Dr. Johanna Shapiro: Part 1

[00:00:00] **Christine Ko:** Welcome back to SEE HEAR FEEL. Today, I have the honor of speaking with Dr. Johanna F. Shapiro. Dr. Johanna Shapiro has a PhD, and she was Director of the Program in Medical Humanities and Arts in the Department of Family Medicine at the University of California, Irvine School of Medicine. She's a Professor Emerita in Family Medicine and received her PhD from Stanford University. Her research interests have been focused on the patient narrative and the doctor patient relationship, communication skills, and literature and medicine. She has written extensively on teaching empathy and medical education, and I will put a link to one of her articles in the show notes, and she is also a poet, and I will put a link to one of her powerful poems in the show notes as well. Welcome to Dr. Shapiro.

[00:00:47] **Johanna Shapiro:** Oh, thank you so much. I am so excited to share this space and this time with you.

[00:00:53] **Christine Ko:** Thank you. Would you start off sharing a personal anecdote about yourself?

[00:00:58] **Johanna Shapiro:** I would love to. This goes back many years, but when I was seven, my family spent three years traveling in Europe and the Caribbean. They were probably like the original hippies. And we spent the last nine months of the trip on the island of Barbados, which was still at the time a British colony. So we'd rented this small ramshackle house in the countryside remote from the main population center, which was Bridgetown. White people did not live out there, and so my playmates were the children of the black laborers who worked in the sugar cane fields and the servants who were employed at this big fancy tourist hotel not too far away.

[00:01:49] My parents let me and my siblings kind of roam free, trusting that the local kids would take care of us, and they did. They taught me how to eat sugar cane, how to climb coconut trees, and how to swim in the sea. It was really an idyllic time in my life, and every evening I'd come back and tell stories about our adventures to my parents who were always very admiring and appreciative.

[00:02:19] But after a while I learned that not everyone approved of these activities. When ladies from Bridgetown occasionally visited, curious about these strange Americans, they bluntly told my parents that white children and black children should not be allowed to play together. They also warned my

mother that if I continued to run around in the sun the way I did, I would soon be mistaken for what they called a mulatto. Apparently a terrible fate. But fortunately for me, my parents paid no attention, and I was able to continue as I was having wonderful time. As a result of these experiences, I first realized the importance of stories, the stories I told my parents, the stories my playmates told me, the stories these ladies told each other and my parents. Stories make us who we are.

[00:03:21] And I also thought a lot about who gets to tell their stories and how they get to tell them, and also how different people can see the same situation in very different ways. And of course much later in my life, I realized that this is also true for doctors and patients sometimes.

[00:03:41] **Christine Ko:** Yeah. I love that. I feel that when I trained, emotions were not talked about. And yet I think a big part of stories is emotion. You have an article where you touch on seeing, observing in the medical encounter, and you also touched on emotions. You talked about the unexamined judgmental reactions of aversion or dislike in the patient setting. Can you talk about that?

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[00:04:10] **Johanna Shapiro:** First, you're absolutely correct that if you have any sort of work that involves human beings, then it's going to involve emotions because that is part of being human. When the term patient-centeredness first came into being, it's a wonderful term because before it was implicitly medicine as physician centered. And then people had the light bulb that, *oh, wait a second, this should be about patients.* And that's wonderful. But personally, I really think that we should use the term relationship centered medicine because you don't want to ignore the fact that the other human being in the room is the doctor. That person is having many emotional responses to their patient situation, to their own lives, to their work environment. A million things. Most people, not just doctors, but most of us don't really know exactly what to do with our emotions, and so we shouldn't expect that doctors can calibrate so perfectly their own emotional responses. That said, to me, it's really important that we do start to provide physicians with some tools to first recognize their emotions.

[00:05:31] I think a lot of times doctor's don't even admit to themselves that they're feeling something. It's been interesting to me, when I worked with medical students, sometimes they would, I would say, *oh, that sounds like a really hard situation. How did you feel?* They'd say, *no,* that *that's just part of medicine.* And it was like, *I'm not supposed to have a feeling.* I won't

acknowledge the feeling, and maybe not even recognize it. So I think recognizing your feelings is really important. Recognize that feelings are just feelings. There are not right or wrong feelings. You can feel angry. You can judge a patient. You can feel helpless as a result of patient care. All these things. You can feel joy. You can feel satisfaction. There are a lot of feelings. To me, the important question is, *what is the relation of my feelings to my care of the patient?*

[00:06:24] You could feel very helpless, maybe, that a patient you worked with for a while, now they're terminally ill, they're dying. And to me it seems natural that that physician might feel helpless and maybe even guilty. If those feelings make that physician unwilling to go into their patient's room or make them less likely to return calls from this patient because now there's nothing they can do for them medically. You know, the patient has known him for 10 years, and the patient just wanna hear their doctor's voice. So that's what I mean about paying attention to where our emotions lead us.

[00:07:05] And then finally, I think it's learning, through breath, through meditation, maybe through prayer, through counseling, I think there are a lot of avenues; not to be so afraid of our emotions. And to have just a little separation from them because even a positive emotion, being happy about something that happens with a patient, it may cause you to overlook something else that's going on.

[00:07:31] Emotions are wonderful, and we have to just attend to them a little bit more than we do because they do move us in different directions.

[00:07:41] **Christine Ko:** I really like what you said because one of the first episodes on my podcast is on emotional intelligence. And David Caruso was like, *emotions are data.* I don't need to run away from emotion. Emotion is just there. Not even judge myself positive or negatively. That's really helped me. [Yeah.] And then one thing you just said, *really what emotion is going to be best for patient care?* That resonated me because I just spoke to Dr. Batja Mesquita, she's a emotions researcher also like David Caruso. And she has put forth this theory about emotions really being between people. [Mmmmmm}

[00:08:20] What's important is, *what is the most functional emotion for this relationship? For this interaction.* And that's essentially what you just said.

[00:08:32] **Johanna Shapiro:** Exactly. I'm so glad you brought that up because I am a big supporter of that idea that it's not emotions are within us, but they are also between us. And I think that one of the really valuable things on a

professional level is that when we can learn not to be so afraid of our own emotions then we are better able to simply accept the patient's difficult emotion and let it play out. That you can learn from it, that it's data. It's interesting, right? You'd be curious like, why is my patient so angry? And what can I do about that? Rather than, *you are a bad patient for being so angry.*

[00:09:16] **Christine Ko:** Before I started thinking about how important emotions are in the doctor patient encounter, I would suppress my own and I would ignore, deliberately or without really thinking about it, patient emotions.

[00:09:28] **Johanna Shapiro:** There was an early study that showed that actually listening to patients as opposed to just telling them what to do, it actually did take a little bit longer. Not like hours longer, but like a few minutes, and minutes are precious. But my conclusion, just watching a lot of doctors and patients is that over time you get those minutes back. But yeah, in the end, you have to have limits. People can run on and on, but actually, I think most patients, they're sensitized to how stressed out their doctors are. I see patients doing a lot of care-taking of doctors. I know you're very busy, or I know you're very stressed or burned out, but, I just had this one little question.

[00:10:11] **Christine Ko:** I get that a lot. My patients are very kind to me. [Mm-hmm] Overly kind, I would say, not as a criticism, but in the sense that they're always like, *doctor, you're so busy, you're not gonna have time for this.*

[00:10:22] **Johanna Shapiro:** I think that this has something to do with developing the capacity, which is not innate or not inherent, to be fully present with others. I think that when the doctor is already onto the next patient, or maybe they're already onto picking up the kids after school or making dinner or reading a research paper, that the patient senses that they're not fully there. When the doctor can invite the patient into their world just a little by saying, *we're at the end of the day, and I have to leave at six to pick up my kid from daycare. Until then I am yours.* The person appreciates that you're a human being, like them, you have a life besides being their doctor. But there again, I think what happens is people aren't honest, the doctor is not honest. They try to cover it up. They try to pretend that they're not late, and that doesn't work because I think part of, you know, the way our emotional brains work, we sense that they wanna be gone. And that is damaging because we don't know why. All we know is that they don't wanna be with us anymore.

[00:11:32] **Christine Ko:** Yes. I love what you just said because I only recently started doing that where I guess I humanize myself? Not that my patients weren't seeing me as human. I think actually the problem was, is that I wasn't

seeing myself as human [Mmmm] in that interaction. And I was like, I just need to do X, Y, Z and fix the problem, and that's my job to do. And I realized that for me at least, that definitely leads to burnout because I can't fix all problems, especially with covid and all the short staffing, and et cetera, that healthcare is experienced and has been experiencing.

[00:12:08] I'm behind on things. I'm behind on messages, and so I started saying, *yes, send me a message, but I'm not checking every day*. Once I started doing that, my patients, they would laugh. They realize that I shouldn't be chained to being a doctor a hundred percent of the time. They recognize that I'm a human being just like them.

[00:12:28] **Johanna Shapiro:** I was just gonna say that what you said about, *I had to recognize that I was human*. It's both like tragic and endearing and funny. That's the key. There are multiple causes, but part of it is the way doctors are still trained, although that is shifting for sure. But there is this sense that, in spite of all the wellness committees that exist, there is this sense that the doctor is all about sacrifice. And, again, medicine does require sacrifice, so I'm not negating that. But it's also become so unbalanced in the sense that it's perceived as wimpy or selfish or something if you ever change the priorities. And of course when you know it's life and death stuff, the patient is gonna be prioritized. But, there are a lot of situations that's not the case. And it's almost, I think exactly the way you said it is, the first step is saying to yourself, *I'm a human being. I'm not perfect. I make mistakes. I'm late. I don't complete everything that has to be done in the right timeframe, but I'm still doing a pretty darn good job of taking care of these patients.*

[00:13:46] This whole issue of time, it's very tricky, but we think of it always as chronological, minutes ticking by. And of course that's our dominant reality. But there are other kinds of time. The Greeks used to talk about *cheiros* time, which was not chronological time, but those moments. Maybe it's what Atul Gawande was talking about, where time expands. There are those studies that when doctors sit down with their patients, the patients think doctors spend twice as long. There are tools out there that we can incorporate more fully into the practice of medicine that will be healthier for patients and healthier for doctors.

[00:14:31] **Christine Ko:** Yeah. Oh thank you. I'm going to stop our conversation here and continue with a part two in order to delve into medical versus narrative listening. Incorporating narrative listening can allow a healthier relationship between doctors and patients. Tune in next week to find out how.