SUMMARY NOTES ART OF DOCTORING GROUP 1 SESSION 3 11/25/03

A began by asking members to engage in a thankfulness exercise, by expressing thankfulness for one professional and one personal aspect of their life. She explained that expressing thankfulness does not mean ignoring or repressing more negative emotions of frustration, annoyance, anger, resentfulness, exhaustion. Rather, it is an attempt to develop a larger context as a way of containing such emotions. Some students acknowledged not feeling much gratitude or thankfulness. A modeled thankfulness statements, then all participants mentioned relevant items. Most personal items had to do with family. Professional items ranged from gratitude toward patients to finishing call or switching from in-patient to outpatient. A also shared research study that people high in altruistic qualities of listening, caring for others have higher mental health than those who do not; and distributed an article by an older physician expressing gratitude toward teachers and patients

B then asked students to list something that was really "pissing them off." C expressed frustration at students leaving a lecture she was giving. D mentioned institutional resistance to admitting patients with no insurance. E mentioned a patient who wanted a natural childbirth, but ended up being "consented" for use of forceps only so that ob residents could "practice." F noted the competitive environment, which caused many residents to make disparaging remarks about students or even each other. G elaborated on this point as an example of "third party communications," and invited students to engage in "right speech" for a week. H and I stated they had nothing they were pissed off about. J mentioned the anger she feels and bad language she uses while driving that results from her levels of stress and tension on in-patient. K made a statement about medical school being an "E-ticket ride" overall, although there were many aspects that frustrated and angered him. L and M both mentioned the constant pressures of being graded and the entire evaluation process, which resulted in feelings of helplessness. C and D additionally noted their own feelings of futility in protesting poor treatment of patients, or other systemic inadequacies. They felt that "nothing ever changed" as a result of such acts, yet they often resulted in negative consequences for the student. There was some discussion of how power inequities in the hierarchy of medical education disadvantaged students in terms of full participation in the system in which they are supposedly stakeholders.

B raised the question of why "good" medical students turn into "bad" (mean, abusive, disrespectful) residents. Students hastened to point out that many of their resident role-models are outstanding and take the time to do extra teaching and mentoring. Students seemed to agree that "goodness" and "badness" are innate qualities, such that "good" students somehow survive medical education to become "good" doctors; while "bad" people's qualities are exacerbated by the training process and turns them into "mean" residents and "uncaring, insensitive" physicians. B suggested the possibility that it is not so much "badness" as exhaustion, lack of awareness, thoughtlessness, and systemic failures into which residents are socialized.

A long discussion of grading ensued. K observed that evaluation has much to teach us and should not be summarily dismissed. He suggested a middle ground, in which attention was paid to others' opinions, but one also develops one's own standards and a trust in oneself. H suggested that stringent criticism, even from people one does not agree with or perhaps even respect, was valuable as an opportunity to learn to work with difficult people. G elaborated on this thought, pointing out that it was an act of cognitive reframing, and encouraging students to think about such people as giving them a unique "gift" that the most supportive and perceptive teacher could not give them.

Students gave examples of how the evaluation process could be made more constructive. K pointed out that specific, detailed feedback was more helpful than general injunctions to "do better." M described a situation in which he had used tact and a "help me understand" strategy to create more of a dialogue about evaluation with his R2. F shared a situation in which she and her supervising residents talked openly and non-defensively about times when medical students were a burden and times when they were helpful. G elaborated that mutuality, communication, and safety are important dimensions of useful evaluation.

There was additional discussion of right speech. E noted that gossip and disparaging speech is not the sole province of residents; in fact, students engage in bad-mouthing residents and attendings as well. C mentioned "medical hexing" (Larry Dossey), in the sense that unskillful, thoughtless language on the part of the physician may do great psychological, emotional, and spiritual damage to the patient.

B gave students the assignment to 1) identify and describe 3-4 recurrent and significant problems associated with their medical education experience 2) make a) systemic and b) personal suggestion that might have a positive impact on changing the current system and culture of medical education.