SUMMARY NOTES ART OF DOCTORING GROUP 2 SESSION 2 10/15/03

began the session by discussing transitions, and the value of approaching them as opportunities to recenter and set intentions. We practiced in-breath and out-breath as ways of 1) taking in what we might need at that moment – calmness, focus, wisdom, kindness etc. and 2) releasing whatever we no longer need or wish to bring forward into the next situation – tension, preoccupations, anger etc. We also talked about setting an intention before each transition, or at least at a couple points in the day. shared that her intention for this group session was gratefulness that the group existed, and that she had the opportunity to participate in it.

Group discussion focused on frustrations of encounters with "anti-role-model" attendings, physicians who deliver health care in ways that the students find impersonal, alienating, or even unethical. We then discussed possible student responses to frustration and anger in these situations. These included confronting the attending, compensating for the physician by clarifying miscommunications with the patient, letting go of the feelings. One student brought up the AA prayer of recognizing things that can be changed, things that can be accepted, and knowing the difference. We agreed that, no matter what the course of action (or inaction) chosen, it was better to choose from an internal space of calm and centeredness. shared the metaphor of allowing emotions to "settle" like dirt particles in a glass of water.

Other ideas for responding included:

1) Understanding the point of view of the attending. One student stated that when she was able to do this, often it "shifted the energy field" of the relationship.

2) Shifting one's own perspective. This might include reframing the situation or putting it in a larger context.

3) Prayer

4) Journalling

5) Yoga, meditation

6) Talking, sharing with a friend

7) Using humor

8) Surrounding oneself with nonjudgmental people

9) Receive validation and affirmation from patients

observed that the predominant feelings expressed by students seemed to be powerlessness and helplessness, to which the students agreed. This point led to a

discussion of the hierarchical nature of medical education, which systematically disempowers students and places them in a vulnerable position.

Another discussion focused on the difficulty of being mindful and aware in the demanding environment of the wards. We talked about "falling off the path, then climbing back on again," as well as the importance of not judging oneself too harshly when one doesn't live up to one's own expectations. We touched on the idea that negative self-judgment can become simply an excuse for not doing the work.

[redacted] facilitated a conversation about how physicians might behave so as to relieve some of the students' burden and discomfort. Students suggested: 1) Acknowledging that students are still in a learning mode, and that they are frequently challenged by the tasks they are expected to complete 2) Giving positive, as well as negative, feedback 3) Simply acknowledging the student's presence. Students further commented that it was sometimes effective to 1) Ask attendings to clarify their expectations for the student 2) Proactively elicit feedback attendings 3) Validate each other 4) Learn to validate themselves, to start trusting their own voice.

Further discussion addressed the harsh, critical, and negative emphasis of medical training. At one point, one student started to cry as she recounted an attending's dismissive comments about her lack of organization. This same student disclosed some disappointment in realizing that not only did some of her attendings have feet of clay, but this was true of many of her peers also. We talked about the importance of being able to see all sides of people and hold this knowledge with some level of equanimity.

One student shared her journaling, which consisted of daily prayers asking for strength and wisdom, as well as noting personally meaningful Biblical quotations.

Each student chose one area to focus on in the coming week:
[redacted] – point of view of others
[redacted] – maintaining perspective
? - not sure - Catherine de Jesus
[redacted] – being positive, letting things go
[redacted] – journaling
? - writing more
[redacted] – not being so hard on herself, not feeling positive attitude as a burden
[redacted] – maintaining perspective
[redacted] – not sure
[redacted] - focus on present

We concluded by considering how we might function as an intentional community committed to mutual support and personal growth, including the importance of supporting and caring about each other in between actual sessions.

Group 2, Session 2 follow-up

Hi all. It was good to see those of you who could make our session, and thanks to everyone else for letting us know you couldn't attend. **Our next session is next week (!), Tuesday, Oct 21, 4:00-5:30 in room 2103. See below for "homework assignment"** ☺.

At our last session, we talked about ways of centering/grounding/reconnecting with ourselves periodically throughout the day, through breathing, awareness, and intention (and how hard it is to do any of these things ever!). We had an interesting dialogue about ways of working with the frustration and powerlessness that arise when we encounter a difficult attending or resident. We also talked about how nice it would be (!) to get a little more acknowledgment and positive reinforcement as part of the educational process. From our discussion, here are some of the ideas people mentioned.

1) Understanding the other person's point of view.
2) Shifting one's own perspective. This might include reframing the situation or putting it in a larger context.
3) Prayer
4) Journalling
5) Yoga, meditation
6) Talking, sharing with a friend
7) Using humor, especially humor that is not directed so much at the other, but appreciates the absurdity of the situation
8) Surrounding oneself with nonjudgmental people
9) Receiving validation and affirmation from patients

Some specific strategies for getting more of one's needs met while on the clerkship included:

1) Ask attendings to clarify their expectations for the student
2) Proactively elicit feedback attendings
3) Validate each other
4) Learn to validate yourself, start trusting your own voice (especially in situations where, if you're wrong, you won't kill the patient!).

Homework Assignment: All of the above suggestions are easy to make, but hard to do. They sound nice, but other things in our lives always seem more important. Well, guess what, in this class these *are* the important things. *You can't pass this class unless you actually do some of these things!* Your assignment, between now and next week, is to choose one strategy (either from the list above or of your own devising) that you think represents a skillful way of responding to stressful, difficult occurrences, and **practice it several times a day!! (Remember to describe in your handy little journals at least 2 or 3 times when you practiced in this manner and what happened).** So, for example, if you decide to work on "understanding the other patient's point of view," this doesn't mean just understanding the point of view of people you agree with, or understanding the point of view of people you agree with so you can tell them why they are wrong. It means, as much as possible, understanding the point of view of *everybody* you encounter, even total fools and impossibly arrogant faculty ☺. In the words of the Buddha, for this one week, you would try to treat every annoying, angry, inconvenient person you encounter as though he or she was your greatest teacher.

Thank you all very much, and see you next week. Dr Shapiro

Why remain in prison when the door is so wide open?
- Rumi

REFLECTIONS ON GROUP 2, SESSION 3, OCTOBER 21, 2003

It's not an easy thing to take a hard look at your chosen profession, especially while you're still in the process of choosing it. This turned out to be our main topic of our last discussion and it was a tough one. We uncovered a range of reactions to the role models encountered in medical training. Several students expressed serious concerns about certain physician attitudes and behaviors they'd observed, typified by arrogance, callousness, and incompetence directed at vulnerable patients (or students). They also commented strongly about the deleterious effects of the uncompromisingly hierarchical structure of medical education. There was less agreement, however, as to how widespread these problems were, and other students emphasized their positive experiences with generative, kind, and competent actions of physicians and residents. In the midst of strongly held opinions, we struggled with feelings of polarity and worked not to see each other as divided into "camps." Some of us may even have had the ironic – and humbling – experience of noticing the angry, frustrated feelings we were criticizing in attendings arising in ourselves and being directed toward other group members. Ah, let's all take a breath, relax, and even try a smile. Our emotions are tricky little things, and always provide much opportunity for learning!

When I looked back on this session, I wondered about the root of its intensity. I think it was a hard conversation to tolerate emotionally because it struck so close to core identities. No one wants to hear that the career toward which they're heading is filled with people who sometimes, if not often, exhibit arrogant, cynical behavior. No one wants to *experience* their profession as filled with arrogant, power-wielding individuals. So it's easy to make the other "wrong." Some might be labeled "cynical" and "bitter". Others might be called "naïve" and "lacking in life experience." When disagreement arises, it's natural to protect our point of view.

Also, there were strong feelings being expressed – not just "polite" emotions of mild frustration or annoyance, but great anger, bitterness, perhaps even despair. These can be uncomfortable, even frightening, emotions to experience and to witness. Often we don't want to feel them and, if we aren't feeling them, we don't want to be "infected" by them. Alternatively, sometimes we might feel that we can't give up these emotions, because we suspect they are the only things standing between us and becoming people we don't want to become.

Now, paradoxically, although it wasn't always a comfortable conversation, our session provided much fertile soil for learning, because we find ourselves in situations like this all the time: i.e., situations in which we see other people "behaving badly" (arrogant, cynical, uncaring etc.), in ways that do harm to others (and likely themselves). So how do we want to act and respond in such situations? Guess what, gang, I don't know! But here are some things I thought about:

1) One issue is how we deal with our own emotions of anger and bitterness. First we may want to ask ourselves, are these emotions helpful? As I suggested above, maybe we're afraid that if we release these feelings, we will give up, no longer

fight the good fight. I understand this fear. I also know that when I act from a place of anger anger, I usually end up saying and doing things that are unskillful and unproductive. Lately, I've wondered whether it is possible to "distill" anger so that the lack of clarity that so often accompanies it "settles," while its pure energy remains. Think of it like a glass of water into which you dump some sand. Initially, the water looks murky. But when the sand settles, the water is clear again. With such clarity, we are almost always in a better position to judge what we need to do, while maintaining the energy to implement whatever course of action we decide upon.

2) Another issue is how we deal with each other, especially when we disagree with what's being said, or when we see things very differently. First and foremost, let's remember some of the attitudes that have brought us together as a group. I think that we want to act toward each other in ways that expression compassion, caring, and respect. We can do this by careful listening, paraphrasing the other's point of view, and acknowledging their discomfort and distress. We can ask ourselves, what does the perspective of the other person have to teach me? (This doesn't mean we have to agree with it). What do I feel about what the other person is saying? What do I want to say in reply, what do I hope to achieve by saying it, and how can I express myself to best accomplish these goals?
3) A third issue is how we deal with people we feel are morally wrong or abusive. In this regard, I've learned a lot by reflecting on the Dalai Lama. Here is someone whose position of authority makes him responsible for an entire people who have been systematically oppressed and deprived of religious freedom. He has worked tirelessly on the world stage and behind the scenes to humanize the actions of the Chinese toward the Tibetan populace. He is neither passive nor helpless. Yet he consistently attempts to cultivate an attitude of kindness and respect toward those who have inflicted so much pain and suffering on his community. In other words, his attitude reminds us that, generally speaking, it is dangerous to demonize others or strive to make them wholly wrong and evil. (There may be a few wholly evil people in the world, but that's a topic for a different discussion!). I'm always amazed at how often people I can't stand and who seem to be very nasty to me can turn around and be kind and caring in another situation. People are so much more complicated than we'd like to think!

In the end, perhaps it matters less whether we view medicine as a very troubled profession, a noble healing profession, or some combination of both. We are all struggling to find our place in it. And I don't think I am too pollyannish to have sensed during our discussion a fair amount of discomfort, but also a lot of caring and commitment, both toward medicine and toward each other. Let's continue to bring attitudes of honesty, openness, compassion, and even forgiveness to our interactions as we work to heal the profession, each other, and ourselves. I have great admiration for all of us in this effort.

Happy Thanksgiving, and see you December 2. Regards, Dr. Shapiro

SUMMARY ART OF DOCTORING GROUP 2 SESSION 4 12/2/03

Discussion commenced with [redacted] summarizing key issues from the last session. In particular, she mentioned differing perceptions of the prevalence and severity of "anti-role models" in medical training; and the related tendency to negate or diminish those whose perceptions differ from ours. However, since only one participant from the previous group was present at this session, it seemed unnecessary to linger on these points. This individual R did share feelings of discomfort and distress resulting from the apparent "splitting" of the group.

Four students presented a brief role-play in which a resident and an attending argued in the presence of two medical students about which student was the more deserving to observe a surgical procedure. Most of the students participating in this group were currently on Ob-Gyn. They confirmed that incidents such as portrayed in the role-play "happened all the time." They elaborated that students were treated as unimportant, even invisible. Students recounted many instances when residents and/or attendings discussed issues of relevance to students without involving or indeed paying any attention to students. Others commented that students were expected to put in long hours without any redeeming educational value, and were often prevented from participating actively in deliveries and other hands-on experiences. They complained that their time and their perspective were treated as irrelevant, and that there seemed to be no awareness that students might have academic, physical, and emotional needs while on the clerkship. Two students ([redacted]) noted that even though they had expressed strong interest in ob-gyn, they were still ignored. Another student [redacted] observed that residents actually often took an interest in students, and tried to advocate for them. In her opinion, the worst offenders were certain attendings, who made harsh, judgmental, and demeaning comments about students (and sometimes about patients) (for example, ridiculing students for appearing tired after 30 straight hours on call). Another student ([redacted]) shared that their group was considered "the best so far," but had been given the label of complainers when they expressed their concerns. [redacted] commented on the parallel process between the treatment of students and the treatment of patients: i.e., patients are sometimes ignored on rounds; their time and perceptions can be devalued; and when they express their concerns, they are labeled as "whiners" and "complainers."

[redacted] noted the underlying theme of helplessness and disempowerment, the sense that students perceived themselves as passive victims of an uncaring system. We then explored different options for dealing with such situations. [redacted] expressed the importance of not internalizing criticism or mistreatment, and not taking such behavior too personally. [redacted] contributed an example of how she had approached a resident, and skillfully "reversed" her concerns so that instead of saying, "I'm not learning anything here," asked, "How can I be more helpful?" and "What are your expectations for me?" [redacted] suggested using the power of numbers, registering concerns as a group rather than on an individual basis, and recommended working through class representatives. [redacted] noted that student opinions are listened to, especially if a respected faculty member can be enlisted to advocate for their position. She emphasized the importance of jump-starting dialogue on these issues to overcome the inertia of the status quo. D expressed the opinion that each student must

reclaim some level of personal power, and learn to trust his or her own judgments and voice to some extent. [redacted] echoed this sentiment, noting that students generally gave away all ability to determine what was right and wrong, important/unimportant, relevant/tangential to the all-powerful "higher-ups" in the system. This led to some comments about how the evaluation process intimidated students and stifled their ability to express their concerns and points of view. [redacted] found value in taking "small steps" that had an acceptable risk, but still confirmed personal integrity and represented meaningful efforts to exert a beneficent influence on the prevailing culture. There were some final observations about ob-gyn faculty being "beyond Type A" [redacted] and needing to be in complete control, so that turning over any responsibility to students was simply too anxiety-provoking. , so Concern was also expressed that the culture of medicine was vertical and hierarchical, so that questioning and dissent from less powerful constituencies (ie., students) was systematically stifled.

SUMMARY NOTES ART OF DOCTORING GROUP 2 12/09/03

Informally, before getting officially under-way, we talked about the session in which [redacted] and [redacted] had dominated with their highly negative views of the system. Those present took pains to state that they did not agree with this perspective, and in general found their attending and resident role models to be helpful and constructive. We discussed the role of anger in identifying problems and motivating action to change, but its risk of destructiveness as well. We attempted to distinguish between the passion that anger brings, and its disruptive, "murky" quality. We also noted our tendency to split into "people like us" and "people not like us" (in this case, viewpoints), and then blame and devalue the other. [redacted] mentioned an empathy exercise to help address this tendency: 1) Think of the "other" who is least like you 2) Enter into the deepest part of that person 3) What would that person like to say or express? 4) Now, how would you like to respond to them? Finally, we examined possible resistances to compassion, in particular that it might make us less likely to take action. The question was posed, "Are compassion and strong action incompatible?" We concluded that they were not.

Most of the session involved presentation/discussion of the "Challenging Situation" model. We reviewed the steps and discussed their relevance to patient care and medical education. [redacted] commented on how much easier it was to focus on other people's shortcomings than to acknowledge flaws and limitations in oneself. We discussed our tendencies to minimize, ignore, or rationalize, justify, and defend ourselves. The idea of a pause seemed to find favor with [redacted], [redacted] and others. We talked about reactivity versus reasoned response. We also discussed the model as a means of maximizing "choice" so that whatever course is followed (i.e., along the acceptance-change continuum), it is important to get behind it rather than see oneself as a victim, helpless, or ineffective.

Two students, [redacted] and [redacted] did a role-play modeling an effective, respectful feedback session for a student. We discussed as a group the various elements that made the feedback effective: sandwich technique, paying enough attention to know something about her charting, specificity, giving student time to improve. We also talked that, regardless of the manner in which it is delivered, negative feedback can be hard to hear, especially if we feel we need to be perfect. We explored the notion of learning to accept ourselves as imperfect, and to see constructive criticism as an opportunity to improve and grow. We revisited the concept of the most frustrating patients or thoughtless attendings being our best teachers, because they provide opportunities to work on difficult parts of ourselves that otherwise would not find expression. However, [redacted] noted that for her, the best teachers were the good ones.

ALGORITHM FOR DEALING WITH DIFFICULT SITUATIONS IN MEDICAL TRAINING

OVERALL GOAL: Art of Doctoring is a small group experience to enhance the physician-patient relationship, expand students' communication skills, and provide strategies to promote compassion and empathy as core physician values. The class uses self-reflective practices, role-modeling, readings, and case-based problem-solving discussion.

STARTING POINT: CHALLENGING SITUATION

↓

Identify CHALLENGING Situation
(systemic abuses, problematic attending/resident behavior, problematic patient/family member behavior → problematic behavior/feelings in student → less compassion toward patients, others, self)

↓

CUES
(Mindful observation of all aspects of situation)

1. **Increase in own negative feelings/behavior (frustration, anger, withdrawal, aggression, helplessness)**
2. **Increase in other's (patient, family member, attending, resident) negative feelings/behavior (often mirror student's)**
3. **Poor patient/educational outcomes (decrease in satisfaction, learning, well-being)**

↓

REFLECTION!
Preparatory Steps

1. **Breathing/centering**
2. **Gratitude**
   a. **That I care enough to address the situation**
   b. **For some positive aspect of the other's perspective/intention**
   c. **For some positive aspect of the system**
3. **Intention (context: to act with clarity and kindness; content: address the issue either through action or acceptance)**
4. **Right speech (avoid blame, attack, aggression)**

ANALYSIS

1. **Where is the problem?**
2. **Am I going to try to change or accept the problem?**

↕	↕	↕
Personal Behavior	**Others' Behavior**	**System/Culture**
Am I contributing anything that makes this	**Is another contributing anything that makes**	**Is the system/prevailing culture contributing**

situation worse?	**this situation worse?**	**anything that makes this situation worse?**
(getting off-center, expressing unexamined anger, helplessness)	**(anger, demandingness, withdrawal, resistance;**	**(restrictive, insensitive policies and procedures)**
↓ ↓	**↓ ↓**	**↓ ↓**
YES NO	**YES NO**	**YES NO**
↓	**↓**	**↓**
If yes, can I change this behavior?	**If yes, can I change or influence their behavior?**	**If yes, can I do something to change or influence the system?**
↓ ↓	**↓ ↓**	**↓ ↓**
YES NO	**YES NO**	**YES NO**
If yes, how?	**How?**	**How?**
↓	**↓**	**↓**
Bring clarity to own behavior	**Emphasize positive**	**Work with sympathetic institutional leaders**
Explore more constructive alternatives	**Give skilful feedback**	**Identify change mechanism**
Practice new behaviors	**Appreciate other's pov**	**Take small steps**
↓	**Explore alternatives**	**Work as a group**
If no, can I...	**Make positive suggestions**	**Choose strategic battles**
Accept responsibility for my contribution	**↓**	**↓**
Forgive myself for not being able to change now	**If no, can I...**	**If no, can I...**
Reflect on what makes it impossible for me to change	**See this person as a teacher**	**Seek out alternative more compatible systems**
	Forgive person for inability to change	**Find ways of remaining true to key personal values w/i system**
	Let go of resulting negative emotions	
↕	**↕**	**↕**

HAPPIER STUDENTS
(increased awareness of self, others, system; greater sense of efficacy, acceptance; more forgiveness of self and others)

↕

MORE FOCUSED, COMPASSIONATE PATIENT CARE

SUMMARY NOTES ART OF DOCTORING GROUP 2
1/6/04

Session commenced with a discussion of the column in Academic Medicine's Literature and the Arts "How to Be Good." We discussed the protagonist's mistaken assumption that practicing an altruistic profession such as medicine guarantees "goodness." Some students thought medicine had to select for "goodness," because it involved so much self-sacrifice. [redacted] pointed out that some people conclude medicine takes idealistic, if not necessarily good, people, and makes them cynical, self-protective, and bitter. We concluded that a profession is neither inherently humanizing or dehumanizing, although it can have elements of both, but that it is the idiosyncratic expression of the person *through* the profession that determines the level of humanism. We then examined the insight that "intention" to be good is not enough. Several students resonated to the part of the reading in which the doctor sets out each morning to be nice and good, but after exposure to a few difficult patients and bureaucratic demands, ends up irritable and nasty.

[redacted] used this point to initiate a discussion about the importance of practice. We identified students who had learned to play a musical instrument or a sport, then asked them to comment on the process. We realized that people have different levels of aptitude for different activities, but almost everyone can improve on their baseline through practice. We also noted that practice often seems tedious, boring, trivial, and not worthwhile, although these are ultimately just excuses for "avoiding the work." We further commented that learning the scientific and technological side of medicine requires an enormous amount of practice over many years, to which no one seriously objects. So why shouldn't we consider devoting at least a fraction of that amount of time and effort to practicing the art of medicine?

We then returned to the algorithmic model of approaching situations and tried to apply it to our session. We did a couple of breathing exercises (breathing in whatever we might need; breathing out to let go of everything that was burdening us). MJ stated the breathing just made her "tired," so we practiced breathing again, this time taking in energy on the in-breath, and letting go of tiredness on the outbreath. DR provided a helpful mini-lecture on the physiological and neurological explanation of why breathing promotes relaxation and releases endorphins. We discussed how processes that work on multiple levels – cognitive, emotional, spiritual, and importantly, physical – have a greater chance of being effective.

We next explored thankfulness. Although the point in the model is to express thankfulness about some aspect of the situation-at-hand, students chose to express thankfulness more generally – about having a roof over their heads [redacted], good health [redacted]), being able to practice medicine [redacted]. [redacted] also offered an example of a seriously ill patient who nevertheless radiated joy and gratitude.

We next turned to intention. [redacted] expressed his intention to learn more about how to support "artful" interactions with patients. We probed his experiences on Geriatrics to pinpoint what he was learning so far that spoke to this point. He noted

patience/impatience as an important physician quality, and then mentioned "personal knowledge of the patient." [redacted] elaborated on the importance of the ability to connect with patients. He noted his three-pronged approach of a) fixing the problem b) healing the patient c) connecting with the patient, and noted that sometimes one prong is followed with little attention to the others, while at other times all three are activated simultaneously. [redacted] pointed out that some patients don't want healing. We made a distinction between healing and expressing caring, which we agreed all patients wanted, although the form of this caring might vary significantly.

[redacted] shared an intention to remember to bring "caring" to each patient encounter, and described a clinical situation in which she thought about her grandmother, and tried to identify ways in which her grandmother had made her feel safe, cared for, and protected. She then tried to behave in a similar manner toward the patient. [redacted] noted that sometimes third year students stated that they had the time to demonstrate caring toward patients "because they didn't know how to do anything else," with the implication that once they became "real doctors" they wouldn't have time for this. We discussed the importance of retaining caring as a crucial element in all patient encounters, regardless of level of provider training.

[redacted] pointed out that part of a physician's personal knowledge of a patient had to do with the ability to "recognize" as unique individuals within a context of their lived life. [redacted] mentioned the example of his optometrist-father making notes about his patients' personal lives and interests on each chart. [redacted] objected that it was difficult to make a connection with a non-continuity patient. [redacted] provided excellent examples as a hospitalist of ways in which connection was possible, even in a limited time frame. Other students confirmed this idea. We discussed students making a commitment to practicing "connection" with patients, regardless of time or circumstances.

SUMMARY ART OF DOCTORING SESSION GROUP 2 1/20/04

Dr. [redacted] was unable to attend the session due to an emergency. We attempted to soldier on without him ☺.

We reviewed student homework assignments. We started with personally meaningful quotes, and how they applied to patient care:

1) [redacted] contributed a quote from Theodore Roosevelt on courage, determination, and the commitment to risk failure. She noted how she had had many personal struggles in medical school, including health problems, and that the quote had motivated her to persist in pursuing this demanding career. She also noted that the quote reminded her to be proud of herself for her persistence and determination. There followed an interesting discussion about the role of courage in practicing medicine. [redacted] mentioned that courage is be brave despite fear, and that led to an exploration of the relationship between fear and bravery, and the importance for there being room in medicine to acknowledge fear. We also discussed how courage could become arrogance, and some examples of surgeons were offered, although [redacted] noted examples of surgeons openly acknowledging fear and uncertainty (which, as a medical student, he personally found somewhat unnerving). JS mentioned the example of Richard Selzer as a surgeon who could explore with authenticity and transparency the loneliness, burden, and fear (as well as joy) in this specialty.
2) [redacted] shared a quote about being kind, and shared how she used this quote to remind her to always make time for kindness. The quote also cautioned that we only have this life to do what we want to do, so not to waste the opportunities each day presents. We talked about examples of what it meant to be "kind" to patients, and how much could be conveyed through small gestures (providing an extra blanket, giving ice, patting an arm). We also discussed that kindness must be patient-centered, in that true kindness is found in the experience of the patient even more than the intention of the physician, so that kindness best grows out of paying attention to the needs, fears, feelings, experience of the patient.
3) [redacted] shared (in absentia) a quote about how trust is in part an act of grace. We first discussed the meaning of grace from a religious perspective as being something unearned as opposed to "good works." From this we extrapolated that the quote (obtained from a fortune cookie no less!) cautions that, no matter what interpersonal skills we develop, to win the trust of patients always entails an element of grace, a kind of minor miracle. This reminds us to be humble in the face of successful connection with our patients.
4) [redacted] shared several quotes. One had to do with setting priorities in life and in work, and not getting too caught up in things, such as exams, that with perspective will not seem important. [redacted] stated that being a husband and father was the most important, because most unique role, he fulfilled; as a physician, he could always be replaced, no matter how good he was. We then discussed the difficulties of balancing home and work lives, and several people shared examples. [redacted] noted living apart from her husband during medical school (he is in [redacted] completing residency there) [redacted] mentioned forgoing applying across the

country for top-rated residencies so she could stay in the same geographic locale as her fiancée. We discussed the irony of paying lip service to the primacy of family, while spending most of our time working. We concluded that striking the proper balance is always difficult, but that awareness of the problem and, as [redacted] expressed it, attention to communication, compromise, and caring always helped.

5) Another of [redacted]'s quotes came from his father, who stressed the primacy of process in life. We discussed the application of this idea to medicine, particularly in the case of chronic illnesses that cannot be cured, but only managed. We also explored learning how to find satisfaction and meaning in the process that occurs between doctors and patients.
6) [redacted] shared a quote about everything being worthwhile if the soul is not narrow. We discussed how we determine what is of value in our lives, how our time on this earth is best spent. We also speculated about what it might mean to have a soul that is "not narrow," and how fear constricts and narrows us. [redacted] noted the concept of a "large soul" as someone having wisdom and compassion.
7) [redacted], [redacted] and [redacted] all shared examples of positive role models. [redacted] talked about her physician father, and how many of her values came from him, but how difficult it had been for her to acknowledge that when she was younger because of her desire to differentiate herself from him. All emphasized the personal knowledge these physicians had of their patients. [redacted] and [redacted] both chose oncologists. [redacted] emphasized the warmth of the physician she described, while [redacted] mentioned her doctor's attentiveness and communication skills.
8) [redacted] used the assignment to apply the difficult situation algorithm. He found many components very helpful in challenging clinical contexts, particularly in helping him to trust his communication skills and ability to intervene in difficult situations with patients.
9) [redacted] explored the puzzling relationship between suffering and joy, and speculated eloquently about the apparently "bipolar" nature of the human condition. He also was painfully honest about acknowledging that much of his problems with medical school were a projection of his own personal struggles. He also expressed his commitment to explore more deeply his "ride into the dark side" and how not to lose sight of beauty amidst the suffering.

INDIVIDUAL RESPONSES TO ART OF DOCTORING GROUP 2 SESSION OF 1/20/04

[redacted]

[redacted] I'm sorry we didn't take longer in class to discuss your beautiful, soul-searching piece of writing. You are a remarkable person, and I admire your courage in probing so honestly beneath the surface. Like you, I also am intrigued by the complex but inextricably intertwined relationship of suffering and joy. In my mind, they are at once diametrically opposed polarities and part of an underlying unity (the yin and yang). For this reason, I believe the puzzling Buddhist injunction to "always cultivate only a joyful mind" is in fact an existential choice. Even when, from our limited perspective, we see only darkness, it is incumbent on us to reach for the light.

I further appreciated your considering the possibility that part of the external struggle you've experienced with medical school is connected to the struggle within. So often we prefer to look outward in anger and blame (not that there isn't plenty to be angry about and that is blameworthy, especially in the process of medical education!), rather than do the hard work of honest inner exploration. Really knowing who we are, befriending our demons and finding our inner anchors can go a long way toward making sense of, and making peace with, the external world, even as we act to change it for the better.

Finally, your insights about our unfortunate tendency to "create dramas" seem very true in my experience. The Buddhists again distinguish between necessary and unnecessary suffering. The self-deceiving, automatic stories we tell ourselves often result in creating unnecessary suffering for both us and others. "Drop the story, just stay with the experience" is useful advice I find. Trying to really see clearly what is happening, rather than becoming lost in our (too often self-serving) story about what's happening is a good place to start.

I feel fortunate that our paths have crossed. I respect your journey, and the work you're obviously doing. The offer of a cup of coffee still holds ☺ Dr. Shapiro

[redacted]

[redacted], thank you so much for your wonderful quotes. I especially loved the one about "the main thing." It was not only witty, but also contained an important truth. It's very easy to lose sight of the big picture. And I couldn't agree more with the way in which you linked this concept to patient care. It would be a wonderful idea if physicians were to routinely ask themselves about each of their patients, "What is the main thing here?" in the deepest, most comprehensive sense possible. As I mentioned in class, it was very touching to see you quoting your father. I hope he knows how carefully you have attended to his words (and his values). The idea of seeing patients – and people – as "works in progress" is so creative – and so compassionate. Finally, I personally agree with the intention of the last quote that sometimes, in life, we must reach deeply within ourselves, sometimes we turn to others for support, but ultimately we need to trust in

something larger, which we call God, the Divine Process (!). I really valued each of your contributions.

[redacted], I wanted to let you know that I shared your fortune cookie fortune in class, and it made a thought-provoking contribution to the discussion. We spent some time wondering about the concept of grace, and contrasting it with the idea of "good works." What came out of our speculations was the awareness that, although we can do a lot to "earn" the trust of our patients, ultimately when such trust is bestowed, it always contains an element of grace. The trust of our patients always has a miraculous dimension which we do not fully deserve but in the presence of which we stand in awe. Even better, this definitely restored the group's faith in fortune cookies!

[redacted], thank you for sharing your thoughts about the oncologist who has been one of your positive role-models. I liked what you wrote about the office atmosphere being "almost as if they were a family." This might strike someone else as unprofessional, but I have just the opposite reaction. Physicians will never be identical to family members, but all patients want to feel as if some small aspect of the caring and concern that family members extend to each other is present between them and their physician. I also liked your listing of all the small things that conveyed this sense of caring between doctor and patient, especially your observation that the oncologist "knew every patient's story." When you know the patient's story (not just the history of their present illness, but something of the story of their lives), the patient feels seen, *recognized* as a unique human being, and that is the basis for trust and for relationship. Finally, your insight about the way in which the physician was able to restore a sense of control to his patients was very important. Illness inevitably results in a loss of control, and all too often the interaction with the physician simply reinforces this experience. In this case, the oncologist was secure enough in his practice of medicine to acknowledge and address this need. I'm really happy you've had such an outstanding exemplar in your professional life.

[redacted] you are quite an amazing guy. I'm impressed by all you shared and wrote. Maybe one day I will be reading your name on the cover of a book – I hope so ☺.

Thank you for experimenting with the algorithmic model I shared in class. I appreciated the example you chose – it was at once simple, yet very representative of many patient-physician problematic interactions. I also was intrigued by the way you framed the cycling experience of frustration and counter-frustration. This was a very accurate and vivid way of describing the dynamic that too often develops between doctor and patient. I was also resonated to your personal disclosures about the tendency we all have to avoid taking action, to hold back because we don't know enough, we might be wrong, you're "only" a medical student. I certainly can recognize that tendency in myself! You learned something very important through this experience – to respect and trust your own voice.

I was very interested in the comments you made about dignity, shame, and humiliation based on one of your quotes. Shaming and blaming are common ways of attempting to control others, and as you correctly observe, inevitably trigger defensiveness and aggression in response. In my experience, giving difficult feedback in a context of caring and personal solidarity between the individuals helps tremendously in reducing defenses and encouraging people to look honestly at themselves.

I also agree that very often what we find most objectionable in others we are guilty of as well. However, the fact that we are all culpable and implicated to some extent (kind of like Yom Kippur group repentance for a whole list of sins, even though personally we've only engaged in some of them) can sometimes provoke valuable dialogue about the difficulties that beset all of us, since if we speak as flawed, imperfect equals, the exchange is generally less threatening.

Moving on to your list of inspiring attendings (I'm glad you found more than one!), you were very perceptive in identifying specific, and quite distinctive, qualities in each of your physician role-models. You reminded me that we may learn valuable lessons from very different kinds of people - lessons about pursuit of knowledge, patience, compassion, thoughtfulness, and ability to connect with others facing difficult situations. Reading the attributes of each of these individuals convinced me you are an acute observer of the human condition, and know how to reflect on what you see.

Finally, I enjoyed the discussion of your encounter with the "difficult patient" in surgery clinic. First, I think your conclusion is right on – when students tell me they're interested in psychiatric illness, I always encourage them to consider family medicine! You are also absolutely correct that "there is no one way to deal with patients." To my way of thinking, that is actually good news, since it would be depressing to conclude that people could be handled in a completely formulaic fashion. That having been said, I was actually quite impressed with the patient-interaction strategy you concocted (although you didn't have the opportunity to fully put it into execution): 1) Recognizing the cues that you needed to "regroup" and rethink your approach 2) Taking a pause 3) Not taking patient statements personally 4) "Allowing her to be as weird as she wanted to be" – (this is my personal favorite! It shows a wonderful potential for compassion and affection toward a patient you barely knew) 5) Keeping the interaction focused and contained. None of these ideas is necessarily incompatible with a more directive approach of interaction. On the other hand, I remain somewhat skeptical that being "short" with patients (in the sense of being annoyed, exasperated, and impatient), interrupting patients, and ignoring the opinion of patients are really necessary elements of a useful model for interpersonal behavior, no matter how "crazy" the patient may be. Perhaps it's a question of means and ends. Such an approach may "manage" the patient, even cow them into submission, and thus accomplish the "end" of an efficient interview, in which a "problematic" patient is coerced to conform to systemic norms. I'd suggest that one can be focused, clear, and firm without being disrespectful or dismissive. Please understand I'm not saying that that's what was going on in the encounter you observed. As you suggest, when a physician and patient have a personal history, they sometimes take mutually agreed-upon interactional "shortcuts" that may appear rude, but actually are

acceptable to both parties within a context of care and commitment. My main point is that I wouldn't be too hasty in abandoning the excellent strategies you generated. I think they would have been both effective and humane.

SUMMARY NOTES ART OF DOCTORING GROUP 2/10/04

First part of the session was devoted to a discussion of how to select a positive physician role-model. One student [redacted] confessed that she could not think of a single positive role-model on the UCI faculty (!). We discussed that mentors (a relationship similar to a role-model) generally did not meet all the mentee's needs; rather, different mentors might be selected for different qualities (parallel to role-models). We also mentioned that role-models from outside the institution could also be invited. Further, we discussed the types of questions it would be useful to ask our guests. Specificity was emphasized, and it was suggested that students might present difficult situations, even situations we had previously discussed in class.

Then we discussed the self-change project. [redacted] used [redacted] as a model. [redacted] said he did not want to engage in "inner growth." [redacted] replied that that was not a requirement, but since this was an art of doctoring class, it should be something broadly relevant to the topics we've covered during the course. [redacted] mentioned "communication skills." We then further specified that [redacted] wanted to develop better skills in dealing with uncomfortable situations, such as seriously ill or terminal patients. This process of specifying the project involved many in the group, with suggestions coming from several students. We proceeded to the next step, trying to operationalize "improving" communication skills. We discussed how students might recognize whether they were succeeding in their project. In this case, we identified dimensions such as decreased anxiety and increased confidence in the student; decreased anxiety and increased comfort in the patient; actual expressions of appreciation from the patient. Finally, we discussed interventions to improve [redacted]'s communication in these difficult situations. [redacted] suggested research, and mention was made of algorithms to communicate bad news. Other students mentioned role-models, and [redacted]k stressed the effectiveness of "absorbing" effective approaches by "osmosis." He also provided several examples of how he had learned to be more comfortable, and make his patients more comfortable in death and dying situations, including a patient who had used humor to put his doctors at ease.

[redacted] decided the project she would like to do would be to be more "playful" with patients. This was especially important to her because when she'd seen an episode of "Scrubs" where a doctor gave a patient a wild wheelchair ride down a corridor, she'd made a promise to herself to do something like that in 3rd year, but now she was completing 4th year, and had never once been playful with patients. It was a goal that was also important to her because she wants to go into Peds. [redacted] then gave some examples of how she would recognize being "playful," such as "hanging out" with patients, playing a game, coloring.

[redacted] also mentioned a project she would like to do. She noted that as a third year, she felt she'd lost a lot of control in her life. In particular, she said she felt out of control in situations where she would like to challenge or question attendings on behalf of patients, but was intimidated or afraid. She further speculated that feeling so out of control in the educational process made her impatient and demanding in her life outside medicine, such

as at a grocery check-out line or a bank. Therefore she hoped that by improving her ability to speak up in educational settings, she could be more relaxed and accepting in other situations. Again other students helped RS think about different ways of talking with attendings: [redacted] modeled a more confrontational approach, SL and VH suggested ways of being unthreatening, emphasizing the student's learning and using questions rather than statements.

The last part of the discussion was devoted to exploring the concept of a "buddy system." We recommended that students pair up in groups of 2 or 3 to support each other's efforts. [redacted] emphasized the importance of having a buddy because it legitimated asking help from others in an interpersonal area. We pointed out that much of medical education focuses on individual accomplishment and achievement, but that a cooperative model in which individuals collaborate for their mutual benefit and good is perhaps more appropriate.

By way of summary, several points were made: 1) The self-change project was simply one more example of "practicing" becoming a better person 2) The self-change project should be something the student cares deeply about, something that really means something 3) All aspects of the self-change project should be operationalized, including the goal; the intervention; and the outcome(s). [redacted] recommended that by the following week, students should have chosen a project, and chosen a buddy. The next step would be to "monitor" or observe the behavior for a week and then begin the intervention.

Overall, students seemed participatory and energized.

SUMMARY ART OF DOCTORING GROUP 2 SESSION 10 3/16/04

We spent the initial part of the group discussing the attendance requirement. In light of concerns about "discrimination," (see [redacted] memos), the option was expanded to include any activity that the student believed would contribute to becoming a better doctor. Students choosing this option were requested to communicate the nature of the activity and why it would help them achieve this goal.

The rest of the class was spent discussing student projects. [redacted] decided to work on being less impatient and more patient. She also realized that growing impatience in her professional work was extending into her personal life, so that she noticed more impatience while driving, standing in check-out lines etc. Group discussion focused on aspects of impatience expressed in the work setting, such as interrupting the patient, or being distracted while taking the history and trying to hurry the patient. We talked about the difficulty of "not" doing something, such as "not being impatient," and focused on alternative ways of increasing patience, such as staying present with the patient.

Another project by [redacted] was to use personal questioning of terminally ill patients to resolve her overwhelming feelings of pity and helplessness that she felt interfered with her ability to be a good physician with these patients. She noted, however, that when she'd tried to ask patients about their feelings, how they were doing, what they relied on for strength, she got blank stares in reply. She wondered whether this was because these were [redacted] patients. [redacted] talked about becoming comfortable with death and dying as an ongoing process, and shared with the group it had taken him a decade to achieve this state. (This project is discussed in some detail in a memo).

[redacted] described an incident in which a gynecological surgeon performed an operation on a patient with ovarian cancer which revealed extensive metastases. He turned away laughing and made a joke about "not buying in bulk from Costco." [redacted] reported everyone on the surgical team was laughing too. We talked about distancing humor and its risks of objectifying and depersonalizing patients. [redacted] noted that this same surgeon was empathic and concerned in his actual interactions with patients. This reminded us that people are rarely all one way or another, but usually exhibit a spectrum of behaviors and attitudes. We talked about whether it was possible to draw lines so that disrespectful comments in the presence of a patient are considered unprofessional, but joking about a comatose, anesthetized patient is acceptable. We also talked about the possibility of not being overwhelmed by emotion ([redacted]'s project), while retaining tender, caring feelings toward the patient. [redacted] also mentioned her enthusiasm at going to hear the [redacted] She thought he would embody the essence of this course, although at a much higher level of wisdom.

We intended to close the session by recapitulating a session [redacted] had done last month with students: 1) listing attributes of a "competent physician 2) listing obstacles toward expressing these attributes 3) listing ways of overcoming the obstacles. However, [redacted] noticed that students seemed really exhausted and depleted. Students agreed. We talked about the importance of taking care of oneself, although this was often not rewarded by

the system or one's colleagues. [redacted] spoke about the practice of medicine as inevitably "giving out," and the need to balance giving with receiving and self-nurturance. We then asked students to go around the room, each listing one thing they'd done recently to "be nice to themselves." For quite awhile, no one could think of anything. [redacted] mentioned riding his motorcycle. Other students mentioned driving to a nearby coastal city, rollerblading, hiking and walking in nature, going sailing, going to dinner and a movie, reading a good mystery book, reading philosophy, doing photography, going dancing, playing music. We discussed how many of the activities mentioned had in common the ability to help the participant "shift perspective," and transpose them into a "different world."

ART OF DOCTORING SUMMARY NOTES GROUP 2 SESSION 11

In the first part of the session, we listened to progress reports on the personal projects of various students. [redacted] reported on her project to develop a more compassionate attitude toward her colleagues and co-workers. Several students ([redacted]) chose to work on aspects of developing patience. [redacted] talked about learning to stay more focused on her patients, and felt the project had been quite successful. [redacted] discussed listening more carefully to patients, and how this had been one of his original goals in becoming a physician, to ensure that patients felt heard and cared about. [redacted] described an interesting project that focused on her relationship with her family, and her feeling that it was "never" the right time to talk with them – either she was too busy or she was relaxing. At first she attempted to shift her feelings during phone calls, but was not successful. Then she listened more carefully to her own needs, and changed the time of calls to one more convenient for her (during driving). We discussed the importance of being able to put out your needs as a physician. [redacted]'s project addressed a similar issue in that she wanted to be able to express her opinions and advocate more effectively for patients. She noted significant progress in this endeavor.

Students who did discuss their projects generally reported a high degree of success. [redacted] had developed an N=1 intervention, and had gathered meticulous data pre- and post- his intervention. Most students seemed to have found these projects valuable and rewarding. The projects appeared to give students a sense of greater control over who they were as physicians. However, [redacted], whose project was to be less judgmental toward patients while on surgery, reported that although she had personally succeeded to some extent, she was disappointed because her behavior had not had an effect on other members of the surgical team; nor had it seemed to really make a difference to patients. This comment generated an interesting discussion about means and ends, and whether the means are invalidated if the desired ends are not achieved.

The last section of the session focused on reading a poem, "Shamanic Journey," by Canadian family physician Kristen Emmett. The poem chronicles the journey from medical student to practicing clinician (including a detour in ob-gyn) through the metaphor of shamanism. The author finds convincing parallels between the painful deconstruction and eventual reconstitution of the shaman and the experience of medical training. Students expressed surprise and perhaps discomfort with the idea of seeing something of themselves in the figure of the shaman. One student pointed out that shamans are identified by their communities, while medical students select themselves for their career (although in a sense the "community" of medicine officially chooses its successors through the medical school admission process). However, students liked the idea that, by listening to their own voices, they could survive the rigorous socialization process, and eventually bend medicine to their needs as well as vice-versa. Students also commented favorably on the humility of the physician, who recognized that her "shamanic powers" all derived from her patients.

The second reading was a short excerpt from a book of essays by Richard Selzer, a retired professor of surgery at Yale University. The excerpt describes a husband's loving

response to his young wife's facial palsy after a successful operation removing a tumor. Selzer recognizes the limits of how much he can do to "cure" his patient – not nothing, but not complete either. He celebrates the resiliency and power of the human spirit he finds in his patient and her spouse. Students were moved by this selection and it raised their spirits. They commented that a sense of relief was generated by being able to recognize the ways in which the patient can heal the physician.

ART OF DOCTORING GROUP 2 SESSION 12 5/4/04

[redacted] comments about course – "a novel experiment…few examples of similar courses offered for credit"; course evolved from gripe sessions in which students aired their grievances to focus on personal struggles on the clerkships, to sharing feedback with each other and feeling less alone; the result was some measure of healing; he hoped his presence provided some balance to views of negative physician role-models

[redacted] also suggested that we implement a "fixed curriculum" for next year, with topics specified in advance

Students' comments – liked "doing things" (personal projects, journal-writing, self-monitoring) in contrast to "just reading things"; the gripe sessions were extremely problematic for a couple of students because of how much negative emotion they observed and how the sessions were not contained; they felt unsafe and polarized; the suggestion was made to establish "ground rules" for discourse that involved active listening and respect for other points of view

Another student suggested emailing a summary of sessions to all participants; as well as using email to notify participants about the upcoming topic

The option of student-run sessions was suggested – students felt this could be an option, but not a requirement

Several students commented that the most worthwhile aspects of the course were the presentations by positive role-models

One student commented that it would have been good to share personal projects and other assignments more fully; as well as to start the personal projects earlier

The suggestion was made to have either optional readers accompanying each session that could be used as the basis to launch a preliminary discussion; or to have brief readings at the start of each session

There was some discussion about the sense in which the class should function as a support group; the consensus reached was that, although the group had elements of support, its focus also included skill-building, particularly in terms of developing self- and other-awareness, and developing different coping strategies for dealing with the stresses of clinical training

One student encouraged more didactic mini-presentations on professionalism

[redacted] identified a fascinating "splitting" between "happy" students who liked everything about their clinical experience and "depressed, grumpy" students who seemed alienated and bitter; there was some discussion about how to avoid polarizing these two groups and helping them enter into constructive dialogue with each other, not with the assumption that the happy group had to help, rescue, or fix the depressed group, but with the idea that both had something to learn from each other

The parallel was made between doctors and patients, in that doctors are perceived as the "happy fixers" and patients are the "grumpy, miserable" people; we discussed how these roles are limiting for both groups

One student suggested more variety in the format of the sessions – in addition to "talking heads," she suggested specific communication exercises and role-plays

[redacted] asked students to list their expectations at the start of the class – one student mentioned values and human qualities that make a good doctor, and how to cultivate them; another mentioned communication skills; a third noted a desire to pursue more humanistic aspects of clinical practice; a fourth cited the importance of "feelings, philosophy, and spirituality" in medicine

The final minutes of the class were spent in reviewing students' self-change projects. All students present felt they had been somewhat effective.

[redacted] had focused on deepening her patient interactions

[redacted] concentrated on becoming less judgmental toward patients in her attitudes and language, and had achieved the insight that judgmentalness was less a function of the particular patient and more a function of how she personally was feeling

[redacted] worked on speaking up more, and felt she had made positive changes in both her personal and professional life

[redacted] committed to chronicling memorable clinical stories, with the goal of becoming more present with his patients.

[redacted] addressed callousness, and felt he had become more compassionate.

Session ended with expressions of gratitude by faculty and students for this interesting opportunity.

[redacted] outstanding choice of topic. My guess is you are already fanta
at showing compassion toward patients, especially those marginal and
disenfranchised members of society. But colleagues may present more of
challenge.

You've operationalized compassion for your purposes to be a) listening
"better" (again, be specific; define this - perhaps not interrupting,
paraphrasing, reflecting, avoiding yes-but) b) smiling more (easy to
measure!) c) cultivating an inner attitude of - ..perhaps we could call it
loving-kindness? (here too, think how you'll recognize this state - ther
may be physiological sensations of being relaxed, calm, not constricted;
cognitive cues - thoughts of "this is a human being too"; and emotions of
accepting, love, even joy (!) in the person's presence) d) non-
judgmentalness (which might be recognized by the absence of negative
evaluative thoughts - "What a jerk this guy is.." - and the presence of
accepting thoughts - "This person deserves to be treated with respect, as
fellow human being, even though I don't agree with her") e)openness (perha
pausing before you launch into a rebuttal; or paraphrasing without then
adding, "but the reason you're wrong is..." f) not "putting up walls" (how
you recognize you're doing this? Start seeing the person as "other," the
enemy? Dismissing what they have to say?)

Terri, you can see from the above that this becomes a lot on which to focus.
To start off, you might choose just a couple of these things (at least in
the way I began to break them down, many of them are overlapping and
interrelated). For example, you might work on cultivating an inner attitude
of loving-kindness and "breaking down walls." Or you could work on specific
ways of communicating to convey more compassion and less judgmentalness.
Again, it's entirely up to you, but just don't overwhelm yourself with too
much stuff.

Your interventions are really creative. I particularly like the one about
treating colleagues as close friends (kind of the parallel of thinking about
each patient as a family member). And you've definitely added a whole new
meaning to the words "Palm Pilot." Great idea! You're on exactly the right
track. In fact, as you point out, you've already started implementing them.

Finally, your "large" outcomes are well-attuned to your target area. You
hope that if you are more compassionate, less judgmental, and with fewer
self-protective barriers between you and your colleagues (up and down), you
will be less stressed and happier... and your patients will benefit as well
because happy docs make for happy patients. Let's see how it pans out!

Thank you for thinking through this project so carefully and with such deep
understanding of what we are trying to accomplish here. I truly will look
forward to hearing what happens. Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Wednesday, March 10, 2004 11:41 PM
To: Shapiro, Johanna
Cc: [redacted]
Subject: [redacted]

[redacted]

Great job, [redacted] I really like this idea, and especially the way you are extending it to both patients and co-workers. You've done an excellent job of "operationalizing" what you mean by "personalizing" your environment ("one new piece of new personal information about one person each day;" "using people's names"). These are actually the "behavioral" definitions of your general goal of "personalizing the environment." "Setting the intention" in this case is the intervention, and it's a good one. See how that works. You might also use little environmental cues to remind you – post a little sign on your dashboard; put an object in your coat pocket that you associate with being more personal. As you proceed with your project, try to keep track of 1) how successful you are with your project (i.e., are you meeting your goals of one new piece of personal information per day; using people's names) and 2) whether a) working relationships seem to be improving b) communication is improved c) you evaluate yourself as being more friendly, less stressed, and more satisfied. Really good work on this. Thank you! Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Thursday, March 11, 2004 7:10 PM
To: jfshapir@uci.edu
Cc: [redacted]
Subject: re: art of doctoring personal project

Hi Dr. Shapiro and Dr. [redacted]

For my personal "self-change" project, I would like to focus on fostering a more personable [redacted] work environment for myself and those I come in to contact with, be they patients and families, [redacted] nurses, residents, attendings, etc.). I would like to take a few extra minutes each day to "get to know" a little bit more about the people around me by taking opportune moments for "small talk". I started with me taking a little extra time to spend with patients or families and the payoff so far has ended up being so beneficial, especially for offering insights into patients' complex psychosocial issues that directly impact the present course of treatment and discharge planning. Also, it seems that patients and their families feel more at ease when someone shows an interest in their story. For me, it's more fun and less stressful to have a more familiar relationship with people.

I'm not generally person, but I find it helpful to know little personal information about the people I work with every day. A friendly functional working relationship is a good goal, but a more personal relationship can enhance the work environment much more. In times when I've felt stressed or overwhelmed, I tend to be less social. I want to practice being social as a way to *decrease* stress and increase overall workplace environment satisfaction.

I was walking with a former attending [redacted] at another hospital - we were both converging on to an elevator when a janitor walked by and they had a very friendly exchange. It was [redacted] that this attending had developed an acquaintance with this man beyond a simple regular greeting.

Hi [redacted] This is an excellent project, rooted in perceptive self-observation. I guess there's a reason for the proverb, "Patience is a virtue." As you heard from the discussion today, it is an easy thing to misplace, especially in the often-frenetic world of medicine. Your approach is also excellent:
1) Establish a baseline by counting interruptions say for a week (or 3 days), just to give you an idea of "mean interruptions per day."
2) Set a goal (and be modest, that way you have a better likelihood of success!): i.e., I want to reduce my interruptions from 10 per patient to 7 per patient (and of course, occasionally it can be necessary to interrupt a patient, although it should not be routine or automatic).
3) It often helps to balance out "do less of" with "do more of." For example, you might say, "Every time I feel the urge to interrupt, I will take three breaths"; or "Instead of interrupting, I will quickly make a note of the question I wanted to ask;" or "I will focus on listening to the patient's story instead of formulating my next question." You might come up with better specifics, but the idea is to identify something positive you can do instead of the "negative" interrupting.
4) See support from a colleague - I can't imagine a better colleague to consult with than [redacted]!

Nice work, [redacted]a. I hope it works out well. Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Monday, April 05, 2004 6:13 PM
To: Shapiro, Johanna
Subject: RE: personal projects

hi dr. shapiro,

[redacted]

thanks,
[redacted]

Hi [redacted]
These are both good projects and I don't have a preference, although I'm wondering if doing something to address "burn-out" wouldn't be the highest priority ("the abdomens of the sick will always be with us"). Let me make two suggestions:

1) If you do the "burn-out" project, watch out that whatever you've chosen to do doesn't become "just one more thing." In other words, making this a successful project might involve working on attitude as well as behavior, i.e., acknowledging gratitude and that "shift in worlds" we were talking about at our last doctoring meeting. So, for example, you might set an intention of being grateful that you're going to chat with a girlfriend, or listen to a great CD or whatever; or make a commitment to really try to relax when you take that bubble-bath! (These, of course, are purely my own projections!). Speaking from my own experience, I know that when I simply add "take care of myself" to the to-do list, I end up even more frustrated!

2) If you do the other project, you might keep in mind the native American approach to doing "necessary harm" (eg., shooting a deer for food). Their practice suggests first asking forgiveness and then expressing thankfulness for what is received. My concern is that an exam that emerges from distancing emotionally from the patient(so as not to be compromised by distress at bothering the patient) may ultimately end up technically competent but uncaring. An exam that is grounded in seeking forgiveness for inflicting (necessary, we hope!) pain; thankfulness for the learning and experience you acquire as a student-physician; and the intention to do some good for the patient, despite the momentary discomfort I think will be an exam that is both confident and compassionate. As far as "outcome," examining your own feelings is very valid. You might also consider asking the patient how the exam went! You might be surprised by what they tell you.

These are just some thoughts, please develop either project as you like. They'll both be very valuable. Let me know if you'd like to bounce off any other ideas. Regards, Dr. Shapiro

-----Original Message-----
[redacted]
Sent: Sunday, March 21, 2004 9:53 AM
To: Shapiro, Johanna
Subject: RE: art of doctoring Group 2 session T Mar 16

[redacted]

I have a couple of ideas that I have been thinking about for my project. One of the areas that I think that I need to work on is balance between my personal life and school life. I have noticed that I am very [redacted] right now because I have not taken much time for [redacted] this year and it is affecting my enthusiasm for my work in the hospital and for my studies at home. For this project, I could possibly try to set aside a small amount of time every night or some time every week to do something for myself and see if this helps me with my enthusiasm and quality of work. Another idea I was thinking about is a project involving patient interaction. I have noticed that I can tend to be afraid of disturbing patients, meaning that I am hesitant to wake them up very early in the morning for an exam or I am scared to push hard on their abdomen during an exam because I do not want to hurt them. I have also noticed that residents and attending do these things without hesitation because they need a good

Shapiro, Johanna

From: [redacted]
Sent: Wednesday, March 17, 2004 3:29 PM
To: Shapiro, Johanna
Subject: [redacted]

Dr Shapiro,

[redacted]

MS4

-----Original Message-----
From: Shapiro, Johanna
To: [redacted]
Cc: [redacted]
Sent: 3/11/2004 11:06 PM
Subject: RE: Art of Doctoring Personal Project-[redacted]

[redacted] outstanding choice of topic. My guess is you are already fantastic at showing compassion toward patients, especially those marginal and disenfranchised members of society. But colleagues may present more of a challenge.

You've operationalized compassion for your purposes to be a) listening "better" (again, be specific; define this - perhaps not interrupting, paraphrasing, reflecting, avoiding yes-but) b) smiling more (easy to measure!) c) cultivating an inner attitude of...perhaps we could call it loving-kindness? (here too, think how you'll recognize this state - there may be physiological sensations of being relaxed, calm, not constricted; cognitive cues - thoughts of "this is a human being too"; and emotions of accepting, love, even joy (!) in the person's presence) d) non-judgmentalness (which might be recognized by the absence of negative evaluative thoughts - "What a jerk this guy is" - and the presence of accepting thoughts - "This person deserves to be treated with respect, as a fellow human being, even though I don't agree with

her") e)openness (perhaps pausing before you launch into a rebuttal; or paraphrasing without then adding, "but the reason you're wrong is..." f)not "putting up walls" (how do you recognize you're doing this? Start seeing the person as "other," the enemy? Dismissing what they have to say?)

[redacted] you can see from the above that this becomes a lot on which to focus. To start off, you might choose just a couple of these things (at least in the way I began to break them down, many of them are overlapping and interrelated). For example, you might work on cultivating an inner attitude of loving-kindness and "breaking down walls." Or you could work on specific ways of communicating to convey more compassion and less judgmentalness. Again, it's entirely up to you, but just don't overwhelm yourself with too much stuff.

Your interventions are really creative. I particularly like the one about treating colleagues as close friends (kind of the parallel of thinking about each patient as a family member). And you've definitely added a whole new meaning to the words "Palm Pilot." Great idea! You're on exactly the right track. In fact, as you point out, you've already started implementing them.

Finally, your "large" outcomes are well-attuned to your target area. You hope that if you are more compassionate, less judgmental, and with fewer self-protective barriers between you and your colleagues (up and down), you will be less stressed and happier... and your patients will benefit as well because happy docs make for happy patients. Let's see how it pans out!

Thank you for thinking through this project so carefully and with such deep understanding of what we are trying to accomplish here. I truly will look forward to hearing what happens. Regards, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: Wednesday, March 10, 2004 11:41 PM
To: Shapiro, Johanna
Cc: [redacted]

[redacted]