Shapiro, Johanna

To: [redacted]

Subject: RE: AoD final project

Hi [redacted]. Thanks for sharing your project in advance - it gives me a better sense of what to expect! I like your intervention - I have done "old lady" yoga for 5 or 6 years now, and it is the one form of exercise that, for me, calms both my body and my soul. As you note, this intervention is a perfect example of how a little self-care can have important ramifications throughout the day. We'd like to think we can by-pass this particular square, but we can't, can we? Although it's not exactly scientific (!), I can confirm all your results from my own experience, including the fact that even though you are getting less sleep, you feel less tired. I applaud your resolution to maintain this practice during residency. Even if you can only manage it 3 times a week, I am certain it will continue to benefit you in many ways. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]ect

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[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Tuesday, January 17, 2006 2:30 PM
To: [redacted]
Subject: RE: Next AoD meeting Jan 17 - make-up assignments for sessions 5 and 6

Hi [redacted]. Thanks for this essay, which raises several interesting issues. One is the issue of pain management for (suspected) drug-abusing patients. As far as I know, you are quite correct about the problem of low pain threshhold as well as "tolerance" of anti-pain medications, making them less effective than you'd normally expect. Of course I'm not a physician, still it sounded to me as though you did some good retrospective problem-solving by thinking of different ways to achieve a reduction in pain for this patient. That made a lot of sense. Another issue is the patient's poor pain tolerance itself. I've heard stories of nurses and residents making derogatory comments about such patients, complaining about their wimpiness or the fact that they've "brought this situation on themselves," with the unstated implication that they "deserve" their agony! The observations about wimpiness and personal responsibility may in fact be true, but concluding that the patient deserves to be in pain is probably not the conclusion we should reach as health professionals. A variant of this theme is that the patient is exaggerating his or her distress in order to "get drugs." Again, such an issue should be weighed on its merits, but often this is not really a credible analysis. Finally, in my experience it's very hard to keep centered when someone is writhing in pain, especially if that person happens to be attracting the attention of a high mucky-muck. Our natural tendency, as per above, is to "blame" the patient for making us look bad. All in all, quite a challenge! I'm glad you were able to pull in the resident; and how interesting that, in the end, the patient appreciated your efforts and even thanked you! Sometimes we find rewards in the most unexpected places. It seems to me you handled yourself well in a difficult situation. Best, Dr. Shapiro

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From: [redacted]
Sent: Tue 1/17/2006 9:24 AM
To: Shapiro, Johanna
Subject: [redacted]

[redacted]

From: Shapiro, Johanna
Sent: Thu 1/12/2006 2:41 PM
To: [redacted]
Subject: Next AoD meeting Jan 17 - make-up assignments for sessions 5 and 6

Hi everyone. Thanks to those who were able to attend our last session for making it such an interesting discussion. For those who missed it, you can review the algorithm included in your reading packet.

Our **next session will be T Jan 17**, and we will be meeting pretty much every T between now and the end of

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, January 18, 2006 1:20 PM
To: [redacted]
Subject: Make-up assignment session #6

Hi [redacted] Thanks for your reflections on "speaking out" in difficult situations. You've framed the issue well. Some of us need a metaphoric shove to plunge into conflict, but for others, it's more about learning to choose battles; and when chosen, learning to nuance our responses. I would *never* counsel inaction or retreat in the face of injustice, wrongdoing, or moral failure. But, except in truly urgent situations (and I've often learned that, for me, the best response to perceived urgency is to step back and breathe!), a little reflection and introspection can't hurt. Anger, outrage, hurt are worth listening to (perhaps more than immediately *acting on)* because they are trying to communicate something of importance. Sometimes it is something about the "other," but if we listen closely enough, often it's also something about ourselves. Understanding these things may help shape how we proceed. As you suggest, paraphrasing the other's perspective *always* helps (and I still have to remind myself on occasion that paraphrasing doesn't necessarily mean *agreement*). People almost always soften (even if just a bit) when they really feel heard and understood. And yes, reciprocity would be nice, but we don't always get it. Still, I've found that by asking the other person directly, "Could you let me know that you hear *my* concerns," sometimes it's possible to *create* reciprocity. Finally, for me there's a balance between guarding against "fixing" and tenacious engagement with a problem. I find that if some of the emotional tension is diminished, it is possible to stay committed, in a friendly way, toward finding a satisfying resolution for both parties. Doesn't always work, I know. But still... In any case, [redacted], I realize that I am mostly just regurgitating your very considerable wisdom and self-knowledge. This email could have been a lot shorter, summed up as follows: Keep doing what you're doing! :-) Best, Dr. Shapiro

Shapiro, Johanna

To: [redacted]

Subject: RE: Catching up on AOD assignments

Haha[redacted]. Very witty. The more things change, the more they stay the same. Or what goes around comes around. (I assume Ms. Smith was the daughter or granddaughter of Dr. [redacted]. I'm reminded once again what a fine writer you are. This little skit shows off your acerbic style of comedy very well. I especially enjoyed "eternal medicine" (I suppose that is a well-known pun, but new to me); and the irony that the thoroughness of the internist can be seen as degenerating into mere dithering; while the "cut"-to-the-chase surgeon may in fact be the one most concerned to end the patient's suffering. You probably could teach both me and Dr. R. a thing or two about [redacted], so suffice it to say that when you have a sufficient breadth and depth of knowledge, the best use to make of it is sometimes for a laugh. Thank you, [redacted]. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted] PM
To: [redacted]
Subject: [redacted]ments

[redacted]

[redacted]

[redacted]

[redacted]

Shapiro, Johanna

To: [redacted]

Subject: RE: Difficult Patient

Oops. Try again.
What I found most interesting in your essay was the shift in the team's attitude (and perhaps your attitude as well?) toward this patient from first to second hospitalization. You know, the Buddhists say hope can be a great enemy. I've never liked this conceptualization particularly, but what they mean is that hope can get in the way of our seeing things as they are. It sounded as though the second time around, people were seeing Mr. C more "as he was." In my mind, there's an important distinction between resignation and acceptance. I see resignation as more hopeless, even a little despairing; whereas acceptance recognizes "what is," yet can hold out the possibility (and for me, this is very similar to hope) that the patient can yet choose to transform himself (even just a little) - and the team as well! (everybody always has the potential for some growth, right?). In fact, it sounds as though on the return trip, this frequent flyer was better behaved, and the team was more resigned/accepting.

As always, I admire your capacity for confronting the "dark-side." From one perspective, what a neat solution if this creepy, demanding, entitled patient would just turn up his toes and disappear permanently. I've had very similar thoughts about more people than I like to admit. I think the real commitment to humane practice is when, darn it all, the guy doesn't evaporate from our lives and instead, bounces right back. I see this as a message that I, at least, still have something to learn: "When the student is ready, the teacher appears." Thank you, creepy, obnoxious, disgusting, lewd man for giving me an opportunity to explore "impatience, disgust, derision, animosity, rejection, resentment, outrage, hopelessness, helplessness, and shame." What better way to examine the relationship I want to have with these emotions, and the extent to which I want them to inform my behavior!

The Brideshead Revisited comparison was perfect. Although large swaths of that book have vanished from my memory, I actually remember the scene in the Algiers apartment with disgust and revulsion. There is no question that this is our first response to some people, whose external ugliness seems to reflect their bent souls. Yet for me, that's where it starts to get interesting! (and of course very challenging. Often, I'd say I never get past that initial reaction. But I've discovered that by learning to be less "panicked" about strong negative emotions, I can be more comfortable with them, and therefore less "ordered about" by them, and can gain greater clarity within the situation. It's a first step!

Best, Dr. Shapiro

From: [redacted]
Sent: [redacted] 3:40 PM
To: [redacted]
Subject: [redacted]

[redacted]

Art of Doctoring [redacted] Make-up Assignment #6

[redacted] this piece of your life has floated insubstantial yet permeating in my mind since I have known you. Learning the temporal specifics makes me realize just how difficult first year must have been for you. Your insight about the overlap of anatomy dissection and the disintegration of your personal life seems absolutely true. No wonder you were struggling – anatomy lab must have been an awful daily reminder of the situation at home. I am so sorry that you had to contend with all of that at the same time you were dealing with the shock of medical school. And I am glad to hear that the nausea is passing. Like Sartre, you seem to be finding your existential sea legs.

The whole business of excavating the shards and fragments of our lives is a powerful metaphor. Reconstructing patterns, instilling them with meaning is what life comes down to. I wanted to know what your personal mosaic would be – but of course it made much better poetry that you didn't divulge the specifics. Amidst the bleakness of divorce and brokenness, it is very consoling to know that whatever your shattered memorial might be, it would bring a smile. I hope in writing this poem it excavates and brings into the sunlight some of the remaining grief.

Final Project

[redacted], I liked the idea of your Book of Days, some way of memorializing through words and images the voyage (shipwreck? – hopefully not) of medical school. The cards look vaguely medieval – what do they represent again? In any case, Ode to a Peach remains one of my most favorite of your poems – Neruda, watch out! Best, Dr. Shapiro

Shapiro, Johanna

To: [redacted]

Subject: RE: Personal grief, loss assignment

Hi [redacted]. Thank you for writing about your loss of the love of learning, and of being interested in subjects outside of medicine. I appreciate your honesty. Like you, I predict that these losses are temporary - or can be. You may have to postpone a complete renewal of these aspects of yourself till after internship, but most important is that you can recognize them. You might even consider setting yourself a small, doable goal for next year. Maybe if you love reading, you might choose a thin novella you've wanted to read, or a collection of short stories, and try to dip into it once a week, even for 10 minutes. It's amazing how losing yourself in a good book, even for a short amount of time, can revive you. Like you, I too love to read, but at a certain point in my career had become increasingly focused on academic reading, to the exclusion of pretty much everything else. To remedy this imbalance, I began reading poetry (not so much because I liked it - give me a fat Dickens novel any day - but because it was SHORT!). This actually led to a whole new turn in my work life, but that is a different story. The relevance here is that even a short little ode a week helped me to feel I had not completely lost that side of myself. Maybe it could work for you! In any case, knowing where our shortcomings lie is truly the important first step in remedying them. I know you will find ways to rekindle your love of learning, and of reading. Best, Dr. Shapiro

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From: [redacted]
Sent: Thursday, February 23, 2006 2:17 PM
To: Shapiro, Johanna
Subject: Personal grief, loss assignment

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Friday, April 07, 2006 1:51 PM
To: [redacted]
Subject: RE: Art of Doctoring

[redacted], thanks for sending me this assignment. You've reached a very important realization - life will not "become easier" simply because you've finished medical school (or residency, or fellowships, or practice). Life is always full of challenges and choices. So in my view you are doing absolutely the right thing to carpe diem so to speak and take responsibility for the priorities you set in life. You've chosen a path that will always involve juggling, but will also be rich and rewarding. In my opinion, you have chosen the two best possible books for engaging with questions of spirituality. I'm assuming you know Dr. [redacted] (of course he is a member of our faculty!); and if he is any kind of mentor to you, you are very fortunate, since he is is a remarkable human being (and psychiatrist :-)). Btw, [redacted], just wanted you to know you received one of the highest marks in AoD and will be receiving honors for the course. Congratulations! Dr. Shapiro

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From: [redacted]
Sent: [redacted]M
To: Shapiro, Johanna
Subject: Art of Doctoring

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[redacted]ani

[redacted]

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Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, March 01, 2006 1:54 PM
To: [redacted]
Subject: RE: Make-up assignment for session 3 – difficult incident

Hi [redacted] Thank you for this essay. It's nice to know you've not run into conflictual encounters with residents and attendings thus far. As you say, a pleasant nature and political savvy help, although unfortunately they are no guarantee. It is also very true that the majority of residents and attendings are good and decent people.

I'm glad you brought up the issue of lack of feedback from academic supervisors. That's surfaced in other years, but no one has mentioned it thus far in our group, and it's a very important concern. Both of the instances you recount sound incredibly frustrating, especially the resident who would "just smile and walk away." Ugh! Feedback, especially face-to-face, is very hard for some people to give, and I've actually attended faculty development workshops whose sole purpose is to train faculty in how to provide constructive - and specific! - feedback. Unfortunately, even with such training, many people rely on platitudes and generalities, as you discovered. I agree completely that all students should receive clear and detailed feedback, especially in areas where improvement can be made. You were actually quite proactive in attempting to solicit feedback when none was offered. You can sometimes shape the response you get by the kinds of questions you ask: "I'm glad I'm doing well. Do you see any particular strengths I have? Are there some specific things I could improve, and if so how?" This may encourage your preceptor to think more carefully about you, in both positive and negative terms. But if the individual lacks the skill, or the will, to provide meaningful feedback, it ain't gonna happen!

I hope these examples were exceptions, rather than the rule, but I know many learners feel they do not get sufficient guidance about their performance. Thanks for sharing, Dr. Shapiro

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From: [redacted]
Sent: [redacted]
To: Shapiro, Johanna
Cc: [redacted]
Subject: [redacted]

[redacted]

[redacted]

[redacted]

Shapiro, Johanna

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

[redacted], your assignment was terrific! The cartoon format was creative and enjoyable to read. You raised several interesting issues. One is when are you a doctor and when are you not? Many years ago, as part of my own training, I participated in an alcohol and drug rehab program, and experienced exactly the same conflict. You handled your situation very well I think. It really helps to ask yourself, what is my role here? If your role is primarily group member (or friend, or wife, or mom, or daughter), then responding from within that context is probably how you will do most good and be most helpful. However, at another time, addressing issues that intersect with other roles you may also have (such as doctor) makes a lot of sense. In this case, you had special knowledge (i.e., that diabetes is a dangerous medical condition and needs to be attended to) that might have helped this woman. However, even here you realized you were not actually "[redacted]" doctor. So you went through a process of reflection - what should you do? - and considered various options. Once you decided to pursue the matter, you still proceeded carefully, by first asking [redacted] permission to "cross roles." This approach may have helped her retain a feeling of control, and was much less intrusive than giving her a "lecture" about diabetes. By "asking" rather than "telling" you gained valuable insights into why she was so upset, and if you chose to counsel her further, this information would certainly have influenced the direction in which you took the conversation. From [redacted]'s response, it was obvious she felt you were taking an interest in her, rather than judging her as "crazy" (the way she herself partly felt about her outburst). In my view, you handled the situation very well, and had the effect of getting [redacted] to think through her own reaction and - who knows? - maybe be a little more open to dealing with her diabetes. Thanks for sharing, and for such an interesting presentation! Best, Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Tuesday, January 17, 2006 2:08 PM
To: [redacted]
Subject: RE: Difficult Patient Assignment

Hi [redacted]. Wow, this was a tough one. No wonder you felt badly! I think you reached the right conclusion, both in saying that you might have been able to approach the issue more tactfully and in feeling that if the patient was very sensitive, he still might have been offended. The most frustrating communication "mistakes" for me personally are when I make assumptions about people but I don't realize I'm making assumptions - I just think I'm putting the "facts" together! Then I usually end up with my foot in my mouth. This encounter might have been complicated by issues of race, age, and gender, so that your delivery of the question might have been fine, but the patient might have read into it a certain jnegative udgment. It is also possible that he detected something in your tone which he interpreted as unprofessional. I have made many blunders like this, and I think all we can do is revisit them, honestly but in a spirit of inquiry rather than self-condemnation, and see what we can learn. Thank you for sharing and reflecting so openly. Best, Dr. Shapiro

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From: [redacted]
Sent: Tue 1/17/2006 8:59 AM
To: Shapiro, Johanna
Subject: Difficult Patient Assignment

[redacted]

[redacted]

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Thursday, February 02, 2006 3:57 PM
To: [redacted]
Subject: Stress and burn-out assignment

Hi [redacted] You are a very conscientious student, I really appreciate the work you're putting into this class (especially with the little one at home). You do an excellent job of identifying the "bottle and stuff" emotional phenomenon. This is also a difficulty I share (perhaps surprising in a psychologist, but on the other hand, maybe that's one reason I went into psychology in the first place!). I know that for me, stuffing emotions has partly to do with difficulty in *recognizing* them ("What's going on? Nothing, nothing, I feel great"); but that below problems with recognition lies *fear* ("Yikes! If I admit I'm devastated, I'll fall apart. If I recognize how angry I feel, I must be a bad person"). So in my case, a lot of my own work has revolved around learning to become more comfortable with difficult - or even just very strong - emotions, *not running away from them.* As I've grown more familiar with and less scared by my feelings, they tend to ambush me less. And I agree with you, talking and journalling are great strategies for recognizing and owning our emotions.

Bingo for me on #2 as well - I don't like to ask for help either. I'm much more comfortable giving help. But, like you, when I cross a certain line, although I still give the support, I start to feel resentment. You, your mom, and I could all line up in front of that mirror! What I've learned is that practice does make - well, not perfect, we're not striving for perfection here, right? But it does make it easier. One of the best things that's happened to me is learning to say no clearly and firmly, but without aggression (a lot of people who have trouble saying no use anger to solidify their position - not called-for, and not necessary).

You've chosen one of the most emotionally demanding specialties, and I have great respect you for that choice. Being aware of the dangers of burn-out in this career path will help you. And I don't think you need to be too afraid. Once again, it is a matter of becoming able to "tolerate" emotionally, to honestly and calmly confront, the possibility of death and loss. This doesn't mean you should ever "like" it. Rather, it is about cultivating the emotional strength to *contain* the fear and suffering of your child patients and their parents. This involves not having *no* emotions, but rather reducing the fear and anxiety that emotions of sadness, helplessness, and anger generate in you. As you learn to accept these feelings as occasionally part of the peds hem/onc territory, increasingly you will be able to help families through their own turbulent, but navigable, emotional waters.

Your final point about how your baby has positively affected your outlook is really insightful. I think you'll find that having a child of your own will make you more sensitive to the parents of your little charges; and will help you keep that much-needed fresh perspective on life. In your free time (:-)), read Perri Klass' Other Women's Children, where she describes, in fictional form, what it is like to be a mom and a pediatrician. It's a really good book.

Thanks for all your thoughts, [redacted]. This was a very carefully done reflection. Best, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: RE: AOD Project

Hi [redacted], thanks for giving me a sneak preview! I like your project - it's a great topic, which I'm sure almost every 4th year student can relate to. You defined it will, and established a good baseline. The intervention was simple and easily achieved (always key elements in effecting successful personal change), and it looks as though you didn't have too much difficulty implementing these reminders. The third week of follow-through was an excellent addition, to see (short-term) how your mental attitude change maintained without conscious intervention. Although you were disappointed in your results, I was impressed. You definitely improved your eagerness to take on patients and reduced your fear of evaluative oversight. Further, you were able to maintain (even slightly improve) this improvement for an entire week. If you continue to notice your mind settling into this conditioned groove (very understandable given how important your evals are in obtaining desirable residencies), you might continue to challenge it in other ways by asking yourself: "Do I really want the attending to exer this much influence on my learning?" "Take a breath, and focus on the patient." "Remember to take the history YOU want to take!" Basically, variations along the lines you already outlined. You did an excellent job, and I really appreciated the little graph. Very interesting data! Best, Dr. Shapiro

-----Original Message-----
From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

[redacted]

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, February 22, 2006 11:07 PM
To: [redacted]
Subject: AoD assignment #6

[redacted]

Hi [redacted]. It was nice to see you in class Tuesday. Glad you're back!

Thank you for this beautiful and touching essay about your grandfather. Grandparents and grandchildren often have a very special bond, quite different from the parent-child relationship, and infinitely precious. I really liked the way you linked your experience to Didion's *The Year of Magical Thinking*. I don't have the courage to tackle it yet, but I've read a couple of reviews, as well as talked to people who've read it, and it sounds as though it captures the completely altered sense of reality that occurs when we lose a loved one. Something of that same feeling comes through in your description of your grandpa's last days. As well, there is that awful, pervasive sense of death, not only in the relation to the person who has actually died, but in relation to yourself. Life as you have known it will never be the same again, and therefore in a sense your "old self" has died. We never put these losses behind us (nor I think should we), but as you discovered each time you make that pilgrimage, we can arise from our own ashes.

[redacted], I remember your poignant "Starbucks" essay. It moved me when I first read it, and it moves me now. It is one of those startling encounters that may mean nothing or everything. These kind of inexplicable events remind us that awe and mystery are all around us, if only we choose to be open to them. And there is a sense in which all the grief in our lives resides in that domain. Surprisingly, knowing that we do not know everything – can not know everything – is sometimes reassuring and hopeful. For example, I think it is much better that we can never know for sure whether the lady at Starbucks was "an angel or just a passerby." Perhaps she was both. In any case, I am so glad that encountering her softened your grief. Best, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: RE: AoD project

[redacted], you are very welcome! The poem you crafted is quite beautiful in its simplicity, and reminds me of Chinese verse I have read with its focus on natural cycles teaching us who we are. I did not catch it when you first read your essay, but the choice of the box-tops is even more apropos when you realize that the magnificent jade screens of your grandmother are now "transformed" cardboard boxes and white shadows. Change is sometimes sad, sometimes exhilarating, joyous, challenging, devastating - but what is expressed so well is that it is part of the natural course of events and we need to trust it and appreciate that within every change, there is both joy and sorrow, and we should embrace them both. Thanks for sharing, Dr. Shapiro

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From: [redacted]
Sent: Saturday, March 18, 2006 1:44 PM
To: Shapiro, Johanna
Subject: RE: AoD project

[redacted]

[redacted]

[redacted]

[redacted]

From: Shapiro, Johanna
Sent: Thu 3/16/2006 11:24 PM
To: [redacted]
Subject: RE: AoD project

Hi [redacted] Thanks for sharing your joy! I am sorry not to have been at Match Day. I planned on attending, but have been laid low by a nasty bug. In any case, I'm so glad yo got your #1 choice - you sound very clear about wanting to be there. Maybe there is something about "you can't go home again," as in return to the Farm! Stanford is a wonderful environment, but you've had that experience, and I think your heart has been drawing you steadily toward the people and program at UCLA for awhile.

Thank you for your more than generous words. You have always been so giving in your praise and appreciation of me (and I'm sure many others). It is a sign of your warm and magnanimous spirit. Tiffany, you are a remarkable person. I am honored and grateful that you have entrusted me with a little of your story and your struggles - and your triumphs. To me, you fulfill the hope we all have that the difficulties and challenges that we all must face can be transmuted into something meaningful and good. I hope you will keep in touch occasionally, and let me know how life progresses for you. In the meantime, congratulations again, and hope to see you Tuesday. Best, Dr. Shapiro

-----Original Message-----
From: [redacted]

Shapiro, Johanna

To: [redacted]

Subject: RE: AoD Assignments

Hi [redacted]. Thank you for sending these along. I really enjoyed reading both of them. Your "difficult" patient sounds... really difficult! Just speaking personally, I am a hundred percent supportive of the practice of crying out to God for help, when we cannot seem to muster the ability to do it all on our own. I know when something goes wrong in my life, I have a habit of getting on the phone to family and friends, as well as of course my husband. Recently, after a particular trauma, are you fogetting anyone when you reach out? I thought for a moment, then said, "Me." My husband (who's a pretty wise fellow) said, "Anybody else?" I thought harder, then replied somewhat abashedly, "God." If we are people of faith and spirit, however we define that, then we shouldn't be afraid to turn over our hard hearts, our unwilllingness to forgive, our negative judgments, and let God work on them for awhile. In this anecdote, I saw you turning to yourself, and to God, both excellent resources :-). Learn to use them (as well as other colleagues, friends, and of course Warren :-), and you will find that, at the least, you are not making already difficult situations even more difficult; and with a little luck and grace, you will be making them easier, softer, more tender, for yourself and hopefully for the patient.

I have to confess to having a few very uncharitable, unforgiving, and hard thoughts when I read about your first two rotations as a third year. Just as the patient is vulnerable to the power and authority of the physician, so the student is vulnerable to the power and authority of the attending. In neither case did your attending use his or her power well. You, on the other hand, rose to the occasion by not allowing yourself to be crushed, and by handling yourself with consistent
professionalism and perseverance. As in the essay about the difficult patient, here too the "rewards" are internal and intrinsic, but perhaps these are the best kind. In your heart, you have proven to yourself that, even when confronted with difficult patients and unprofessional attendings, you have enough of a center, enough of a true core as a person, to behave with both grit and grace. I'm proud of you, and more importantly, you are proud of yourself. I'm also happy that, FINALLY, you received excellent role-modeling and mentoring. Those good doctors are out there, and before you know it, you're going to be one of them!

All the best, and see you Saturday. Dr. Shapiro

From: [redacted]
Sent: Thursday, June 01, 2006 1:38 PM
To: Shapiro, Johanna
Subject: RE: AoD Assignments

[redacted]

From: Shapiro, Johanna
Sent: Mon 4/10/2006 5:04 PM
To: [redacted]
Subject: [redacted]

Hi [redacted]. Thank goodness, I do feel much better! I was worried we had kind of "lost" you in class (we always struggle with trying to allow in as many students as want to take the course, while still keeping it somewhat personal).

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Tuesday, January 17, 2006 1:41 PM
To: [redacted]
Subject: RE: Art of Doctoring Course

Great job, [redacted]. If you make it to class today (2103-4) I hope we can discuss this interaction. Your reflections are very thoughtful and perceptive. I agree with you that there is a place for sternness in interactions with patients (and others). We should never think that we need to accept verbal or physical abuse from a patient. But being the "strict parent," although sometimes necessary, merely curtails aversive behavior - it doesn't get at understanding. *Why* is this patient such a jerk? Maybe it has to do with previous poor medical encounters. Maybe it has to do with the fact that he's dying and no doctor can change that. Maybe it's a lack of trust. Be curious! I think it is very wise to realize that, while sternness may have provided space in the relationship, it was *persistent kindness* (treating the patient with care and dignity, regardless of his behavior) that eventually turned the tide. He started trusting you, and he started opening up, just a bit.

The issue of the code status is a difficult one. I suspect many factors were involved, and perhaps in this hospitalization they could not all be sorted out. Sometimes people are just not yet ready to go; and ethically, although we may be concerned about their quality of life or the waste of medical resources better employed elsewhere, that decision must be respected. However, there may be other issues involved, such as trust. If you are not *very* comfortable with and *very* trusting of your physicians, you are going to have trouble when they suggest a DNR. Such counsel, although usually appropriate, can be (not necessarily is) a bitter pill to swallow. So again, it's best to approach these questions with an open hand. Ideally, you would want to be able to get patient and doctor on the same page during this hospitalization. But it might not happen. Who knows? The discussions may have planted a seed, so that if the patient doesn't expire from natural causes, he may voluntarily reconsider his code status. The outcome isn't the only measure of success. By beginning a dialogue, you might have done more good than you realize. Thank you very much for sharing such a complex but ethically very rich scenario. Best, Dr. Shapiro

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From: [redacted]
Sent: Mon 1/16/2006 10:55 PM
To: Shapiro, Johanna
Subject: [redacted]

[redacted]

[redacted]

[redacted]

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[redacted]

to have been complicit, i.e., known what you were doing was wrong, and said nothing. The ethical burden here, I believe, lies with the resident.

However, I do agree that, having become aware of the inappropriateness of the resident's behavior, you incurred a professional obligation to discuss the situation with him. As you point out, it is unclear whether this was an oversight or intentional malfeasance on the resident's part. If the latter, an incident report and/or reporting the resident's behavior to the clerkship director might both be good options. If, for some reason, the resident was simply uninformed, you could do future patients and medical students a lot of good by educating him.

This was a very thought-provoking example, and you analyzed it well, although I think you blamed yourself unnecessarily. Not that it is any excuse for what happened, but given the quality of most informed consent procedures, personally I might want to take my chances with a caring, if not totally knowledgeable 3rd year student. You should not have been placed in that position to begin with, but I trust that you did a good job with the skills and information available to you.

Much good luck, [redacted]j, next year. I'm glad that you and [redacted] will be keeping each other company at Harbor. Just don't get into too much mischief ☺ Best, Dr. Shapiro

[redacted]
[redacted]
[redacted]icine

From: Shapiro, Johanna
Sent: Wed 2/8/2006 9:54 PM
To: [redacted]
Cc: [redacted]
Subject: Art of Doctoring participation

Hi [redacted]. Dr[redacted]k and I are quite concerned that you have only attended 2 of the 10 AoD sessions to date. Speaking for myself, you are one of my most favorite and admired students. I have been consistently impressed and touched over the last 3 1/2 years with your leadership, creativity, commitment to patients, and kind, compassionate heart. AoD seemed like a perfect match for you, so it is especially hard for us to understand why you have missed so many classes. We understand that 4th year presents unique challenges because of away rotations and interviews. Nonetheless, attendance is a crucial aspect of this elective. If you are still intending to receive credit for the elective, we strongly encourage you to attend all the remaining classes (6), as well as turn in all required written assignments. We welcome discussing this situation with either of us if there are any extenuating circumstances we should know about. Thank you, Dr. Shapiro and Dr. [redacted]

Shapiro, Johanna

To: [redacted]

Subject: RE: AoD assignment #6

Hi [redacted], I am so touched by what you wrote. I can feel the love and admiration you have (not past tense!) for both of your grandparents. I think you have a beautiful insight into the ritual process. There are a lot of rituals in my religion (Judaism), and I've learned that ritual is all about attitude. Sometimes rituals can be mechanical, behavioral, just going through the motions. But with the right attitude, they can be inspiring. I agree completely that they are a way of transforming a moment of secular, ordinary life into sacred space. I also like very much what you say about grief "shape-shifting." It is not so much that it vanishes (nor, I believe, would we want that), but that as we begin to be more familiar with it (like a close friend) we see other facets of it - it does contain anger, bitterness, but it also contains acceptance, gratitude, and many other things. I believe you are "working with" your grandparents' deaths in a healthy and healing way so that you are not as afraid and bitter about loss. When you achieve this (and it's an ongoing process, right?) in your personal life, you become a much emotionally "safer" person for patients and family members who are also having to confront death and dying. You are really *doing* art of doctoring in your life and your practice. All my best, Dr. Shapiro

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From: [redacted]
Sent: [redacted]PM
To: Shapiro, Johanna
Subject: [redacted]6

[redacted]o,

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Best,
Tiffany :)

[redacted]
Co-President, Class of 2006
UC Irvine School of Medicine

From: Shapiro, Johanna
Sent: Tue 2/28/2006 2:19 PM
To: [redacted]
Subject: RE: AoD assignment #6

[redacted] thanks for the encouragement re the Didion book. I am making a personal resolve to read it. I just wanted to share with you that, even for me, not knowing your grandparents, there was a beautiful "closing of the circle" by reading your two essays side by side. I imagine your grandparents lying in peace together. Rituals, like the ones you describe, are one important way we have of moving through grief. Thank you for sharing yours. Best, Dr. Shapiro

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From: [redacted]
Sent: Sun 2/26/2006 12:37 PM
To: Shapiro, Johanna
Subject: RE: AoD assignment #6

Hi Dr. Shapiro,

[redacted]

[redacted]

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]
Subject: [redacted]

3/3/2006

FEEDBACK SHBEEB/JIVCU 1/06

[redacted]

Substance Abuse Experience (Make-up):

[redacted], it is obvious to me you got a great deal out of your substance abuse rotation. I think I mentioned I went through a very similar intensive program as part of my own training almost 30 years ago. Like you, I learned an enormous amount about patients with addictions, about their families, and about myself and my own family. For example, I learned that I had many ACA characteristics which initially puzzled me since neither of my parents abused alcohol; but my mother was chronically ill, which produced similar attitudes and behaviors in me, the oldest, "parental" child.

From my observations of family medicine residents, I know how difficult it can be to refuse a patient with an addiction the narcotic they are demanding. It must have been reassuring to hear from recovering addicts that, in fact, although they might grumble and take off, this is really a helpful approach that sends an important message of limit-setting – and true caring. I also thought you made an excellent point about the workplace. I'm sure you know that one workplace it makes sense to look for addiction is the hospital, where professionals with alcohol or drug problems are often ignored, or intentionally overlooked until their situation is egregious. It is much better to raise concerns either through direct discussion with colleagues with whom you have a close relationship, or by making use of anonymous reporting mechanisms. The right thing is not always the easy thing, right?

[redacted]

[redacted], I like what you said about the "difficult" ob patient. You probably know better than I how frustrating and challenging such patients can be. I think Rafael Campo, the physician-poet who wrote Maria, agrees with you. His poem conveys both the frustration and helplessness that such a patient engenders in a resident or attending, as well as the dangers of the physician's descending into indifference, annoyance, and dismissive contempt. Sometimes we have to reach deep to find compassion and caring. It's easy to think how, if "Maria" had only made different choices, she would have made our lives so much simpler. Yet, as you rightly point out, we know nothing about the pressures and constraints of her life, the influences of her culture, the limitations of the lack of a shared language. It's hard to see beyond what seems like unnecessary difficulty. But it is essential, to be a truly good doctor. Most of all I liked that you would continue to bring "passion" into the encounter, rather than simply going through the motions. It is the desire, the "passion," to heal in *all* situations, with *all* patients that, as you rightly point out, makes for a truly authentic, meaningful doctor-patient encounter.

Jivcu "The Difficult Patient"

[redacted], I thought you wrote a thoughtful and insightful essay. Many years ago, as part of my own training, I participated in an intensive substance abuse rehab program, so I know first hand just how valuable that experience can be. And I agree that the poem manages to convey the dissimulation, the denial, the bargaining, the deception that addiction brings both with others and with oneself. As you point out, it is difficult to confront

patients, but as you also observe, it is the optimal intervention. I'm glad you had a chance to hear that many patients battling addictions (eventually) are grateful to physicians and others who challenged their using. It's important to remember that you can be very honest, you can "tell the truth," in a way that is not judgmental or punishing, but loving.

The second point you raise is complex, and I think in your reflection you go through a couple of permutations. Initially, you make the distinction between "deserved" and "undeserved" suffering. I think this is a dichotomy that is easy to make and is a familiar way of thinking to most of us. But in your next iteration, you realize that denial and self-abuse may be parts of the "disease"; or products of this person's very difficult past; or both. And with this awareness, your patience and empathy start to flow again. For myself, I've come to the conclusion after many years of pondering this issue, that it is both a more complex and more specious question than we might initially think. Apportioning blame and determining innocence in the end might best be left to others. Perhaps our job is smaller – just to alleviate suffering wherever we find it. Best, Dr. Shapiro

MAKE-UP AoD ASSIGNMENTS[redacted]

[redacted]y – difficult interpersonal encounters

[redacted], thank you for speaking up today in class. I thought it was brave of you to volunteer right off the bat, in an art of doctoring class, that you tend more toward the emotional detachment end of the continuum and that that is the right place for you to be. Sometimes students in AoD feel that the point of the class is to learn to be more touchy-feely. That is *not* our intention. Rather, our hope is that students will not to be *afraid* of emotional connection with patients, to realize that such connection has value to both their patients and themselves, and then to reflect on how they can best make those connections in ways that honor themselves and their patients. It is all about awareness, honesty, courage, and personal choice. There are many, many ways of being a caring, compassionate physician (or surgeon!).

Thank you also for your make-up assignment. In terms of Meyer-Briggs, I suspect that I am a lot more F than you are, but interestingly, there's a large part of me that's a rule-follower too (J), so I think I understand that pretty well. For me, rules help make the world more understandable, more predictable. Like you, I get upset at people who cut in line, run red lights, don't pay their taxes. On the other hand, I've come to realize that not all rules are fair (or perhaps equally important, not all rules are *perceived* as fair, or reasonable). Some rules give certain people, or certain groups, unfair advantage. When people have no stake in the rules, it becomes much easier to break them. I'm not saying it's okay to break rules, but by taking a larger perspective it makes it possible to mix my anger or annoyance with a little more understanding. And understanding why people break rules is the first step toward figuring out what might help them follow these same rules. Unfortunately, this isn't going to help you with your fellow passengers on Southwest, but it might be relevant to your "rule-breaking" patients. For example, if you give a post-surgical patient certain "rules" about wound care, and the patient ignores them, it's easy (and perfectly understandable) to be upset with the patient. But if you also try to figure out *why* your rules don't seem important to the patient (maybe they cost too much, or they don't seem realistic given the patient's need to return to work, or they conflict with the patient's culturally-based health beliefs) , then maybe you can negotiate a set of "rules" that make sense to both of you.

[redacted], I hope your needs are getting met in AoD. If they're not, or if you have some ideas about how the course could be more helpful to you, I hope you will let me or Dr. [redacted] know. Best, Dr. Shapiro

[redacted] make-up difficult patient

Hi [redacted] I'm selfishly glad you decided to comment on [redacted]'s poem, because you provided an entirely new interpretation which I'd never thought of in many years of teaching this poem in the literature and medicine selective. Specifically, it had never occurred to me that the poem might be written from the perspective of the *patient,* and be an expression of the unrealistic hopes that so many patients pin on weight loss (and that underlie tv programs such as The Biggest Loser). This is a completely original and

creative perspective that can be justified by the text, and helped add a whole new dimension to this poem for me.

My own interpretation is closer to the first one you offer, although somewhat more ironic. Like you, I think counseling weight loss is often the physician's "greatest tool" – or fallback. One of the things that strikes me about the poem is the way it links weight loss to progressively more and more unrealistic goals. As you point out, it is possible (although not inevitable), that weight loss will assist in the management of HBP or diabetes. But the problems of so many patients are so much more overwhelming – poverty, violence, loss of hope. As the poem suggests, so many patients have "hunger," (emotional, spiritual) that they try to assuage through eating. These patients are hopeless and discouraged, and their doctors often are too. It is very tempting for physicians to offer simplistic solutions and promises, not only to make the patient feel better, but to make *themselves* feel better. If only the sins of the world could be forgiven by shedding a few pounds!

In any case, thank you for giving me the opportunity to revisit this wonderful poem with completely new eyes! Best, Dr. Shapiro

Feedback [redacted]2/14.06

[redacted], thanks for letting us know about the Betty Ford rotation. I've heard it's great, and a wonderful example of art of doctoring in practice. Your time will be very well-spent there.

Thank you for all these assignments. You must have been working very hard. I appreciate your efforts and wanted to give you some specific feedback.

Being something of a closet writer myself, I found your essay on "Neglect Parts" particularly poignant. I bow to your professor's greater expertise regarding the sanity of writers, but I do challenge his assertion that writing can never be combined with a "regular job." In fact, in contemporary literature, there are many examples of outstanding physician writers: William Carlos Williams (pediatrics/general practice), Richard Selzer (surgery), Rafael Campo (medicine), Danielle Ofri (psychiatry), Frank Huyler (emergency medicine) – and I could go on. If writing is a passion, then fan the flame a bit. I love what you write about "gain[ing] strength from the stories of my patients and colleagues." That is exactly what all these physician-authors say about combining their two crafts – that the one nurtures and sustains the other. I am confident that you can write your novel if you so choose, with or without your rich widow! ☺

Thanks for giving the ED-EI monitoring a whirl. You have some good insights into the possible biases introduced by implementing the project at the Betty Ford clinic, all of which may have contributed to making you slightly more emotionally involved than you normally would be with purely medical patients. It sounded as though you were saying that a setting filled with intense emotional experiences to which you could personally relate, a clearly defined language of discourse, and a structured role helped you to express somewhat more emotion than normal; and further that you found this experience valuable. Of course, you are the only one who can decide what is the most comfortable and appropriate place for you on the emotional continuum (and, of course, different patients will require different positions on that continuum). But perhaps your time at Betty Ford will open up additional possibilities in terms of exploring a range of emotional connection with patients.

In terms of the compassion fatigue assessment tools, as screening tools they are necessarily rather crude, and probably yield more false positives than otherwise. Therefore, I would interpret the results with caution. It seemed in your case that they triggered serious reflection on your part, which is all to the good. In general, I would tend to agree that by the end of their fourth year, medical students are very much able to express empathy and compassion toward patients, despite the "intense politics" and "unconsciously/consciously deceiving patients" that you mention. In fact, as you suggest, learning more about illness and disease may even enhance students' original more intuitive feelings of compassion and concern. Nevertheless, attendings, residents, and even medical students are all at some risk for emotional burn-out because of the stresses and demands of the medical profession. Finally, you make a good point that empathy cannot be expressed equally toward all patients; and I'm not sure that is even a

desirable goal. Rather, perhaps it makes more sense to strive for a certain empathy "threshold" regardless of patient below which you do not want to fall. I also think sometimes if we do not "rigidify" around our first impressions of patients, but learn to stay open to the possibility of their surprising us in positive (as well as, unfortunately, negative!) ways, we may find our empathy flowing toward them more naturally.

Nice work, [redacted]. Thank you for your thoughts. Best, Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, November 02, 2005 12:54 PM
To: [redacted]
Subject: RE: Art of Doctoring in the PICU

Hi [redacted]y, it is very good to hear from you and to learn something about your experiences at Stanford PICU. You wrote a beautiful essay. Thank you for sending it to me. We ended up not reading it yesterday, because the issue you tackle is one we plan to address (in a general way) later on in the course. I will hang onto a copy, and you do the same, and you can either read it or share it with the class by email when we reach this topic (by the way, I really like the idea of circulating writings among the class. I realize there is no reason why "assignments" or other thoughts should flow only vertically from student to teachers. It would be much more beneficial for thoughts, feelings, insights to flow horizontally throughout the entire group. This is what we encourage in the in-class discussions, and it makes very good sense to handle assignments that way as well, at least as an option).

I did just want to share a few personal thoughts about the situation you described, which really was heartbreaking. I have never been in the situation of that adoptive family, but having two of my grandchildren born prematurely and spending 3-5 weeks in NICU gave me a little sense of the devastating emotional burden the family of a fragile infant must bear. I can only imagine how incredibly painful it would be to finally have reached the decision to withdraw life support, as did this family, only to be second-guessed by a specialist waltzing in at the last moment. People like the GI docs can only behave like that because they have lost sight of the human context, and the child has become nothing more than an interventionist challenge. I'm sure the GI team only wanted to do what was best for this little patient, but they probably used very narrow parameters in defining that concept. The result was needless suffering for the family, and the loss of invaluable moments that can never be restored to them.

I notice that you wrote, almost in passing, "This is the first patient I have lost." [redacted]y, I can't know exactly what that is like either, not being a physician, but from listening to many, many physicians and students over the years, I know that first death is one that will always stay with you. Like the family, you have your own grieving to do, and I believe writing this essay was a step in that direction. You also may have some forgiving to do, of the GI team who didn't pay sufficient attention to the family's wishes, of the treating physicians as a whole who (unintentionally) confused and tormented the family by not presenting them with a clear assessment of the child's prognosis, and perhaps even of yourself, just for being part of the system that caused such unnecessary suffering to a family already undergoing the terrible loss of a child.

Finally, you ask such an important question, which we will be able to turn to later in AoD, namely why is it so hard for physicians to let go? I agree with your insights, they are very perceptive and right on the mark. There are no perfect solutions in the indeterminate, "messy" situations. The only thing I feel is that, if you can always be asking yourself, what is truly best for this patient at this moment, rather than being swept away by ego needs to be a hero, or by one's own anxieties about death, or by the fear of failure, or the many other unconscious motivations that may influence our actions, you will probably learn to recognize most times when it is right to fight for life, and when we must acquiesce to death. It is a hard thing that this most significant of choices is a decision based as much on art as on science, but in the end, I think none of us would want it to be made formulaically. When this decision is made by many people with differing expertise and perspectives, all of whom love or care about the patient, who know that person a lot and even a little, and whose intention is to honor that person's values or being, then that's the art of medicine, uncertain, mysterious, imperfect, but as it should be.

[redacted], thanks again for sharing your essay with me. I know that you were both very moved and verytroubled by what happened with Zach, Emily, and the family. By spending a little time reflecting on it, you've understood much better what it means and what it might have to teach you. This is the kind of process that makes a competent doctor a humane doctor, and exactly what we hope to model and encourage in AoD.

Best, Dr. Shapiro

Shapiro, Johanna

To: [redacted]

Subject: RE: attendance make-up and assignment information for AoD. Please read!

Hi [redacted]. Thank you for such thoughtful and valuable essays. In your first essay, you put your finger on 3 very difficult areas of medicine: death and dying, breaking bad news, and interpersonal conflicts among the medical team. You're right - in some ways, these never get "easier," and in a sense, nor should they. But I do believe that there are ways of learning to be in the presence of death that allows room for your own grief, while containing the grief of family members, such that while you are still fully feeling and empathic, you are able to be present and not emotionally disintegrating. Your insight about breaking bad news vs. good news was very insightful and I appreciated your honesty. Knowledge and information help, but they do not "solve" the problem. Again, I think this has more to do with learning how to work with one's emotions and not being overwhelmed by helplessness, guilt, or any other feeling that may detract from your ability to be with the patient. Finally, as I hope we'll address tomorrow, interpersonal conflict is inevitable, and therefore we all need skills in handling it. When we overpersonalize, we can act in ways that simply exacerbate the problem. That is not to say that it is wrong to stand up for yourself - certainly not! But it helps when you can stand up from a centered, kind place, even toward people who are acting like jerks :-).

Your analysis of the apparent contradiction between a career in pediatrics and the importance of family and friends is cogent. I agree with you, these are both really manifestations of an underlyig unity - your concern for human relationships. I also was interested in what you said about the negative and positive aspects of having "potential." Yes, challenging yourself is a good thing, especially when you thrive on it, as you do. But you're right to be cautious about "constant driving." I call it "using the whip," and indeed that can become masochistic. When we push ourselves solely out of duty, guilt, fear of failure, we tend to burn out. When we are "drawn forward" to new heights, when this happens out of the abundance in our lives intellectually, emotionally, spiritually, then we often do better. Finally, [redacted], I'm delighted to learn that even as a medical student you've made the time to learn to surf, snowboard, and play tennis. This is what balance is all about!

I know we will talk more about all these issues. You are definitely in the right class, and I'm very glad indeed that we will all have a chance to benefit from your perceptiveness and authentic searching. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

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[redacted]

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]
Cc: [redacted]
Subject: [redacted]

[redacted]

12/5/2005

Shapiro, Johanna

To: [redacted]

Subject: RE: More AoD assignments

[redacted]y, thanks for your diligence in continuing to churn out this work. Your effort is much appreciated.

You had a great insight that your position on the ED-EI continuum can shift markedly from patient to patient. That in itself I take to be a good sign, because it means that you modulate your level of engagement depending on the patient and, presumably, the nature of the encounter. Of course, what you recount with the family of the Betty Ford patient is classic counter-transference. By noticing the usually unconscious factors that "hook" us, we can usually gain more control of them, and ensure that they are operating for the benefit of the patient rather than otherwise (as in your example of discharge arrangements - here I think the trick is to allow yourself to feel fully the parents' and patient's desire to be together; while not becoming so lost in their perspective that you fail to see that temporary separation may be in everybody's best interest longterm, although short-term very painful. I guarantee you that this ability to feel fully while still seeing clearly gives you the best chance of being perceived as trustworthy by your patients).

The other type of "error" is excessive detachment, which subjectively I would place around 1 or 2. It is reasonable to expect that you will not have the same level of emotional connection with every patient, and I see no reason why you should. I guess what each of us must decide for ourselves is kind of a "minimum threshold," below which you do not want your caring to fall, regardless of how frustrating or unpleasant the patient is. This concept of a threshold is based on an assumption of basic human dignity even in people who strike us as unworthy, even depraved. I agree with you that being aware of biases and preconceptions is a giant step toward opening ourselves to the possibility that people may surprise us, of course often in bad ways, but sometimes in good. Understanding others does not excuse or justify behavior, but it does tend to make us feel less judgment and more compassion toward them.

You know, in terms of the stress and burn-out scale, I'm inclined to agree with you. I think many people (including the psychologists who delight in constructing such scales) associate deeply felt emotion with stress and negativity. This *can* be the case, but it doesn't have to be. As I've tried to convey in class, I believe it is possible to *feel* very deeply the distress of others without being excessively *burdened* by it. I don't know if that distinction makes sense to you, but it is one that intrigues me greatly. My sense is that, if we can moderate our *fear* of strong feelings, we can open ourselves up to experiencing for what they are - expressions of emotional solidarity with the patient - without feeling obligated to "solve" the problem or "save" the patient from suffering, if these are not options.

Regarding the burn-out scale, these questions seem to have more face validity to me. Since I answer yes to most of the ones you mention, and agree with your analyses of the items, I don't think this makes us "bad" people (in fact, I think up to a point these qualities are what make us "good" people), but these tendencies also do make us vulnerable to burn-out. The way I look at, if you know you are somewhat at risk, you're better off than proceeding blindly. The questions also sound a cautionary note - i.e., it's great to be achievement-oriented, but when does this get in the way of living our lives the way we want to? Similarly, taking on additional responsibilities can be challenging and fulfilling, but when this habit crosses a line, even pleasurable things become burdensome. So, at least for me, it's about knowing myself, and knowing where even good tendencies can lead me astray, to the point of exhaustion and resentment.

The best thing you did in this essay, from my perspective, was to recognize your defensiveness, the embeddedness of these qualities, and your resistance to change. Bravo! This statement shows a sophisticated level of self-awareness and honesty. As you rightly point out, by and large none of these qualities should be purged from your character (indeed, as I note above, and as you say, they are what make you an excellent physician), but they can lead you into difficulty if they are not acted on with awareness and reflection.

The fact that you recognize the need for coping strategies, and actually *have* coping strategies also suggests that you have already devised ways of modulating your stress level. Humor, exercise, asking for help, staying emotionally connected to family and friends are the mainstays of a balanced life. Courage, acceptance, and wisdom, my friend! I'm not worried about you turning into a cinder any time soon.

3/13/2006

Shapiro, Johanna

To: [redacted]

Subject: RE[redacted]

Hi [redacted]e. Thanks for being so conscientiouis about these assignments, and glad to hear you are getting something out of them.As far as the "sisterly dialogue" goes, were names changed to protect the innocent? Just wondering :-). In any event, you captured quite well how two different personality styles can clash, almost without being aware of it. What's interesting to me is how easy it is to say with negative judgment, "You're so obsessive and controlling, you never have any fun" or "You're so irresponsible and distractable, when are you ever going to grow up?" And the battle lines are drawn! It's really more productive to say with equanimity, "Wow, we have really different styles don't we? How can we work together to accomplish this task of Thanksgiving dinner that honors both of us?" Of course, it's probably Leslie bringing up the topic!

I really enjoyed your MB self-analysis. In contrast to the negative framing of the other I expressed above, one of the things I like about MB is that there is no right or wrong, different styles have different strengths and potential pitfalls. When you wrote about becoming a "jaded" N, you illustrated that simply "expecting the best" people, while often a good strategy, may be a little simplistic. As you say, life is complicated! So perhaps the trick here is to allow that N sense of possibility and optimism to continue to orient you in the world, while having a more realistic (and therefore less "disappointed") understanding that, because life is complicated, people (including us, sadly!) don't always come from their "higher self." Ah, sigh. But knowing this may lead to more compassioni, less judgment.

I was also interested in your comments about trusting your feelings. I guess the way I look at it is that there is a difference between trusting my superficial reactions on a given day or time ("This has been a terrible day. I think this residency sucks!") and learning to identify and pay attention a deep, steady core of "knowing." It's still hard sometimes for me to tell the difference, but over time I've learned to trust the latter, which has a different feel than if I'm reactively bouncing from one fleeting feeling to another. In my opinion, in choosing a residency, listening to that core wisdom is really important. Almost all residencies will give you more or less the same content (at least that's true in family medicine), but the subjective "atmosphere" of a program can make all the difference between a miserable and a happy (although at times stressed out, goes without saying) 3 years.

I thought you had a terrific insight when you wondered whether you had changed over the course of medical school, or whether you were just more honest about who you were. Fascinating point. I relate to it well because I always used to think of myself as a P, but when I really thought about the questions, I'm much more of a J (INFJ). The relative stability of personality traits doesn't mean that we are "locked in" by any means. We can explore other ways of being in the world to a certain extent, and that is why you and your fiancee have the potential to really learn from each other (as well as drive each other crazy occasionally!). It's all about knowing yourself, accepting yourself, then working on yourself to become the best version of the person you were "meant" (by genetics, social circumstances, culture, God [!]) to be.

I also related to what you said about breaking bad news. This is where being intuitive, feeling, and empathic can be both a wonderful gift and a burden. Imagine how easy it would be if you never thought, "Gee, it must feel devastating to learn your child has a potentially fatal cancer"! Simple, you could just focus on the chemo and the statistical chances of survival. However, because NFs "feel the pain" of their patients, to avoid creating suffering in both the patients/families and themselves, they may tend to minimize, to obfuscate, to offer unrealistic hope (which of course creates even more suffering, but it's more subtle). So again, it's all about how to hang on to the sensitivity and caring without being bowled over yourself by the implications, so that you can still be available emotionally for the patients and parents. In terms of day-to-day vs. looking at the big picture, as you imply, this can get a lot of physicians into trouble. To me, stepping back on occasion and asking, "What is the point of all this? Where are we going?" seems essential, so that you do not mindlessly prolong suffering under the guise of care. At the same time, a strength of most physicians is that they can just put their head down and go, and sometimes this is essential too. And sometimes parents or patients must take refuge in the day-to--day, because they simply aren't yet emotionally ready to face the overall picture. In this case, it is the physician's delicate task of honoring where they are while moving them gently forward to where they need to be.

[redacted] obviously your thoughtful essay provoked a lot of thought in me! Thanks for sharing so openly. We will

[redacted]

Shapiro, Johanna

To: [redacted]

Subject: RE: AoD catch up

[redacted]y, great insight about making yourself happier vs. the patient more effective! That's really wise. It's so hard to know - I'm by no means convinced that was the exclusive, or most important, aspect of your desire to boundary-set, but it is very important to do our best to sort out when we're doing things that will benefit the patient vs. when we're doing things to ease our own frustrations and anxieties. It's also convenient to believe that we can always influence the outcome of events, but this isn't true, no matter how caring *or* firm we are. My goal in these very difficult interactions (broadly speaking, obviously I do not have experience with the FTT situation) is 1) to come from a place of caring and nonjudgmentalness, no matter how "soft" or "firm" my action 2) to pay attention to what's happening, so I can evaluate whether my "approach" is effective or ineffective 3) to be flexible and creative in my problem-solving, so my ego (or my anxieties) don't interfere with my doing the best thing for the patient/person 4) to not focus solely on the outcome; and to set not only big goals (child gains weight), but a series of little goals that may be more achievable (building trust with mom; improving mom's understanding of child's condition). One thing that strikes me about this case is that most FTT kids do *better* when they're hospitalized, yes? In any event, I'm looking forward to seeing you (in the flesh!) next week. I already have scheduled a meeting with [redacted] after class, but maybe you can come a few minutes early, or we can chat the following week for sure. Best, Dr. Shapiro

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From: [redacted]
Sent: Wednesday, February 15, 2006 4:46 PM
To: Shapiro, Johanna
Subject: RE: AoD catch up

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

Hi [redacted] I liked your poem a lot (or rather, it was painful to read, but very real, and that made it good, because I could really feel your frustration with this situation). The scenario you present fairly shrieks *irresponsibility*! Why is this mom having unprotected sex and having more kids when she knows she has a condition that results in prematurity and all its potential complications? Why is this woman a mom at all, when she seems to do such a self-absorbed, lackadaisical job of taking care of the kids she does have? Why is she so hostile to physicians, when so much in this predicament is her *fault*?

And yet I'm not sure that your ideal alternative ending would be the answer. Or maybe not the whole answer. Let's think a minute. What would make a mother act so irresponsibly? Lots of things (lack of understanding, a true religious conflict, being overwhelmed, helplessness, fatalism, indifference, anger). People do respond to boundaries, and it is critical to know how to set them (this is coming from someone who is very poor at boundary-setting!). However, I've come to believe that boundaries are most effective when they're established within a context of empathy, caring, and nonjudgmentalness. Maybe this woman is a bad mother (if it's up to us to decide that), but if what she *hears* from us is that

Shapiro, Johanna

To: [redacted]

Subject: RE: Session 10 make-up

[redacted], once again I'm dazzled by your level of self-awareness. I should have known you were a meditator (even a lapsed one - which is a pretty good description of me. And of course you are absolutely right - I try to use that thought "I don't have time to meditate" as a CUE to start meditating right away :-). Doesn't always work :-(. Still I think once you touch that stillness, you can never be quite as frazzled and "mindless" as before. Btw, Robin was a resident of mine in FP, and now I consult with her for overall "well-being" maintenance. She's terrific!). It is true that sometimes our significant others can see us better than we can see ourselves (I know that is true for me), so it was a great idea to consult with Bill and be open to his feedback.

Doing, not being, is a pervasive problem in our culture. Of course, doing is good - that's how we conquered smallpox and build bridges. But to lack the capacity to BE makes it possible to be present for many precious aspects of life, both joyous and otherwise. As you suggest, "being" is a way of relaxing - deeply, at a core level - and thus of truly replenishing yourself.

I agree, those articles are quite good. I personally love the idea of "refuge," finding a sacred space and allowing oneself to be in it occasionally.

Hey, congratulations on your upcoming wedding! This is wonderful news. And a honeymoon in Thailand sound terrific. My son has been there once, and one of my daughters twice (she is a mindfulness meditation researcher, and spent a month in a Buddhist monastery there). At your age, I know it's hard to slow down, but you're right, there's plenty of time, so linger a little :-).

One thing I find helpful, in addition to making the what-bugged-me list (which is a good idea), is to remind myself of one thing that happened during the day for which I'm grateful (sometimes the best I can do is, this day ended!). We are caught up in lives that are difficult, complicated, challenging, and often frustrating, so it is easy to focus on the problems (which definitely are there). But the good things are there as well, and they deserve attention too :-).

Thanks, [redacted] for another excellent analysis. I see you working hard, and taking advantage of many aspects of the course. I appreciate your sincere effort. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

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[redacted]

AoD Make-up Assignment and Final Presentation [redacted]

[redacted], thanks for turning these in. I know this must be a very busy time for you with graduation, GHHS, etc. At least stress over residency is over. Congratulations on going to [redacted].

It was nice to hear you couldn't think of a difficult patient interaction – knowing you, I'm not surprised! However, the difficult patient incident you shared regarding the high-risk ob resident was quite interesting. The way I interpret it, it shows the importance of not allowing one's ego to be prioritized over patient distress and anxiety. Of course, a senior resident is going to be highly qualified to care for patients, so the patient should not have been worried. The key here is "should not." Carrying twins is already a challenging experience. Depending on how far along the patient was, preterm labor might pose a significant threat to the survival of her babies. Therefore it is easy to understand how out of control, how terrified this woman might feel, how she might grasp at any straw to improve her chances. Unfortunately, when she escalated the situation by insulting the resident, the resident responded in kind, walking out and saying she would not provide medical care to the patient. Clearly, the patient was not at her best (as patients often are not). This is not to excused her behavior, but to remind ourselves that the physician's responses should not be determined by the actions of the patient, who is always more vulnerable, more frightened, more distressed than the physician (although sometimes not by much!). As you rightly point out, the resident could easily have defused the situation by empathizing with the woman's feelings, thinking out of the box to find a mutually acceptable solution, and not take the patient's lashing out so personally. If we restrain our impulses to behave badly (which I admit are *extremely easy* to indulge!), we have less to apologize for as we go through life! ☺. Thanks for sharing this, Tania. Best, Dr. Shapiro

Final Project

[redacted], I think we all enjoyed the excerpts you read from your journal. I could see your fellow students journeying back "to the beginning" with you, then moving through anatomy, the basic sciences, the bewilderment and excitement of third year, and pulling it all together (hopefully) fourth year. The accompanying pictures were very appropriate as well, especially fourth year burst of sunlight and translucent waves. I also liked your choice of ocean – it is ever-changing, yet constant (perhaps something to remember as you make your way through internship). You know that the ocean, the waves, the storms, the sun are just part of the richness of life. Enjoy as much as you can! Best wishes, Dr. Shapiro

Shapiro, Johanna

From: [redacted]
Sent: [redacted]
To: Shapiro, Johanna
Subject: [redacted]ct

Dear Dr. Shapiro,

[redacted]

From: Shapiro, Johanna
Sent: Tue 3/14/2006 11:20 PM
To: [redacted]
Cc: [redacted]
Subject: AoD project

[redacted], your project (as always) was quite amazing. I love Margaret Atwood (she's also written a wonderful poem about her own heart condition, btw), but I had never read this poem. It brings to the surface one of the mysteries of life – how horror and beauty can be inextricably linked. I was so impressed by your response to Dr. [redacted] in class. Things are rarely as straightforward as we make them – good or bad, beautiful or ugly. Rather, more often than we'd like to acknowledge, they contain elements of both. As you said, beauty can be found in grief, which does not in any way attenuate or detract from that emotion. Your painting, complementing the poem, was also both lovely and disturbing. I appreciated the detailed explication, because as a layperson I didn't see into it as deeply as I could have the first time around.

Your personal essay was equally if not more incredible. It made me wish I had had a chance to get to know you better because you are a remarkable person. I was truly awed by your statement, "I craved the vulnerability that medicine entailed." To be able to write something like that (and more importantly, feel it) tells me that you have penetrated to the true core of your profession – and are not terrified by it, but rather welcome it, and seek it out. After reading your essay, I understand more clearly from where your remark to Dr. [redacted] emerged. This is such a profound insight – that not only the "good" and "noble" emotions, actions, events are morally beautiful; but that anger, greed, mistrust, dishonesty are profoundly human, and therefore have a certain strange beauty of their own. Bravo! I can't say more. You get it. Best, Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Monday, January 30, 2006 2:23 PM
To: [redacted]
Subject: RE: difficult patient assignment

Hi [redacted], thanks for the reminder about the reading packet. Will do!

Your difficult patient assignment was wonderful, although I understand that is not how it felt to you. Some day, when you get a chance (ha!), read Oliver Sacks' The Man Who Mistook His Wife for a Hat, a beautiful collection of tales about patients with severe neurologic impairments. Two of these stories describe patients I believe both with some form of severe Korsakoff's dementia, one who could remember nothing for more than a few seconds; and one who had more long-term memory deficits. Sacks, in his deeply compassionate way, reflects on what has happened to these men's identities, and whether it can be said that they have still retained their "souls." This is one thing your patient's situation made me reflect on. The other thing is the ancient Japanese tea ceremony, in which the same ritual is repeated daily. To us in the West this might seem boring, a waste of time. Yet its practitioners claim that they can learn something new each time they pour tea, because there are always minute variations in the environment, in themselves, in others present that subtly changes the experience. I don't know, but it would be interesting to think of Mr. C as a kind of Ground Hog Day (did you ever see that movie?) opportunity, where you can calibrate your compassion, your centeredness, and your presence with his consistent failure of recognition and understanding. The issue, which Sacks addresses eloquently, is what are our responsibilities to treat people humanely when they have lost some (or most) aspects of their humanity. Worth pondering, I think. Thank you so much for sharing about this patient's situation. It presented a really unique slant on patient care. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted] PM
To: [redacted]
Subject: [redacted]t

[redacted]

[redacted]

[redacted]

[redacted]et..

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, January 18, 2006 3:57 PM
To: [redacted]
Subject: RE: [redacted] Assignments

Hi [redacted] Thank you for all this work. I appreciate your conscientiousness, and your efforts to make as many classes as possible. I see that you follow the discussion carefully, and I'm sure what you hear will be useful when you return to the wards. Again, don't hesitate to chime in if you like. I know that you have much of value to contribute.

Your make-up assignment for session #4 demonstrates that you have an excellent grasp of the SJ and NF temperaments. I also like your conclusion that, with a little flexibility on both sides, SJs and NFs can complement each other well. Best of all, it sounds like your parents had a 30th anniversary bath that was both creative and well-organized! Congratulations to them.

I believe I already responded to your essay about the difficult lab situation. If you didn't receive that message, just let me know.

The difficult patient interaction you shared deserves much reflection. Sometimes you may be on the right track (domestic violence), but end up antagonizing the patient. When you suspect the patient is not telling you the truth, as in this case, it is especially important to paraphrase and reframe, rather than contradict directly. For example, "I hear that you're telling me you received these bruises when you fell. Is that right?" When patient agrees, you can say, "You know, in my experience bruises like this are much more likely to be caused by someone's fist than a fall. That is such a hard thing to say, but sometimes it needs to be said, and believe me, I've heard it from many people. Could that be what happened here?" Nevertheless, the most important thing is that you followed your "gut," and got this patient to open up and admit what had happened. It is natural to feel helpless and horrible in that situation. Of course, it's not something a second year student has to deal with on his own, and fortunately the attending physician took over. By the way, with the physical evidence you cite, this was *definitely* a mandatory reporting situation (not your responsibility, the internist's). He did the right thing by persuading her to leave her abusive partner, and hopefully she followed through. You learned a great lesson in terms of dealing with domestic violence and its aftermath. Thank you for sharing.

Best, Dr. Shapiro

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]
Importance: [redacted]

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, January 18, 2006 3:33 PM
To: [redacted]
Subject: AoD make-up assignments

Hi [redacted] My, you've been busy! Thank you very much for all this work. I'll be sure to record it properly.

Session 5 assignment:
The first situation you shared (about the bad-mouthing resident) is a difficult one, and you may well have made the best possible decision not to say anything. However, as you are discovering, sometimes it is difficult to let go of our feelings, so that they continue to trouble us. If this continues to be the case, you might consider different strategies. One, as you suggest, would be writing down your feelings and what you'd like to say. Sometimes that may be enough, and you are able to move on. Sometimes, by writing down your feelings, you may discover that you really need to "close the loop" by talking with the offending party. That does not necessarily mean a knock-down, drag-out fight! Generally speaking, in my life, I try to discourage what are known in psychology as third-party communications (Anne told me that she thinks you're stupid) because they are so often distorted. However, sometimes they are inevitable. Here, if you decide to pursue the matter, you might start off by saying,

[redacted]: I've wanted to talk to you for some time because [fellow-student] told me you thought we were getting by easy when we worked with you. I wanted to check it out with you directly. Is that really how you felt?
Mean Resident: Yes, you pretty much glided through when you were on this rotation.
Then you could then share your own feelings:
[redacted]: Wow, I have to admit I'm surprised and hurt to hear you say that. In fact, I feel betrayed. I had the impression you always thought I was doing a good job. Can you help me understand better where I fell short?
Mean Resident: Where to begin? ...After she points out all your "failings," you could say,
[redacted]: Thank you very much. I can learn something from what you've shared. If you'd shared those observations with me directly while I was on the service, it would have been even more helpful, because I honestly felt you were satisfied with my work. I'm glad we had this talk [you mean, nasty witch - this is a thought bubble].

Anyway, by having this kind of interaction, you could probably put the issue to rest, decide for yourself whether the resident's concerns had any merit, and in the process, teach her the value of direct communication!

Session 6 assignment
As someone with a tendency to speak first and regret later, I do agree with you about the value of a "pause." When we feel attacked (betrayed, judged etc.) there is a natural human tendency to jump with both feet to either attack back or defend ourselves. Those strategies are always available to us, but I've learned that taking a breath almost always helps me collect myself and see the situation more clearly. Another good way to buy time and calm down a bit is to paraphrase the other person, which also gives you empathy for their point of view and allows them to feel understood: "So it sounds like you think I'm a real loser?" And I definitely agree with the point you make in your final paragraph that "There is always a way to voice your differences... without others feeling disrespected." If the world worked harder to make this so, I think we'd see a reduction in violence, bloodshed, and war. Having respect for different values (which does not mean changing or relinquishing your own values!) is an essential first step in meaningful communication. It seems easy in the abstract, but I know when some of my most cherished values are negated ("men have a right to subordinate their wives"), I really have to work hard not to dismiss and demean this viewpoint. Thanks for sharing your thoughts.

Session 7 assignment
Great example of a difficult patient situation! You make an excellent point that the path of least resistance in patient care is not always in the best interest of the patient, even if it is the easiest. From your description, I have the impression that a morphine injection every few days is not optimal management of this patient's pain. Because she is a "difficult" patient, understandably the harassed attending just wants to take care of her as quickly as possible. Your suggestion of a referral to the pain clinic for evaluation and plan seems reasonable, as would empathizing with the patient to let her know her doctors understand she is in a dificult position (as well as being a "difficult" person!). I wonder if there were insurance issues that interfered with this idea. You know, patients with multiple medical, social, and perhaps psychological problems are overwhelming for everyone - for the doctor, the office staff, and the patient herself! Having lots of problems sucks. But it doesn't follow that the goal of treatment is to appease the patient and get rid of her as fast as possible ("treat 'em and street 'em, right?). Thanks for bringing this up. Plenty of food for thought, and for sure no easy answers!

Thanks for your hard work, [redacted]. Best, Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, March 08, 2006 1:13 PM
To: [redacted]
Subject: RE: Self Change Project

[redacted], what a great project you came up with. Focusing on tensions on the team was a very good idea. And you're right - not only can such conflict be unpleasant, but it can also spill over negatively into patient care. I also liked the simplicity of your intervention – just smiling seems as though it couldn't possibly change anything. And yet perhaps it did! Of course as you point out this is not a well-controlled, double-blind study. But it's worth at least considering the possibility that a simple smile can have a positive effect on group dynamics. By smiling, you are putting positive energy into the mix, and it may well influence people's attitudes and behavior. The data reported was quite interesting, and your interpretation was grounded in the data. Well done! Dr. Shapiro

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From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

[redacted]

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, January 18, 2006 1:39 PM
To: [redacted]
Subject: Difficult patient assignment

Hi [redacted]. What a painful, tragic situation. It is impossible not to feel heartbroken at the future awaiting Mrs. C and her family. I agree that your team proceeded with great skill and care (I'm still dumbfounded that a neurosurgeon would have considered surgery, but perhaps there are aspects that as a layperson I don't comprehend). I am usually suspicious when health care workers start talking about denial, not because denial doesn't exist (I wouldn't deny it!), but because the term often becomes a club with which to bash the patient. "This patient is dying! Doesn't she get it?" Sure Mrs. C is in denial. For goodness sakes, why not? As you noted so compassionately, denial was what was fueling the couple's spirit. The terrible issue here is that Mrs. C is going to die and medicine cannot further help her except through palliative care. Despite her being on home hospice, maybe up to this recent hospitalization, she'd been able to walk around a bit, play with her children. Maybe she knew she was going to die, but she didn't know she wouldn't be able to walk, or move, or barely breathe. Terminally ill patients often focus on the "small" things they can control (or think they can control) as a kind of psychological compensation for the impending death they know they can't change. So perhaps the loss of mobility was just one more terrible defeat piled on to the horrible course of this disease that had consumed life as she knew it and was literally consuming her. Under these circumstances, the delicate role of the physician and health care team is to understand and *feel*, rather than hide from, Mrs. C's overwhelming helplessness and anger (emotions probably felt by the team as well), while gently helping her not to waste her final days in useless medical procedures. What you had the agony and privilege of witnessing was the final turning point in this couple's understanding of this disease. Out of respect for the patient, we should do all we can to encourage this shift, but *never* force it because of our own emotional discomfort or sense of inconvenience. [redacted], you describe a very, very sad event, but also one that was full of learning, both for Mr. and Mrs. C, for you, and for the team. Thank you for sharing. Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Thursday, February 02, 2006 3:25 PM
To: [redacted]
Subject: Stress/burn-out assignment

Hi [redacted]. Thank you for completing the stress and burn-out assignment. It is a very encouraging sign that you responded in the affirmative so infrequently. (I like "the duck syndrome." I hadn't heard of that before, but it fits me pretty well too!). You've discovered an important "life-truth" as well. Living a balanced life usually results in improved functioning in all spheres - personal, professional, physical, emotional, cognitive, spiritual. Of course, living a balanced life is quite different than "hiding" from difficulties and challenges by partying into the wee hours when we should be preparing for an exam; or staying in bed instead of getting up to go to the hospital. These are rather warning signs that your life is seriously *out* of balance! This, of course, is not your problem; rather, what you have to watch out for is the "duck syndrome." What really seemed to make the difference between 1st and 3rd year was your level of self-awareness. You knew how to recognize "slippage," and when you saw it, you could self-correct. You are quite right that internship in particular is not as flexible as 4th year. You may have to reprioritize and settle for a "bare-bones" balance (holding on only to those things that are "most precious"), However, as you point out, the key is paying attention to yourself, and the confidence that balance in your life is better not only for you, but for your patients and loved ones. Hopefully, that will give you the strength to fight for balance even when the system around you pushes you to devote yourself 110% to the residency. I am confident that you will do very well next year. Thanks for sharing, Dr. Shapiro

Shapiro, Johanna

To: [redacted]

Subject: RE: AoD 11/15

Hi [redacted]. We'll miss you tomorrow, but thank you for completing these assignments. I thought you did a great job of illutrating how different "temperament types" could respond to the same physician prompt. Obviously, these differing responses would lead the discussion in very different directions, so the take-home lesson for the doc is, be quick on your feet! (And that's not even considering that doc has her own temperament to take into consideration :-)).

I appreciated your sharing about the changes you made to create more balance between attention to family and friends and studying. It's a great skill to be able to identify a problem, come up with an intervention, and then actually implement it (for me, this is sometimes the hard part!). But the end result, as you discovered, is that because you are honoring more of your needs, you will be a happier person, and therefore able to stick with the studying and work with a more positive attitude. Too bad about the books and the swimming. Unfortunately, internship is also not all that conducive to lots of leisurely reading or swimming. But don't forget how much you love these things, and look for ways to bring them back into your life at the first opportunity. Like your contact with people who are important to you, they will enrich your life. Thanks again, [redacted] Dr. Shapiro

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From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

[redacted]ents.

[redacted]

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: AoD 11/15

[redacted], please don't worry (that will contradict the whole purpose of AoD :-)). Dr. [redacted] and I understand completely about the Substance Abuse rotation. We fully support your attendance there - it is a powerful and valuable experience.

What I'd suggest is that for next week you either a) write a little skit (very short, as was modeled in the hand-out, but maybe with a medical emphasis) on different temperament "types" interacting or b) write a paragraph about what you learned about yourself from the inventory, how accurate you thought it to be, and how it might help you as a physician. If you would like to make up the missed first session, you can either write a couple of paragraphs about a) the ways you changed since starting medical school that you like and that you don't like as well or b) what are your goals in participating in AoD. As Dr. [redacted] suggested, these make-up assignments will be counted as half-credit for a session. We will make every effort to accommodate students who want to present, but have valid conflicts. So no worries, be happy :-). Best, Dr. Shapiro (and that, as you can see, is a typical NF response, with a little J thrown into the mix :-)).

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Wednesday, March 08, 2006 1:16 PM
To: [redacted]
Subject: RE:

[redacted], you did a great job on this project. You defined a worthwhile goal ("being less tense and more calm and confident"); an appropriate intervention (speaking with confidence and calmness, without worry about evaluation); anticipated obstacles (feeling anxiety because of focusing on grades, evaluative analysis, and time constraints).

Your summary of your project was also quite interesting. For one thing, it shows that even personal qualities that we count on as "part of us" can go into hiding in response to external pressures and stresses. Luckily, as you discovered, such qualities are rarely gone for good, and with a little attention can be revived and nurtured. I especially liked the way you used "self-talk" to overcome your feelings of anxiety and nervousness. This can be a very effective way of challenging the story you're telling about your situation, and replacing it with a "better," more comfortable one. It also sounds as though being more relaxed and confident also may have had a positive effect on your patients, in the sense that they seemed more open and forthcoming; on your residents: when you behaved confidently, they treated you more respectfully; and on your attending and nursing staff. Perhaps most importantly, allowing yourself to be confident and comfortable made you feel happier and less burned-out.

I hope very much you are able to keep this project in mind as you begin your internship year. Although you will be back in a situation of frequent evaluation, hopefully you can remember that acting with appropriate confidence and calmness will have positive consequences all around.

One small suggestion - did you actually compile any data? In other words, did you monitor how many times you felt anxious etc. in your control week versus how many times you felt calm during the intervention? If so, it would be interesting to see those data. But regardless, you did an excellent job!
Best, Dr. Shapiro

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: FW:

[redacted]

thanks,
[redacted]

[redacted]

3/13/2006

[redacted] 2/21/06

[redacted], thank you for your little skit summarizing the frustrating encounter with mom, dad, and baby with otitis media in the ER. You identify several problems that any other student, resident, or experienced physician can surely identify with: 1) parents who don't restrain their child properly 2) parents who bring a child with otitis media to the ER 3) Too much responsibility on the medical student, without sufficient nursing support or attending oversight. Two of these difficulties involve the patient, the last staffing and training. You are right to be frustrated by all these obstacles, because they make your job much harder. Personally, I've learned that it can be helpful to use this kind of frustration as a starting point for further analysis and understanding.

Once I recognize my own feelings, I try to reflect on the other perspectives involved in the situation. For example, in this case we might think about things from the parents' point of view. In my experience, it is often a challenge to get parents to restrain little kids adequately for ear exams. Most parents hate to hurt their kids, and they tend to worry that holding them firmly *is* hurting them. This is especially true if the parents are tired and worried, and the kid is out of control. It can take a really clear explanation plus much reassurance to turn parents into effective nurse's aides. In terms of inappropriate use of the ER, we know this is a huge problem throughout the country. Sometimes people come to the ER out of lack of education – they don't understand their other options. Sometimes people truly have no alternative because they lack adequate insurance. This is a problem which can be helped through patient education, but ultimately must be solved on a societal level. It is understandable to be upset with these parents, but a little reflection reminds us that this is a difficult situation all around, for you and for them. Everyone is suffering, they because their kid is sick and they don't know where to turn; you because it seems you ended up with an awful lot of responsibility in rather ambiguous and confusing circumstances. In fact, I wonder whether an attending who wasn't quite so busy could have rechecked your original ear exam and saved you and the parents some stress and strain.

Regarding your second essay, I found it to be absolutely beautiful, honest, and authentic, starting with its poignant title, "Thing that don't happen as much." You wrote a truly amazing reflection on the value of writing and language, and how words are so often transmuted from gold into lead in medicine. Andrew, I remember your poems – you have a uniquely expressive feel for language, and the images, feelings, and thoughts behind the language. You are funny (watermelon-behind-the-lemon image), lyrical ("inverting daylight…etc."), and profound ("finding meaning where life is mean…etc."). I encourage you to keep writing – if only as a way to preserve your voice as you become more and more a physician, more and more "medicine." I'm also going to find a couple of wonderful poems for you written by an oncologist, Marc Straus, who is sublimely sensitive to the perversions and blessings of the words of medicine. Words are powerful, and it is in that truth that writing and medicine overlap.

Shapiro, Johanna

To: [redacted]

Subject: RE: Skit ish

[redacted], I probably didn't express myself well, but you and I (and Dr. [redacted]) are on the same page. I've listened many times to students talking about their "invisibility" in a very negative way, exactly as you describe. You are perfectly right, it is diminishing and does lead to feeling powerless and worthless. Third year students make many valuable contributions to the team (just ask any patient who's had a student spend those extra precious minutes by the bedside or clarifying something everyone else was too busy to bother with). Invisibility should never be anyone's goal (remember Ralph Ellison's The Invisible Man, basically about how oppressed minorities, in this case African-Americans, became "invisible" in the majority society).

Thank you for sharing about the learning curve, and that precious pause before speaking. I tend to be a blurter myself, and usually just spit out whatever pops into my head. But as I've learned, the first thing out of our mouths isn't always the best thing. "Right speech" does tend to kind of dampen spontaneity, especially when you're first developing it; and I don't think we need to be so cautious all the time. But in highly charged situations, where there's a lot at stake, trying to ascertain the most skillful course of communication can be invaluable in terms of fewer unintended bruised feelings, fewer argumentative tangents, and even better outcomes. I think you'll see that as you develop greater self-awareness of your language, you'll use it more and more successfully as an extension of your "higher self." This can be a good thing, believe me! :-) Take good care, [redacted], I always enjoy hearing from you. Dr. Shapiro

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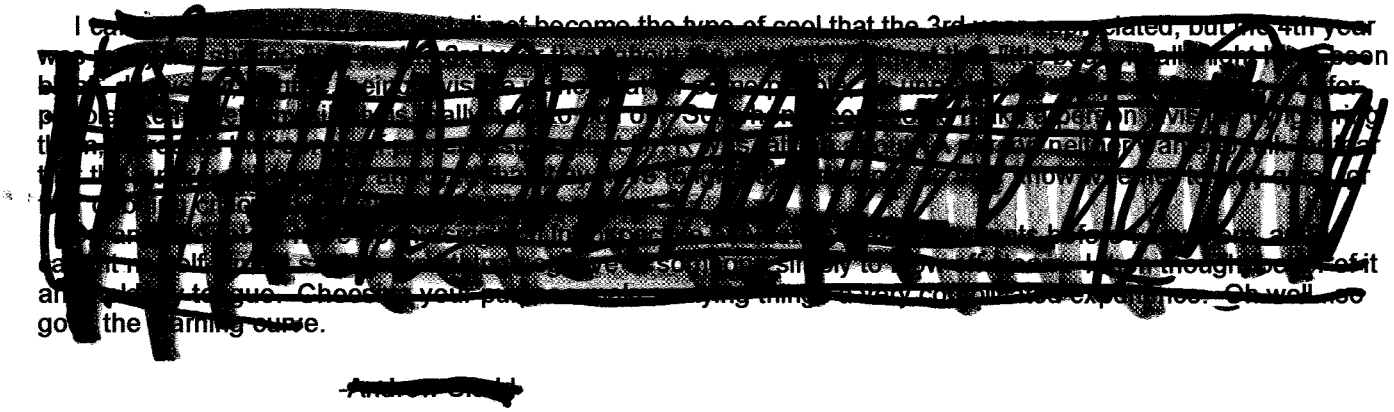
From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

[redacted]



[redacted]

A.D 2005-6

Shapiro, Johanna

To... [redacted]

Cc...

Bcc...

Subject: R[redacted]t

Attachments:

Hi [redacted]. Thank you for such a thoughtful essay on a very interesting comment and true reality about medical education. I think what lies behind its one-sidedness (and it is certainly not wrong, only unbalanced) is not indifference toward the patient, but rather the assumption that what is difficult is to learn how to communicate with other physicians and medical personnel; and that communicating with patients is easy, something that one does naturally. Here, I believe, lies the fallacy. Communicating correctly, accurately, and efficiently with other professionals is key to good medical care. Any specialist, for example, can tell you in a second the difference between a good and bad referral from a primary care physician. Understanding the nuances, the implications, the inferences of all that is said and unsaid in communication between professionals is therefore essential. BUT - and it is a big but in my book - it is only half the equation. It is equally essential that the medical learner develop skills of communicating clearly, humanely, authentically, and meaningfully with the patient - and this is just as hard. It is not natural, and it is not something that you just pick up. It takes work and attention and reflection and commitment. Is being a physician a complicated process? Yes, it is, because you are always wearing at least two hats - the colleague of your peers and the advocate and ally of your patient. The more than merely competent doctor learns to juggle both roles. Ideally that is what fourth year (and residency) are all about. I appreciate your reflection and I especially appreciate that you were troubled by the discrepancy between your growing success with presentations and your growing distance from your patients. Awareness is always the first and often the most important step in change. I am very confident that you are in the midst of learning to cultivate the delicate balance needed between professional and patient. Thanks again, Steve. I wish you a very merry Christmas and a Happy New Year. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted] PM
To: [redacted]
Subject: [redacted]ent

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[redacted]r.

[redacted]
[redacted]ar!

[redacted] FEEDBACK 2/14/06

Hi [redacted], I liked your poem a lot (or rather, it was hard to read, but very real, and that made it good, because I could really feel your frustration with this situation). The scenario you present fairly shrieks *irresponsibility*! Why is this mom having unprotected sex and having more kids when she knows she has a condition that results in prematurity and all its potential complications? Why is this woman a mom at all, when she seems to do such a self-absorbed, lackadaisical job of taking care of the kids she does have? Why is she so hostile to physicians, when so much in this situation is her *fault*?

And yet I'm not sure that your ideal alternative ending would be the answer. Or maybe not the whole answer. Let's think a minute. What would make a mother act so irresponsibly? Lots of things (lack of understanding, a true religious conflict, being overwhelmed, helplessness, fatalism, indifference, anger). Sometimes people do respond to boundaries, and it is critical to know how to set them (and this is coming from someone who is very poor at boundary-setting!). However, I've come to believe that boundaries are most effective when they're established within a context of empathy, caring, and nonjudgmentalness. Maybe this woman is a bad mother (if it's up to us to decide that), but if what she *hears* from us is that she's a bad mother, she will hate and mistrust us, just like she hates and mistrusts all the other doctors. I think you were on the right track to keep her trust and empathize with her *truly* scary and horrible circumstances. Within that context, you also have to say what is necessary clearly and directly. And even then she may not change, she may not have the capacity to change. And that's why medicine can be so frustrating, because people are often very limited (not excluding ourselves).

It's difficult to express all this in an email, so if you'd like to talk about this case further, please let's talk. Regards, Dr. Shapiro

[redacted], your essay on approaching difficult interpersonal situations was very impressive. I truly admire your ability to reflect so clearly on your own process. You recognize how your body signals a difficult interaction, so right away you have awareness, rather than denial. Your analysis of people who form a negative impression of you is excellent. First you find a cause, as in the example you cite, you apologize (always a good thing to be able to do). If there is no cause, or if the opinion is intractable, you try not to take it too personally (that might be a little different way of looking at it than "emotionally detaching" – after all, you still might be concerned about this person, or even like them!). You realize there are many reasons for someone to form a negative impression (maybe you remind them of an ex-girlfriend, or maybe they don't trust a woman, or a Caucasian – it could be a million things). Until you know what it is, and if it's something you can do something about, it's probably best to simply continue to take the best care you can of the person, and hope their opinion will soften.

In the second example, someone rubbing you the wrong way, you showed great insight and self-awareness. You have outstanding skills for working with your negative emotions. By listening to the woman's story, by being willing, even for a moment, to

consider her perspective and stand in her shoes, you shifted from irritation and annoyance to empathy and understanding (which of course are not necessarily agreement – as you point out, no medical mistake may have been committed). I have nothing to add. Well done!

In the final, and most difficult, situation, you consider what happens when you witness an injustice. As you realize, these situations often develop because of a lack of shared values. I would like to believe that, ultimately, between two people, with enough exploration and effort, it is almost always possible to find common ground, but we do not always have the time nor the inclination to engage in this process. When confrontation occurs in the absence of at least some common ground, the result is usually a drawing of battle-lines, and an escalation of the disagreement. Each side becomes entrenched in their position, and ultimately one side wins while the other side loses. The whole premise of negotiation is to understand the validity of *each* position, and then seek an outcome satisfactory to both parties. But such an approach is not always feasible. When, after reflection, you determine that, consistent with important personal values, you must speak up for yourself, or on behalf of others who perhaps cannot speak for themselves, it is an act of courage. You are quite right that you must choose your battles, but I suspect you would not respect yourself if you became a passive observer of what you considered to be wrongdoing. Keep fighting the good fight, [redacted]. Best, Dr. Shapiro

Shapiro, Johanna

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: AoD

Hi [redacted] Thank you very much for turning this in. Since you wrote a poem AND an essay on ED-EI, I will count it as assignment completion (5 points) plus extra credit (1.5 points). Therefore, according to my calculations, you have 72 points total, so you have officially passed AoD. Yea!

Your poem was lovely, and before I read your essay, I interpreted it in two ways. One way made me worry a little, because I read it as you elaborated in your essay - i.e., being so emotionally sensitive that you use yourself up, literally burn out. We don't want that to happen! But the poem also reminded me of a Buddhist concept that as we go through life, we give to others on a daily basis; and finally, at the end of life, when we breathe our final out-breath, there is nothing left: that breath is the last thing we have to give. Not in a bad sense, but simply that we have given all that we had and were, and the cycle has ended.

I think the challenge for any giving person is to do the latter without succumbing to the former. I know PICU is a terrible challenge, especially for sensitive, compassionate people. I am thinking of a former UCI student with a wonderfully kind and caring heart, who from day 1 had wanted to be a pediatrician; and after his PICU rotation decided to be a pathologist (I'm changing a few details to protect anonymity, but you may know this person anyway). So it definitely can be a devastating experience. In a sense, it is presumptuous of me to comment on your feelings, because of course I've never experienced PICU. Further, you may not know this, but one of my early areas of research was emotional coping in families of pediatric cancer patients, and I moved away from that because it was so distressing to me at the time (of course, that was 1970s, and more kids were dying then). So in that respect I am very much an inadequate and wounded healer :-).

Nevertheless, I hope you won't mind if I share a few "life" observations from my precarious perch as an older woman. First, you are absolutely right when you say that you must nurture yourself, otherwise the well does run dry. However, it is worthwhile to consider *how* you nurture yourself. Most people rely on distraction - going to the movies, going running, getting a spa treatment - or emotional distancing - closing up your heart. There's nothing wrong with either of these, especially distraction (when I was first diagnosed, I was so panicked that all I could read were mysteries - pure escapism, but that's what I needed). However, as *exclusive* strategies, I think they more cover over, rather than truly help us heal. So, in my book, "nurturing" oneself might also involve talking deeply with a trusted friend to achieve better clarity, crying out one's anger and incomprehension to God, meditating to develop centeredness and wholeness, listening or making music that connects oneself with the great Beyond, reflective writing, walking in nature to appreciate the beauty of this world, etc.

The second point I'd make is that in the West, we have an unnecessarily bifurcated model of emotions, ie., positive emotions, good; negative emotions, bad. As a result, we pursue positive emotions ("I want to save this kid, because then the kid'll be happy, the parents will be happy, and I'll be happy"); and flee negative emotions ("Suppose this kid dies? The parents will be devastated, and I'll be devastated"). *Of course we want little kids to get well and go home!* We would be monsters if we didn't. So when "happy feelings" happen, we should just appreciate them and be grateful as heck. What we're really talking about is our fears, our rage, and helplessness, our despair (and believe me, although I've never been on PICU, I do have some familiarity with this little entourage of emotions).

What I've learned is that, if we don't run away from these feelings, but sit with them calmly, get to know them, get more *comfortable* with them, they "gentle" a bit; that is, they lose some of their power to devastate and overwhelm us. For me (and this is very personal, so what I'm about to write is not prescriptive, just descriptive!), I accomplish this to some extent first, by just not "running away" from my negative feelings ("Omigod, if I feel this despair one more minute, I'm going to die - no, actually I can just hang out with despair for awhile longer, it's okay, I'm strong enough to hold it"); two, by allowing other more positive feelings in ("I might not be able to save this kid, but I've reduced her pain a little"; "This kid might not make it, but he sure is a fighter"; "It is so painful that this kid might

die, but the love I've seen in this family is a privilege to witness"); and three, by moving back and forth in my mind and heart between two perspectives, the human and the cosmic (On a human level, suffering just sucks, and I will never accept it or rationalize it away; on a spiritual level, I choose to trust that we are somehow part of a benevolent universe, and that our suffering is a piece of this cosmic puzzle, which I will never understand but which I turn over to God). Further, if you think about it, those terrible, negative emotions which we feel actually *belong* in these tragic situations. They're what we *should* be feeling when a little child might die. So all they're really telling us is that we're human. But as we "soften" these feelings, and reduce our fear of them, we may discover that they are not so burdensome for us. And when we are not so burdened, we can do a much better job of "containing" the fear, rage, helplessness, despair of the patient and his or her parents, which is what we want to do in the first place.

[redacted] I share all the above with you because I think you are such an extraordinary individual with so much to give, and I want to do anything I can to help you continue on your path with joy and contentment, even in the face of sometimes terrible and tragic suffering. Best, Dr. Shapiro

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From: [redacted]
Sent: [redacted]PM
To: [redacted]na
Subject: RE: AoD

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Best,

[redacted]

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]y
Subject: RE: AoD

Thanks, [redacted], for the assignment. (I found it too in draft form!). Re Healer's Art, I checked the website (http://www.commonweal.org/ishi/programs/healers_art.html) and UCLA is the ONLY UC campus that does not have the course! (I see a project for Tiffany in the making :-)). Remember, HA is the undergraduate version. I think for residents the Institute offers something called FMM (Finding Meaning in Medicine), which seems to be less structured and more of a story-telling experience. I'd contact ISHI and talk to folks about getting something

Shapiro, Johanna

From: Shapiro, Johanna
Sent: Tuesday, February 07, 2006 3:12 PM
To: [redacted]
Subject: RE: Burnout assignment

Hi [redacted] Thanks for completing this assignment. You have achieved an important insight about how difficult it is for you to ask for help. Believe me, that is not unusual among physicians! (and I hate to ask for help myself!). Often, people who are helpers do not like to be "receivers" of help. Yet I've learned in my own struggles with this issue that there is so much to be learned by allowing, even inviting, help in. For example, it teaches us that "receiving help" is more complicated than we might initially expect. It also shows us that there are ways to be a gracious, generous receiver of help and ways to be curmudgeonly and resentful. In short, we can get a lot of insights into the patient's role by learning how to accept help. It is also true that there is a link between burn-out and not being able to ask for help. When other people help us, it means we can put down some of the burden. Otherwise, we have to soldier on completely on our own. Gets tiring, right? However, in order to set down the load, we have to become comfortable with things being done "not our way," and recognizing that we are not indispensable to the process. I'm delighted to see you've already developed an awareness of this dynamic. It deserves exploration and thought. Ask for help even when you don't absolutely need it, and notice the pros and cons of what happens. The more you "play with" asking for help, the more you'll learn to be more flexible in this area. I appreciate your sharing. We could form a support group (or would that be asking for help! :-)). Best, Dr. Shapiro

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From: [redacted]
Sent: Mon 2/6/2006 3:12 PM
To: Shapiro, Johanna
Subject: Burnout assignment

[redacted]

Shapiro, Johanna

From: Shapiro, Johanna
Sent: [redacted]
To: [redacted]a
Subject: [redacted]

Hi [redacted]a. Thank you for all this work! You are very conscientious. Don't worry too much about the absences - I know you come to AoD when you can. When Dr. R gets back, we will review all attendance, make-up, and assignment records and make sure no one is in trouble. You will definitely pass AoD, but I just hope you are able to get something out of it :-).

Your role-plays are cute, and show a good understanding of one of the most significant "demarcations" in the Meyer-Briggs personality traits. The first one demonstrates clearly how people can fall into "parallel communication," where each thinks he or she focusing on what's important about the patient, but in fact they are talking past each other. As you know, this can be very frustrating. It's not that either person is "right" or "wrong," it's that each style has certain strengths and weaknesses, as your dialogue well illustrates. Getting on the same page is obviously critical in effective communications about the patient - and about lots of other situations in life. As you astutely observed in the second skit, the reason things went relatively smoothly is that you (an SJ) had an "interpreter" (the patient's friend) who was able to provide some of the details that you needed to make an assessment. In the absence of such a mediating influence, we have to learn to adapt our interaction styles to be as effective as possible with patients (and others).

I thought your analysis of the difficult staff encounter with the case manager was terrific. I understand how exhausted and overwhelmed you were feeling that day, and bursting into tears is something I can readily identify with! It's like our emotional container is just too "full" to hold any more, and it spills over. Thank goodness your attending was Dr. R, who could empathize and help you out. However, I agree that the goal as much as possible is to take a breath, come from a centered place, understand the other person's point of view (empathy exercise - doesn't matter whether the person is "right" or "wrong"), and then decide on the most appropriate course of action. The dialogue you imagined for yourself in retrospect (I'm always better in retrospect too!) was excellent. I think an important lesson for us "criers" is that we don't have to collapse *and* we don't have to be harsh. We can be very firm and clear, exactly as you outlined. Now, of course translating this into action takes practice - lots of it. But by reviewing less-than-perfect interactions (which would describe the majority of my own interactions!) with not too much judgment ("what an incompetent creep I am!") and more curiosity ("Could I have handled this situation any better? What was going on with me that made me cry?") I think we can make a lot of progress.

The example you offered of an interpersonal conflict I think is familiar to everyone who's ever lived with anyone else! These "conflicts" seem so trivial that they almost don't seem to deserve to rise to a level worthy of attention. However, by thinking about them, precisely because they aren't life or death, we can learn a lot about how we typically behave. For example, like you, I am conflict avoidant, and tend to stuff negative emotions. I've had to work hard (and am still working on!) distinguishing between being able to honestly "let go" of a disagreement, and "hoarding" it, only to lash out later! For me, I've learned that the "little" conflicts are wonderful to practice on, and experiment with self-assertion and negotiation. Dishes are a great example: "How about you do the dishes tonight, since I'm exhausted, even though it's 'my' night; and I'll do them tomorrow?" And remember to think outside the box: "Let's order in tonight, and eat off paper. Voila, no dishes!"

I deeply admired your honesty regarding the difficult patient encounter. You were very aware of your skepticism, anger, and dislike toward this patient. Thank you for disclosing these feelings so openly. *They are normal human feelings!* yet we are extremely reluctant to acknowledge them, even to ourselves. Without this first step of self-awareness, we will never be able to influence our own behavior in a positive direction. Without a second step, exploring these difficult emotions with others, we deprive ourselves of valuable ideas and problem-solving skills. Of course we will always feel more sympathy for some and less sympathy for others. It is very easy to fall into the (pretty useless, in my opinion) trap of deserved versus undeserved suffering. It's not that we can't make these distinctions, but how accurate are they? And how do they help us care for patients? I thought your insight at the end of your essay was brilliant! You got it. How we react to patients (and people) depends a lot on the stories we tell ourselves about them. Who knows which story is right? Probably both - the guy is a bit of a jerk and he's also

lonely. What we want are stories that help us do the best job possible for all patients, not because we like them, but because they are suffering, and all suffering beings merit care and compassion. This awareness *does not* mean necessarily that the patient should be coddled or enabled. But by being open to his possible loneliness, you have a much better chance of understanding him, and then helping him.

[redacted] clearly your brief essays stimulated a lot of thought on my part. I can see you are reflecting carefully on these issues, and digging deep to find what they might mean for you as a doctor and a person. That's all we can hope for in AoD. Good luck on your remaining interviews, Dr. Shapiro

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From: [redacted]
Sent: [redacted] PM
To: [redacted]anna
Subject: [redacted]

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From: Shapiro, Johanna
Sent: Thu 1/12/2006 2:41 PM
To: [redacted]
Subject: [redacted] 6

Hi everyone. Thanks to those who were able to attend our last session for making it such an interesting discussion. For those who missed it, you can review the algorithm included in your reading packet.

Our **next session will be T Jan 17**, and we will be meeting pretty much every T between now and the end of March, so mark your calendars, palm pilots, whatever. Our upcoming topic is "'Difficult' Patients and What To Do About Them." There is a short written assignment for this session: write an essay, role-play, or poetry reflecting on a difficult patient encounter you either observed and/or participated in; then try to craft an alternative ending.

Written Assignments: Remember that all written assignements need to be turned in to receive credit for them.

Make-Up Attendance for sessions 5 and 6: If you missed session 5 (Dec 12) or session 6 (Jan 10), you can

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi[redacted] I'm sorry to have missed your presentation, but as the supervising faculty member for this activity, I wanted to share a few thoughts. My main thought is that I'm very glad, despite everything, you still had those "5 minutes of humanity" left in you (and likely much more!). What a great insight "we are neither alone, nor in control." If you can keep listening to those whispers, and remember to keep those pesky numbers in their place (for you *and* your patients) you will be a good doctor, no worries. Thank you, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi, and thanks for sharing your humanities project. Although I missed your presentation, I wanted to express a brief comment. I heard about your creative "Picture Book" - truly "through the patient's eyes." To step so close to your patient, especially a dying patient, is a great act of caring. It sounds as though Mr. YO brought out the best in everyone indeed. I'm glad his passing was a good experience. Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted] I apologize for having missed the presentation of your humanities project, but as the faculty member supervising this particular activity, I wanted to share a brief comment. Mostly my comment would be... hahaha! This was really funny! And so honest and real. I laughed at every line, and so appreciated your evolution as your clerkships proceeded. Keep up the great attitude. Thank you, Dr. Shapiro

IM 003

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi[redacted]r. I'm sorry to have missed the presentation of your project, but as the faculty member supervising this activity, I wanted to send you a brief comment. Honestly, this was a simply incredible poem. It was a joy to read (not in the sense of taking joy in the narrator's anxiety and suffering, but in its wonderfully ironic, authentic tone). You are so right in your conclusion - remember those feelings, remember that confusion and lostness and aloneness. Your poem reminded me. Thank you, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

H[redacted]. Although I was unable to attend the humanities session, as the supervising faculty for this particular activity, I just wanted to send you my reactions. Thanks for writing a series of beautiful and evocative haiku. I am a fan of this form (once I read a haiku by Basho to a group of PM&R residents about Basho wandering cold and alone in northern Japan, seeking shelter in filthy barn, and as he drifts into miserable sleep, being peed on by a horse. A resident commented, 'That sounds just like my life!'). Perhaps one thing you're suggesting is that, amid the (increasingly mundane and familiar) reality of medicine, we should never forget its mystery. Perhaps another thing we should all, patients and doctors alike, remember, is that we get through life one breath at a time. Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]. I'm sorry to have missed your humanities presentation. As the supervising faculty member for this activity, I thought I could send along a brief comment instead. Unfortunately my Spanish isn't great, but I caught the drift of your little fable, and its moral. I would love to have understood better why you chose to write it in Spanish. It certainly had the effect of reminding me how much is hidden by language (whether English, or "medicalese") that is inaccessible or unfamiliar. Thanks for participating, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]. I apologize for not being present at the humanities session, but thought I could share a thought with you anyway. I really liked the way you connected with this patient and appreciated the sense of humor that has obviously seen him through much pain and suffering, perhaps some of it iatrogenic. I hope not only your patient, but you as well, can keep a sense of humor and a smile about some of the inevitable stresses and absurdities of medicine. Thanks for sharing, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]. I'm sorry to have been absent for your humanities presentation, but at least wanted to drop you a note. Sounds like an "amusing" project! Seriously, the ability to laugh at the absurdities of life is indeed a powerful coping mechanism. There is a lot of laughter in medicine, and sometimes it is destructive (i.e., when we laugh "at" or against patients or colleagues). What we're seeking is the laughter that puts us and our patients on the same side against despair and desolation. Good for you for recognizing this. Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi[redacted] I apologize for missing your humanities presentation, but since this activities falls within my bailiwick, I hoped you wouldn't mind if I shared a comment by email. When I read about "the perfect cake" I especially regretted not being able to attend this session. And of course, tongue in cheek (or smacking lips) aside, you're perfectly right - cooking is an art that often brings relaxation, pleasure, and a sense of accomplishment to people (a good stress reduction mechanism for some) as well as a vehicle for gaining wonderful insights into our patients' lives and customs. I'm sure it was delicious! Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted] I'm sorry I was unable to attend your humanities presentation. Since I'm the supervising faculty for this activity, I hope you don't mind if I share my reactions by email. What a lovely poem! I was particularly touched by the way you used this assignment to speak directly to "Joseph," treating him with dignity and caring. Your last line is eloquent. Although we know so much diagnostically, in some ways we know very little, and judgments about the value of life can often be presumptuous. A thoughtful piece of writing. Thank you, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hello, [redacted] I'm sorry I could not attend the humanities session, but as the faculty member "responsible" for this activity, hope I can share a few thoughts by email. I liked your reflections on the "white coat." A nice insight indeed about all it holds, symbolically and metaphorically as well as literally, and how it literally "grows" with your own growth as a physician. Sometimes you may want to strip yourself of it, and all its meanings, but truly it is your companion, "your friend." Thank you for sharing, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted] I apologize for not being able to attend your humanities session, but I appreciated the opportunity to read your thoughts, and wanted to share a few of my own in return (since I am technically the "supervising" faculty for this activity). Believe me, I do empathize with your awful ordeal, having had a daughter with a torn ACL that we tried to rehabilitate for several years nonsurgically, and finally had the full replacement; and a son with a torn (and still unrepaired) PCL, and partially torn MCL. Unfortunately, I don't think your experience was unique. It is never trite to remember to listen and treat your patient respectfully. I'm glad that you were able to extract that crucial lesson from all that you went through. Thanks for sharing, Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]e. I'm sorry I couldn't be present to actually "see" your humanities project, but I wanted to let you know that I'd read your description and was certainly intrigued. You intimated many possibilities for what that "black box" might contain. People's expectations, prejudices, resentments pour into that box, but so do their hopes and aspirations. And although what is supposed to come out of the box is a uniform product ("white coats"), in fact the doctors that emerge come in every shape and size, with every sort of possibility, cognitive, emotional, spiritual, still clinging to them. In social science research, the black box is a term of mystery. Likewise in medicine. Thanks for coming up with such a creative way of thinking about medical education. Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi. I apologize for missing your humanities presentation and, as the "supervising" faculty for this activity, at least wanted to respond by email. I suspect these "dramatic presentations" were pretty funny spoofs of the 5-E model. Is that possible?! Keep laughing, it's probably the best communication skill you have. Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi[redacted]. I just wanted to let you know that, as the faculty member "responsible" for this activity, I did receive and enjoyed (maybe "was moved by" is a better phrase) your humanities project for medicine. Without the benefit of having heard you discuss it, I can only guess at what it meant to you, but it is clearly a disturbing portrait of isolation, grief, perhaps despair, the emotions we encounter so often in medicine. Thanks for completing this project, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]. I just wanted to let you know that, although I was unable to attend this humanities session, I did receive your project (since I'm technically the "supervising" faculty for this activity, I try to comment on all student work). Without the benefit of hearing your explanation of your collage, all I can intuit is that "running on fumes" (the perennial condition of the medical student) is a lot like having a bad hair day. Maybe chronic terror makes your hair stand on end?! Anyway, it was a cute way of addressing a very real aspect of third year. It definitely made me smile! Thanks for sharing, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hello, [redacted]. Although I was unable to be at your humanities presentation, as the faculty "responsible" for this activity, I at least wanted to acknowledge your work. Since I wasn't able to hear your explanation of the images you chose for your collage, I don't know what this effort meant to you. To me, however, they expressed something of the power of the human spirit - our dogged determination to overcome obstacles, physical and mental, and to persevere with life. The poster reminded me that we all have our challenges, and somehow, often with the help and support of others, we find the strength to keep going. It's true for our patients, and it's true for us. Thanks for giving me a moment of reflection, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]r. Sorry I missed you on Medicine. Still, I wanted to let you know I had the chance to see your project, which told such a hopeful story. I'm a big proponent of documenting the successes and triumphs, as well as the failures. There are those remarkable encounters when everything is in flow, patient included, and it all comes together, and the system -- works! Mr.[redacted]sounds like a very nice, and patient, man who deserved better than he initially got. Thank goodness you had the opportunity to participate in this process - so you know what it looks like! Hope all is going well for you this year. Take care, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

[redacted] thank you for the opportunity to review your humanities project. I'm sorry I was unable to hear you present it in person. Still, as the "supervising" faculty for this activity, I wanted to let you know that I had read it, and smiled in the process. It was really cute - and really deep! (I appreciated the explication that helped me understand all the symbolism! :-) - ah well, and I thought that sometimes a cupcake can be just a cupcake... that's what you get for going to medical school). Seriously, you did a lot of thoughtful pondering - in a humorous vein - on medical school, patients, and doctors. Meditating on your ultimate reward - whether it be a cupcake, or assume some other form - and seeking it in the present moment shows a lot of wisdom. Hope there were no ill-effects from the two-year-old delicacy. You were right to carpe diem! Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted] I'm sorry I wasn't able to be present for your humanities project, but I wanted to let you know I'd seen it - and appreciated it so much. What an honest and soul-searching introspection (and creatively conceived as well). I don't mean to presume, but it seemed to me you used this exercise to reflect deeply on the complex person that Susan is, trying to bring all the parts into harmony, honoring the role of each. If I may share a personal insight, I think there comes a time in everyone's life when the coping strategies we've relied on to "get us through" aren't enough. Specifically, smart people who learned to count on that old brain, and the simple equation of hard work=success, find life is a lot more complicated. This can be a hard lesson, but it truly is the best lesson there is, because it forces us to reclaim aspects of ourselves we've previously discarded as irrelevant - art, literature, spirituality, faith. When we start reclaiming them in ourselves, we can begin to recognize the important roles they play in the lives of our patients, and this will make us much better healers. It can be scary, but trust the process. It will all come out right. Warm regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hi [redacted]. Hope all is going well for you this year. Sorry I missed your humanities presentation, but since I'm technically the "supervising" faculty for this activity, I wanted to let you know I'd seen it - and really appreciated your writing it. Sometimes it is literally when we are "in the patient's shoes" that we learn the most about what it means to be a patient, with all the indignities, uncertainty, and fear. Thanks for being willing to learn from your own experiences. Regards, Dr. Shapiro

Shapiro, Johanna

To: [redacted]
Subject: medicine humanities project

Hello [redacted] I apologize for not being able to participate in your humanities session. Since I am the faculty member "responsible" for this activity, I hope you don't mind if I share a couple of thoughts by email. I really liked your "summary" of life as a physician - it acknowledges both its difficulties and its amazing joys. Your collection of quotes was great - I've used wise sayings drawn from a variety of sources for many years to inspire me and remind me of where I'm going and how I want to get there. Thanks for introducing me to some new ones. Finally, the qualities of serenity and courage (another good conceptualization by the physician Jack Coulehan is steadiness and tenderness) are the anchors of truly good physicians. Learning to cultivate these qualities is in part what your education as a physician should be about. Regards, Dr. Shapiro