Self, Patient, and Family: The Art of Medicine Rediscovered

Statement of the Problem: Today, the demand for ethical, humane, and compassionate reflection in the field of medicine is most critical; yet it appears to be receiving less and less attention as a legitimate training emphasis. Increasingly, medical education tends to demean and devalue that which cannot be objectively measured. As Leon Kass has observed in Toward a More Natural Science, there is a discomfiting trend in medical practice and education to give excessive control to a narrowly defined scientific perspective. It is common and comfortable to think of the physician as a highly trained scientist; it is less common, and certainly less comfortable to think of the physician as a highly trained "wounded healer," (K.C. Asklepios, 1959), capable of being profoundly moved by the patient's suffering. Despite this discomfort, the doctor-patient relationship remains primarily a person-to-person encounter, an I-Thou relationship which imposes stringent moral demands on both patient and physician. Yet this moral imperative is barely understood and rarely more than superficially addressed in physician training, especially at the post-graduate level. Similarly, issues of ethics, values, and personal awareness are increasingly taking a back seat in medical training to a concentration on the technology of medicine. Unless this situation is remedied, we may end up regarding health care as nothing more than a commodity, patients only as sophisticated machines, and physicians, as highly skilled technicians.

Physician self-awareness, the ability to sift through difficult ethical dilemmas, the willingness to extend compassion and respect to patients remain central to the core of medicine. To truly be healers

of patients and families in distress, physicians must first start a process of emotional healing within themselves. When fear, defensiveness, or anger are brought to interactions with patients and families, the emotional result is a sense of distance and negative judgment on the pat of the patient and/or family members. However, these interpersonal skills are not easily acquired or utilized. Rather, they require training, practice and most important, an atmosphere which encourages and validates their expression. While most medical schools now include at least exposure to "humanizing" topics (eg., ethics seminars, medicine through literature etc.) during the undergraduate years, during residency, humanizing influences are rarely integrated into core curricula.

Family Medicine has long been a refuge for more humanistically inclined physicians. However, with the recent advent of the gatekeeper system in health-maintenance organizations, as well as burgeoning advances in the science of medicine, increasingly even this primary care training tends to emphasize practice efficiency and knowledge mastery to the virtual exclusion of systematic attention to the "human side" of medicine. As a result, many Family Medicine residents are unprepared to be the kind of "whole-person" physicians they might like to be. They develop a sense of inferiority, some tacit judgment that they are approaching medicine "unscientifically, whenever they venture into psychosocial aspects of their own or their patients' lives. Even though the specialty of Family Medicine includes some training in behavioral science, this training is often approached with the same lack of attention to the individual learner

and the same exclusive emphasis on knowledge acquisition which characterizes training in the "harder" sciences.

Residents lead a chronically overwhelming and stressful life, in which the vast majority of their energies are directed toward acquiring, integrating, and using traditional medical skills and knowledge. Although they may have valued a compassionate and concerned attitude toward the whole patient as medical students, little in their current environment will systematically stress this particular aspect of medicine. Despite a certain amount of lip services toward humanistic values, the residents' required behavior will tend to stress just the opposite. This experience can be demoralizing and debilitating to residents; at worst it may also be contributory to subsequent physician impairment. Thus it seems especially critical during this period to provide the resident with a hiatus, to strengthen and encourage in him or her a somewhat different perspective or world view; to provide the resident with time during the first year to reflect on himself or herself as a person; in relation to patients; and in relation to patients' families and his or her own family.

Proposed Project: This proposal attempts to remedy in part the above defects by developing a curriculum in the "Art of Medicine" for third year residents in Family Medicine. This curriculum would consist of a required one-month rotation, during which time the resident would focus on the following topics: The Physician in Relation to Him (Her self: The Development of Self-Awareness; The Physician in Relation to the Patient; Rapport, Communication, and Risk-Taking; and the

Physician in Relation to the Family: Understanding the Interpersonal Context.

The proposed rotation is unique in that it focuses directly on the resident as a person, thus legitimizing this point of view as an important dimension of physician training, and also giving the resident some specific tools for understanding both self and patients in the context of practice of medicine.

The purpose of this rotation would be to help residents feel less afraid and more in control of their own emotional responses to patients; to understand the psychosocial forces that have shaped them as individuals, and how these continue to impact on their perception of others and themselves.

This rotation would specify several learning objectives:

1) To enhance resident self-awareness and encourage personal growth.
2) To keep a personal journal for the month period, recording feelings and thoughts about self, patients, and family issues.
3) To develop increased awareness of interpersonal dynamics.
4) To develop interactional skills designed to increase authenticity and enhance communication, such as active listening, confrontation, self-disclosure.
5) To develop a broad awareness of the importance of the family in influencing symptoms of the individual patient.

6) To complete a personal genogram, and to be able to make linkages between family of origin experiences and attitudes toward patients' families.

7) To complete an assigned reading list of books and articles.

8) To complete an assigned workbook(to be developed).

The difference between this proposed rotation and more traditional behavioral science training is that it will rely heavily on personal development rather than didactic lecture. The core of the rotation would be the cultivation of "physician-mentors," who would guide the resident through the month's experiences. These mentors, to be selected from the department's volunteer faculty (practicing family physicians), themselves would demonstrate a high level of personal insight, excellent interpersonal skills, and a willingness to incorporate the personal dimension into professional training. These mentors would have the capacity to model for physicians-in-training not only how to develop as competent physicians, but also how to develop as competent human beings. Their participation in the rotation would validate issues of personal awareness, values, and ethics as of more than peripheral importance in the practice of medicine.

Physicians participating in the rotation would receive in-service training in the mentor role, to be conducted by Dr. Shapiro. In addition, they would be encouraged to maintain an ongoing, informal

relationship with residents beyond the limits of the structured rotation.

Residents would also receive individual supervision from Dr. Shapiro during the month rotation, to consolidate learning and insights from their various educational experiences, and to reinforce their efforts to bring a more humanistic perspective to their role of physician.

WORK PLAN: The proposed project consists of a 4 week seminar, conducted as a one-to-one tutorial for the third year class of 11 Family Medicine residents. This format has been selected because it coordinates with the existing structure of the residency program. What follows, therefore, is a detailed description of the proposed rotation, which would repeat 11 times during the year.

The first week of the rotation would start with an exploration of the Socratic premise, know thyself. The resident would spend 5 half-days with a physician role-model or mentor, 3 half-days in supervision with Dr. Shapiro, and 2 half-days in continuity family medicine clinic. The 5 half-days of mentoring in this first week would focus on discovery of the authentic self. Resident and mentor would engage in encounters, focusing on such topics as: Medicine- A Personal Choice: Values and Ethics: Taking and Receiving from the World; Writing a Personal Obituary. The purpose of supervision would be to focus on similar topics through a series of self-awareness exercises and readings.

The second week of the rotation would continue with the same basic structure, as well as the same physician mentor. However, the

emphasis would shift to the physician/patient relationship. Again, the 5 half-days of mentoring would combine direct observation of the mentor-physician's interaction with patients; as well as discussions about the physician's feelings toward these patients and how these feelings influence the type of medical care rendered,. The emphasis of this training would be on physicians self-disclosure for both resident and mentor. The purpose of supervision during this period would be to stress the development of interactional techniques to enhance efficient, open, and compassionate communication between physician and patient, and to develop an understanding of how the physician's own emotional reactions can influence the dynamic interaction between doctor and patient.

The third week of the rotation would require the resident to participate in a family program at Care Unit, a drug and alcoholism rehabilitation in-patient hospital. During this week, the resident would learn something about the interactive effects of family members regarding a specific disease entity alcoholism). Residents would also learn something about themselves and their relationship to their own family of origin. Two half-days of supervision would provide a "debriefing" experience for the resident, and allow each resident individual time to reflect on and deal with personal issues which emerged as a result of family program training.

The final week of the rotation would involve observation and training at a community-based family therapy center. The resident would participate in exercises to develop understanding of his or her own family of origin. The resident would also participate in

case conferences, observe family therapy sessions, attend didactic lectures and presentations, and watch videotapes of family therapy. Further, the resident would also spend 2 half-days in supervision, pursuing family-oriented topics from a personal perspective. The resident would also spend 2 half-days with the physician-mentor, participating in activities with the mentor's own family(an evening meal, for example) as well as making at least one home visit with a patient and family.

Evaluation: Each resident would be evaluated according to pre-post attitudinal data, with changes noted in comparison to his or her own performance. In addition, group data would be compared to the 3rd year resident class of San Bernardino family practice residents, a comparable family medicine residency program which includes behavioral science training. Finally, residents' subjective reactions to the rotation would be gathered and presented in summary form.