ART OF DOCTORING

I. **Start with an apology – due to budgetary constraints in the UC system, our 3 presenters have morphed into one. I am very sorry my colleagues cannot be here, but I will do my best to present their perspectives.**

II. **Overview**

III. **I hope very much this can be an ongoing conversation, rather than a lecture. We have lots of time so please ask questions, make comments, share your experience**

IV. **What is Art of Doctoring?**

A. **4th yr elective**

B. **2 wks credit**
   a. **16 2 hour sessions over 6 mo period**
   b. **One half-day weekend session**
   c. **Written assignments and final project**

C. **Approved by Curriculum & Educational Policy committee**

D. **Enrolls between ¼ and 1/3 of graduating class (25-35/100 students)**

E. **Developed by psychologist, general internist, and hospitalist**

F. **No additional support from Medical Education or School of Medicine**

G. **Students must negotiate time to attend sessions with supervising residents**

V. **History of AoD**

A. **My colleagues and I repeatedly observed frustration, burn-out, cynicism in 3rd yr ms**

B. **As we encountered students, we urged them to focus on relationships with patients, be compassionate and empathic; but we felt increasingly hypocritical about these injunctions to "hold onto values" when we were doing nothing to help our students do so**

C. **Awareness that cultivating relationship takes skills of reflection, intention, centering, empathy, appreciation of other; it also takes practice**

D. **We felt we had an ethical obligation to create a learning environment that provided opportunity to explore relationship-centered aspects of clinical practice**

VI. **Goals and Objectives in Designing AoD**

A. **Make a connection between a theoretical model (Relationship-Centered Medicine) and daily practice**

B. **Help medical students understand the usefulness of reflection and imaginative perspective in**
   a. **cultivating self-awareness**
   b. **enhancing compassion and empathy for patients, patients' family members, peers, attendings, residents, nurses, medical team**
   c. **developing insight into how best to convey compassion and caring in the patient-doctor relationship**

C. Help medical students develop specific skills for empowering themselves as learners and as student-physicians
    a. Be able to identify and assimilate relationship-centered attitudes and behaviors modeled by others
    b. Know how to use re-centering techniques and compassionate curiosity in difficult and stressful situations
    c. Be comfortable recognizing and working with relational "patterns"

Questions ?

VII. Primary guiding theory we used in AoD was Relationship-Centered Care

A. Context: Genuine relationships in healthcare are morally valuable

B. Relationships depend on
    a. Self-awareness and self-knowledge
    b. Other awareness (empathy, understanding of the other)

C. Personhood of both patient and doctor, as well as their roles, is always implicated in relationship
    a. Patient is a human being, not a scientific object or passive recipient of care
    b. Physician is also a human being, not merely an active instrument
    c. Both physician and patient can suffer or benefit as a result of their encounter

D. Engagement and connection are cornerstones of relationship
    a. Detachment and neutrality do not further relationship

E. Communication is more than vertical information transmission
    a. Communication and its influences are bidirectional and reciprocal

F. Medical encounter is not completely predictable or controllable
    a. Patterns of meaning and relation are constructed moment-by-moment
    b. Without awareness and ability to recognize and work with patterns, they can rigidify in dysfunctional ways

H. Patient-doctor relationships occur within a complex web
    a. Societal, institutional, cultural, and familial relationships

VIII. RCC is intimately connected to Narrative Medicine

A. RCC is intimately connected to NM

B. Relationships depend on storytelling

C. Creating and sharing stories is how we connect with others

D. Listening to stories is how we communicate concern, caring, and respect for others

E. Sharing stories ("clinical anecdotes") is the backbone of AoD

IX. Model of course

A. Introspection/Reflection
- Exploring our core person (as individuals; as healers)
- Exploring the other (as individuals; as participants in larger social systems)

B. Interrogation/Application
- Reframing self/other
- Cognizant of larger systems

- **Working with patterns, assumptions**

C. Retrospection/Anticipation

- **Looking back and looking forward: both looking back over the class and over the 4 yrs of medical school; looking forward both to internship, and to life in general**
- **Appreciating relationships personally and morally**
- **Intention/preparation for future relationships in medicine and in life**

Questions

X. Methods

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

XI. Writing Assignments

A. Meyer-Briggs type personal assessment

B. Personal experience with loss and grief

C. Compassion burn-out scales

a. **current self-care**
b. **plans for addressing problems**

D. Cultivating positive emotions and attitudes

b. **Kindness, patience, empathy, compassion**
c. **Altruism, service**

E. Critical incident report/creative representation of difficult encounter and possible alternatives

a. **Resident/attending/nurse**
b. **Patient/family**

XII. Special Session – Healer's Art

- **Healer's Art (Rachel Naomi Remen)**

- **Half-day experience**
- **developed by Rachel Naomi Remen, M.D.**
- **to teach physician self-awareness and humanistic ideals.**

- **Seed Talks**
  - **Finding meaning in medicine**
  - **Medicine as service**
- **Sharing meaning object**
- **Writing/sharing personal Hippocratic Oath**

XII. Grading

Questions?

XIII. Breakdown of 16 sessions:

A. I'm now going to quickly take you through how the sessions progress and build on one another

B. I want to emphasize how important these final "project-sharing" sessions are. Over the years we've increased them from 1-3 because they are so moving and involving for the students.

Questions?

XIV. Two Examples of Mini-Lectures and Exercises

A. Finding your emotional equilibrium

1. Start with Osler and equanimity, a concept I believe has been misinterpreted, leading to its equation with detachment

2. Emotional connection continuum (EXERCISE)

3. Background/definitions of centering

4. Presentation of some centering strategies

5. Small group discussions of finding equilibrium

B. Cultivating positive qualities in patient care

1. Ask students for ideas about positive qualities

2. Remen quote to reframe thinking about "giving" to others

3. GROUP EXERCISE

4. Ideas collected from student essays

Discussion

XV. Outcomes and Evaluation

A. What we learned from students' personal projects

1. Overall, students choosing self-change projects decreased

2. Students varied in their desire to work together on projects

3. The projects were almost uniformly thoughtful, insightful, self-revealing, honest, and moving (or hilarious)

4. Occasionally, it was obvious students "blew off" the project and had done it the night before

5. To encourage students taking the project more seriously, we required students to submit a written description of their proposed project half-way through the class; and then faculty dialogued with them about how to improve, focus, deepen the project

6. We also required that in group projects, every student have a written product and participate in the presentation

B. Evaluation:

1. No matter how we tinkered with the course, our evaluations were quite consistent, and showed a consistent pattern

2. Students felt they improved self-awareness, developed more empathy, learned specific skills

3. But it was the commitment of the teachers that meant the most to them

a. I point this out trying not to be egoic – I don't think it was our brilliance or our insight that really impressed them, but just that we were present; we kept showing up and kept trying

b. This fits very well with the literature that says the most effective, successful student learning about professionalism comes through role-modeling

4. Positive and negative comments

a. Positive – meaningful experience that students really took advantage of

b. Negative – talk less, listen more!

XVI. Future Directions

A. More small group work

B. More student leadership

C. Intersperse personal projects throughout the curriculum

D. More involvement of physician faculty

E. Required vs. elective?

F. Institutional culture of caring