting an intention, so that you are not behaving automatically; and deciding on what sort of action should be taken and how
Student also made the point of not personalizing patient behavior
[redacted] presented situation in which attending did an excellent job of working with an agitated father who wanted to remove his child with MR [redacted] because child acquired other infections every time hospitalized
The points that were stressed included: 1) explicitly acknowledging and paraphrasing the parent's concerns; empathizing with and normalizing them, saying they are understandable; avoiding the "yes-but" syndrome 2) stating one's own reasoning transparently and avoiding power moves 3) finding common ground (best interest of child) and negotiating a plan; this latter includes using "we" language to build sense of being on the same side, part of the same team; incorporating the key features of each perspective, and looking for areas of compromise (ie., giving child private room)
[redacted] commented that attending "ruined it all" by "rolling her eyes" when she left the patient room; [redacted] and [redacted] both noted they "liked" this sign that the attending was human; further discussion that it is possible to "do the right thing" even when you don't always "feel" like doing the right thing
[redacted] and [redacted] continued to discuss whether it is necessary to "feel" empathic in order to act empathically; they agreed that it is mutually influencing relationship, so that sometimes a feeling will trigger behavior, but at other times by overcoming a reluctance to express

empathy and demonstrating the behavior, feelings will subsequently change in a more positive direction

Final situation was presented by [redacted], who reflected on a challenging situation between medical students and residents at the [redacted] focusing on poor communication about whether med students had to be on call a certain weekend; ML defined his position as "being able to see each side" when he was talking with either camp; retrospectively, he felt he could have done more to mediate explicitly, and might have taken a more proactive role; he noted that the emotions triggered by the issue quickly became disproportionate to the actual issue itself – we talked about the "looking at the issue from the vantage point of 5 years from now" to gain a more balanced perspective

[redacted] wondered whether successful negotiation was possible in a circumstance where the options were all or none; we discussed the possibility that simply being heard and treated respectfully might help injured feelings, even if the party did not get its way

[redacted] mentioned the difficulty in leaving wards to attend sessions – after some discussion, we agreed to leave the time as is

ART OF DOCTORING GROUP 1 SESSION 6 2/3/04

Students had the assignment of either sharing a favorite quotation or "wisdom saying"; write a paragraph about a positive physician role-model; or share a difficult experience. [redacted] shared two quotes: 1) "You must do the things you cannot do" 2) "You must create your own future." [redacted] interpreted them as follows: It's important to believe in yourself and push past apparent limits. Along with this, no one should believe in fate, destiny, bad luck, or good luck. It's up to the individual to determine his or her own future. We discussed how these messages could be liberating for individuals overly constrained by perceived societal, cultural, or socioeconomic limitations; but could also be burdens because they seem to imply that, with sufficient will, individuals can exercise complete control over their lives. We experimented with how these statements might be relevant to patient care. Again we decided that their appropriateness would depend on particular circumstances. A patient who felt helpless about managing a chronic illness might feel empowered by them; but placing too much responsibility on the individual patient ignores the limitations imposed by environmental, genetic, and psychological circumstances.

[redacted] shared a positive role model, a Vietnamese-American physician who went to Viet-Nam every year to deliver health care to indigent people using mobile clinics. Despite a full-time clinical practice and a family, he devoted a significant part of his life to this endeavor. [redacted], who spent a summer in VN with this physician, said the experience taught him to keep his own life in perspective. He also shared that he was inspired by this example to help the poor, but that he found he was moving farther and farther from this ideal as he proceeded through medical school.

Each student then made a statement about a special commitment they felt in medicine. Several mentioned an initial intention to do international, third-world medicine, but all of these students [redacted] felt this was no longer a practicable goal. Reasons for this withdrawal centered on family commitments, feelings of just struggling to survive medical school, or realizing they can't save the world. We discussed the importance of staying connected to early visions, while adapting goals to meet changing life circumstances. We also considered the possibility that such goals might be related to phases of life, so that international work for example might be more appropriate or feasible at some phases than others. Finally, we talked about trying to find the root issues embedded in idealistic visions which could sustain a commitment over a lifetime (ie., beneath international health might be the desire to help those who are forgotten, marginalized, disadvantaged).

[redacted] suggested a difference between dreams and commitment, making the point that it is relatively simple to dream, while commitment takes sustained seriousness of purpose, effort, and skill-building over an extended period of time. [redacted] offered a model of "deepening commitment" that would honor exploratory, more superficial efforts while using reflection to continually evaluate the direction of one's commitment, and challenging oneself to progressively deepen and extend commitment.

[redacted] stated that her commitment was to really understanding the motivational model that explained how people change lifestyle behaviors.
[redacted] said that her commitment was simply to do her best with patients every day. We discussed how this could seem platitudinous, but that it was actually a hard challenge to meet.

[redacted] talked about saving one person, rather than a country, and described his special commitment as working with difficult patients whom other physicians found frustrating.

We discussed how a true commitment involved a mutual relationship, rather than self-sacrifice . Most commitments involve some measure of self-satisfaction, such as being successful with a patient whom other physicians find impossible to work with.

The remainder of the session focused on suggestions for the rest of the class. Students commented that venting of frustrations in early sessions had been helpful. [redacted] noted that students talk about different issues than they do on the wards. [redacted] mentioned she would like to see a session dedicated to how to overcome the dehumanizing influence of technology in caring for extremely ill and dying patients in [redacted]. She has been experimenting with directive and indirect methods, and has found respiratory therapists and nurses receptive, but that it was very difficult to influence the team to more compassionate ways of interacting with the patients.

[redacted] suggested each student choose a specific area of improvement to concentrate on, and commit to a personal change project. Later, after class, he elaborated on this idea by also suggesting a buddy system to problem-solve and reinforce.

[redacted] made the assignment that students would select physician role-models to attend the class and talk about how they attempt to incorporate caring, compassion, and empathy in their practice of medicine. [redacted] volunteered to find a physician to attend the Feb 24 session.

ART OF DOCTORING GROUP 1 SESSION 7 RUCKER 2/24/04

Dr. [redacted] was our guest as a positive physician role model. [redacted] asked a question about how to truly serve patients compassionately and empathically and resist oppressive systemic forces that encourage more callous, indifferent attitudes. [redacted] responded that medical students were actually her main source of inspiration for cultivating empathy. She went on to say that the challenge is not how to develop empathy during medical training, but rather how to maintain empathy in the face of factors which tend to extinguish it or treat it as irrelevant. In her opinion, most medical students begin their training with excellent innate empathy, but medical training often works in opposition to this quality.

When asked how she maintained her own empathy, Dr. [redacted] attributed it to her contact with students. She said patients sometimes elicit an empathic response in physicians, but also can trigger anger or frustration.

[redacted] asked about how to balance personal and professional lives. [redacted] responded that she sets firm boundaries in her personal life, especially around evening work. She also uses her long drive home to decompress.

[redacted] asked about working with difficult patients. In his one month experience at FHC, he had seen a steady stream of patients who didn't listen to their doctors, didn't comply with their medical regimen, and didn't seem to care about their health. He found these patients extremely frustrating and "a waste of time." [redacted] probed this attitude, attempting to facilitate a process of self-reflection. We learned that [redacted] experienced this attitude among patients as "disrespectful" to the physician. He also revealed some cultural influences on his thinking. For example, in his culture of origin, doctors are venerated, and seen as figures of respect and authority. Patients unquestioningly follow doctors' orders. [redacted] supported his view, noting that she came from a culture where it was very difficult to access health care, and people who finally received medical care were invariably appreciative and grateful. In this country, by contrast, patients seemed to take health care for granted, a right not a privilege. [redacted] noted that she did not experience the same frustration as [redacted] but agreed that the physician could only present the information, then it was up to the patient to use it. All three students stated that when they reached a point where "there was nothing more they could do," it seemed pointless or a waste of time to "keep repeating" the same information to these recalcitrant patients.

[redacted] addressed this issue by saying that when she got to know difficult patients, and understanding their perspective, they usually became a lot less difficult. She also mentioned considering the difficulty many patients at [redacted] have in accessing resources, buying medication, or prioritizing their own health. She further disclosed that the patients she found difficult were wealthy, entitled, demanding patients.

[redacted] clarified that emotions of frustration, anger, helplessness are not wrong, and that the goal is not to "not have" these feelings. Rather, the point of reflection is to see if you can't understand the feelings at a deep level rather than simply reflexively acting on

them. noted the idea of questioning the stories we reflexively tell ourselves to reinforce our initial emotions. By carefully exploring our emotions, we can discover the underlying assumptions that produce them. For example, if a noncompliant patient is perceived as disrespectful, that "justifies" and likely increases feelings of frustration and willingness to "dismiss" the patient. If, as shared, he believes that when a physician "dedicates his life to patients", patients have an obligation to respond with appreciation and compliance, then there is an implicit contract in place that, if violated, again "justifies" feeling frustrated with the patient and "throwing in the towel."

suggested the possibility that there might be other ways of understanding the doctor-patient relationship. shared his view that treating disease sometimes can be less important than creating relationship, and that success in medicine needs to be measured in more ways than simply curing the physical problem. reminded students that the majority of illnesses are now chronic ones, not susceptible to simple solution. said that rather than reach a point of "quitting" on the patient, he tried to be creative about brainstorming different approaches to enlisting the patient's cooperation. summed up with the insight that physicians often have "invisible strings attached to their patients" that influence the way they interact with them, and make it more likely that they will miss what's going on in the patient's world.

pushed students to consider *why* a noncompliant patient produced feelings of frustration, and whether other emotional reactions were possible. [We did not pursue this direction, but it would be possible that such a patient could produce feelings of challenge, compassion, enjoyment, curiosity etc. depending on the meaning attached to the patient's behavior]. He similarly encouraged students to explore whether they agreed with assertion that in many situations, physicians knew what was best for the patient. The point that emerged from this discussion was that although the physician might be able to say fairly definitively that a certain drug would lower blood sugars, for example, the patient might have a very different view of the significance of this achievement than would the doctor. The statement assumes that physicians and patients prioritize certain outcomes equally, which is often erroneous.

suggested the model of physician as consultant to the patient. He noted that physicians themselves often ignore the advice of their medical consultants, and are therefore "noncompliant" with the medical advice they have sought out. The consultant provides expertise, exerts influence, and shares her assessment based on her best understanding of the situation, but recognizes that the patient may reject the guidance, or even accept it, but be unable to act upon it. In this model, readiness to change is critical, which is something the consultant can facilitate or encourage but not compel. If the doctor-patient relationship remains intact, regardless of level of compliance, then when the patient is "ready" and motivated to engage, the physician is there and also ready.

Art of Doctoring Summary Notes Group 1 3/2/04

We focused on discussing and refining students' personal projects. [redacted] summarized the basic aspects of doing the project. We then worked with her to develop her focus: "judgmentalness." She operationalized this in terms of language. [redacted] suggested a different approach based on mental attitude, that might influence the language that "emerges." [redacted] empathized with the tendency to become judgmental, especially on the [redacted] clerkship. Her comment led to a discussion of negative and positive role-models as a way to address judgmentalness. We also discussed other interventions, such as increasing awareness and rehearsing appropriate language.

[redacted] discussed her project, reconciling the patient's agenda with the doctor's agenda. She noticed that often she became distracted or impatient when patients discussed issues that seemed tangential to the differential diagnosis or to treatment. She wanted to develop the ability to be more present in listening to the patient and not so quick to divert the interview back to her agenda.

[redacted] presented her project on playfulness, which included such behaviors as interacting informally with pediatric patients, playing games, and making jokes. So far she felt she had not been successful in implementing any playful behaviors. We again discussed interventions that might increase the likelihood of engaging in low frequency behaviors, such as setting a specific goal.

[redacted] emphasized the importance of identifying specific, observable behaviors, defining terms such as "more of" "less of," setting measurable goals, and monitoring on a daily basis. [redacted] reinforced the idea of monitoring, pointing out it provides a more objective measure of progress.

[redacted] wanted to do a "caring" project. He discussed giving 3rd year students on the [redacted] clerkship $5 to do something nice for a patient, and having them write up the results. He wanted to have more "fun" with patients.

The remainder of the session was devoted to a discussion of an article by Patch Adams brought in by [redacted]. To [redacted], the article was inspiring, and a model of what was important in medicine. To most students, the author seemed "naïve" and his suggestions "impractical" or "absurd." [redacted] expressed the concern that Adams is "egomaniacal." He noted that his views of medicine bore little relationship to the real world, and ran the risk of making "real doctors" feel guilty. [redacted] suggested the group think about the concepts in the article metaphorically rather than literally. In particular, she invited the group to think about how the health care system encourages patients to feel they "owe something," rather than that they "belong" to the system that cares for them. We also examined the provocative phrase regarding physicians and patients "falling in love with each other," and explored whether it might have useful meanings for clinical practice.

ART OF DOCTORING SUMMARY NOTES. GROUP 1. SESSION 9 3/23/04

Guest speaker Dr. [redacted]:
Why do nice medical students become mean interns? Arrogance; they lose humility
Other factors are stress, and the resultant feeling they are "owed"
Be respectful of other staff, including other health care personnel; can learn a lot from nurses
Being a good doctor means not being a crappy doctor – just remember to be "normal"
There is a lack of communication between specialists
Medical student [redacted] who invited Dr. [redacted] told an anecdote of when she was on the ICU, and having a difficult time; Rosen approached the husband of a young teacher who was dying, and asked him how he was doing. The man responded "Fine," and Rosen said, "No you're not. Tell me how you really are." The resultant exchange made her see what medicine should be all about, and restored her faith in doctoring
Secret of being a good doctor is being happy
Be responsible for your choice of career – medicine is still a noble profession, with many rewards
Dr. [redacted] himself had cancer as an intern, and several years ago was diagnosed with a painful chronic illness that made it impossible for him to continue to practice medicine; he now volunteers in the ICU, and recognizes that this is very important to his own survival
Sick people tend to be "cranky" – so do overworked, stressed out nurses and doctors; when you get two sets of cranky people together, bad things happen
Still, it is the responsibility of the doctor to help the patient through the crankiness, not the other way around
Better to make the patient feel "good" rather than argue; having a friendly face around "anchors" the patient in a scary situation
Lousy patient relationships means misery for the doctor
Important to make your own choices about how you want to practice medicine
10% of his practice was no charge – if someone taught him an interesting fact, he wouldn't charge them; if a young couple was getting married, he wouldn't charge
Talking to patients is important, especially when you don't know what's going on
He also makes personal disclosures to his patients – they know the names of his kids, what causes he supports; he knows the names of his patients' grandkids
Social history shouldn't be just smoking, alcohol use – should be "what makes you happy?"
He takes real enjoyment in his patients
Appreciates the lessons he learns from patients
What destroys relationships with patients? – forgetting that what the doctor says is what the patient clings to
Aloofness is not professional
"Some people like to stay on the pedestal" on which medicine still places them
Importance of finding out what the illness means to the patient
Watch use of medical language
Hospital stay is set up to do things in ways that are totally inconvenient for the patient
Most patients don't really understand the doctor's explanations

Importance of getting patients to write down questions, and doctor writing specific instructions for patients
Many examples of compassion in action – concrete behaviors to facilitate comfort and care
Don't rearrange the patient's hospital room – this is the patient's territory
Importance of preserving as much of the patient's autonomy as possible
Toughest families are the easiest to get on your side – acknowledge that they're in a tough situation, let them talk, hear their perspective, acknowledge their sense of powerlessness
Treat patients and family members both
When inconvenience or hurt patient, apologize!
[redacted] asked his opinion of Patch Adams – philosophy is great, some works for him personally, some doesn't; importance of always establishing patient preference before acting
It is always valuable to volunteer

ART OF DOCTORING GROUP 1 SESSION 10 4/13/04

Guest speaker [redacted]

Dr. [redacted] grew up in Santa Ana – always had a commitment to health care for all individuals regardless of insurance status; she feels she's found the right balance at Anaheim FHC
Her practice has lots of geriatric patients – they need extra care, more patience; she considered it disrespectful to confine patients over 65 to 10-15 min. visit – Dr. [redacted] protested to clinic administrators and effected a policy change to 30 min/geriatric patient
She has good colleagues who give her support, both intellectually and emotionally
With Dr. [redacted], she regularly their compassion fatigue level and assess each other to determine "where is your inner spirit?"
Underserved patient population requires patience and understanding regarding why they don't always do what the doctors tells them to do – it's hard not to get frustrated
With one patient, Dr. [redacted] explicitly shared her frustrations, and it helped to turn around the situation
With another patient – she evaluated a developmentally delayed patient's lack of social support and came up with creative ways of getting him extra help through a neighbor
Also must learn to accept limits of what doctor can do for the patient
Homeless patients – she worries about them – you have to be learn to be happy for small improvements
This population has many psychosocial and psychological stressors – unhappiness, isolation, depression, other psychiatric disorders – pcp is the only psychiatrist available; hard to get used to, not what physician feels was trained to do
Doctors can't change patients' circumstances – what they can do is give 10 minutes of undivided attention
Easy to experience emotional overload – gave example of a morning that started off with a grieving mother whose daughter had unexpectedly died; patients backed up, doctor harried; afternoon clinic began with same scenario of grieving mother whose daughter had also died; "You want to show you care, but it wears on you"
To replenish, she's learned she needs to take a vacation every 3-4 mo; at first, she didn't realize what was happening – she became short-tempered, impatient, thinking "I really don't care" when she heard difficult stories from patients; now "I don't let myself get to that point"
Dr. [redacted] enjoys her work, considers it "a privilege" to serve her patient population
But tells story that when she went into private practice in Pacoima (rough, poverty-stricken barrio), her own father was disappointed ("What are you doing in the barrio?"), although she tried to explain "This is where I'm needed"; her father said, people would think she wasn't a good doctor because of where her practice was located; she was disappointed her father was disappointed, but it taught her people may view your life choices negatively, and you must do what will give you satisfaction
[redacted] commented that Dr. [redacted] practices compassion-in-action in that she attends to and follows-up with all sorts of details to ensure patients get proper care
Dr. [redacted] finds joy in knowing her patients as people through continuity practice; she also feels a cultural connection with her patients because share a similar background
When she was a medical student, she didn't know who she could talk to, didn't know who she could trust

Tells anecdote that when first patient died, she didn't know what to do; an attending commented she didn't seem as "peppy"; when she opened up to him he said, "Patients are like a black box. You stick your hand in, wiggle your fingers around, but you don't get involved." At this point, Dr. [redacted] made up her mind, "I will not stop caring – I will learn to find a balance"

Dr. [redacted] also resented clerkship evaluations of her intelligence, motivation, work ethic based on two weeks contact; and residents who would write negative comments but never give her direct feedback

[redacted] asked about how to survive residency; Dr. [redacted] replied it was a matter of day-to-day survival, but cautioned that you can't wait for the vacations; you have to learn how to care for yourself daily, even if in small increments

[redacted] asked about coping with loss of patience, becoming more short-tempered; Dr. [redacted] laughed in recognition, shared that in medical school not only she but her family noticed she was changing for the worse, becoming more impatient and demanding; she went on to say that you need the skill of "being the team captain," giving orders, getting people to do things because you say so; but you need to decide how you are comfortable doing this

Her mother taught her to respect everyone's work, and this helped her to remain humble

Medicine bag – a grateful patient made a little Indian beaded bad in appreciation of her compassion and care; now she wears it whenever she feels her patience and compassion are wearing thin, to remind her to be the best doctor she can

She also says prayers daily for patience

During internship year, had a "meltdown" – patient with RA, DNR, was admitted; resident ordered her to do a lumbar puncture; also inserted NG tube; finally she did the puncture correctly, but patient died at that moment; later she learned NG tube had been inserted incorrectly, and might have contributed to patient's death; she felt alone and powerless, and considered quitting medicine, but her chief resident supported her and encouraged her to empower herself by always getting a second opinion when she was unsure of the right way to proceed

Another attending told her the same thing: "You never want to carry that coffin alone"

ART OF DOCTORING GROUP 1 SESSION 11 5/12/04

Students reported on their individual projects:
[redacted]- noticed that he favored Spanish-speaking patients, spent more time with them, and assumed they needed more help. Conversely, he assumed that all NHW patients would encounter no barriers in navigating the health care system. His project was to focus on NHW patients and spend more time with them. He did so, and in the process discovered that all patients can benefit from more education about their diagnosis and treatment. The project served to make him aware of previously unconscious prejudices, and help him work toward remediation.

[redacted] – noticed that she did not focus on patients because she was so worried about things she had to do to take care of the patients, help her resident, or prepare for presenting the case to the attending. She worked on not writing so much when she took the history, arriving earlier, and trying to do her tasks sequentially (listen when she was with the patient, think about the case presentation after she saw the patient). She concluded that she was able to shift her focus back to patients and away from multi-tasking.

[redacted]- commented that she already had very good interpersonal and relational skills. Similar to [redacted], she noticed that anxiety about presenting, plus the pressure of gathering all pertinent information, caused her to be less skillful in her patient interactions. Her intervention was to relax and focus on the patient. She realized that this helped her to think more clearly about the patient. She concluded that "it is just as important to interact with patients as it is with colleagues." There was some discussion about what an intriguing statement this was, with its implication that student-physicians become socialized into thinking that their relationships with their supervisors are more important than their relationships with patients. [redacted] project was a good way to help her return to patient-centered medicine. Discussion focused on the insight that most students do have excellent communication skills, but it's important to identify what compromises or interferes with these skills.

[redacted]- this student focused on counteracting her growing impatience and frustration, in medicine and with life generally. She involved her parents, asking them to give her feedback about her behavior, especially when she became "snappish." She discovered by monitoring her behavior that impatience was related to stress in that when she was more stressed, she became more abrupt and impatient. Feedback from others, plus regular writing in a journal, and the daily reciting of the Serenity Prayer, helped her remain patient in most situations.

[redacted] – since she also felt she had excellent doctor-patient relationship skills, her project focused on deepening her connections with colleagues and seeing them as 3-dimensional people. She did this by asking personal questions, which frequently led to rich and interesting conversations. By shifting the focus of interaction from exclusive instrumentality, she was able to experience her colleagues not just as doctors and nurses, but as real people with real lives. She felt that most colleagues appreciated being asked

about themselves, and she also felt this process increased her liking of the people with whom she worked.

[redacted] – this student noticed increasing impatience and judgmentalness, and a tendency to reduce patients to numbers or diagnoses. His goal was to have a non-HPI conversation with every patient he cared for. He made it a point to learn something personal about each patient and include this information in his case presentation. Despite some "eye-rolling" by some residents and attendings, it turned out having such information was often useful in the care of patients, and helped with treatment plans and clinical decision-making.

[redacted] – this student wanted to learn more about her patients, both so she could have a better understanding of all aspects of their medical condition and so she could do a better job of updating the team. She accomplished this goal by spending more time talking to patients although, unlike some other student projects, she focused more exclusively on medical issues. The outcomes were positive. [redacted] reported that her team felt helped by her ability to give them more detailed information about patients. The patients themselves, in her opinion, received better education about their condition; and seemed to be extremely appreciative of these interactions. Our discussion focused on the value of attending carefully to patients in all areas, not just psychosocial and personal. Sick people don't always want to talk about their personal lives, but they do want to communicate with the health care team about their condition.

[redacted] – this student also concentrated on judgmentalness. She observed that her tendency to use derogatory or dismissive terms in identifying patients was largely a function of her own mood. Such appellations occurred more frequently when she was overwhelmed and stressed. This insight that she could be respectful of a patient one day and demeaning the next made her focus more carefully on choosing appropriate language in presenting patients and even discussing them informally.

[redacted] – this student kept a journal of significant clinical stories and events. His goal was to increase his ability to be present with patients. He was not sure the project helped him in this way, but he did find it valuable to reflect on particular events and try to understand what might have been done differently or why an interaction had a positive effect. He gave a negative example of breaking bad news (patient with newly diagnosed Hepatitis [redacted] informed in front of his girlfriend) to illustrate the kinds of issues that concerned him and what he learned from the journaling process.

Students also provided some feedback about the usefulness of the projects overall. Some commented that they felt less depressed after having employed some of the self-change strategies. Certain students also stated that these skills provided a foundation for the future. Although they didn't feel they would be able to use all of these approaches in residency, they thought that they now had a baseline that could help anchor them even in very stressful situations. One student commented that the group process itself was helpful, because it provided a place to "leave" his problems, rather than taking them

home and burdening his family. Another student confirmed that she felt less alone by coming to the sessions and hearing what other people were going through.

We concluded the session by reading two poems. One, by a student-author, humorously recounted an anti-role model Ob-Gyn surgeon who treated the medical student disrespectfully and cruelly. Students commented that such behavior was unexpected and traumatizing, and therefore writing provided a therapeutic way of dealing with the experience. We also read John Stone's valedictory Gaudeamus Igitur, as a way of bringing closure for those students not returning for the final session.