Art of Doctoring Group 1 Session 6 2/3/04

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

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

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

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

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

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

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

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

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

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