SUMMARY NOTES ART OF DOCTORING GROUP 2 1/6/04

Session commenced with a discussion of the column in Academic Medicine's Literature and the Arts "How to Be Good." We discussed the protagonist's mistaken assumption that practicing an altruistic profession such as medicine guarantees "goodness." Some students thought medicine had to select for "goodness," because it involved so much self-sacrifice. A pointed out that some people conclude medicine takes idealistic, if not necessarily good, people, and makes them cynical, self-protective, and bitter. We concluded that a profession is neither inherently humanizing or dehumanizing, although it can have elements of both, but that it is the idiosyncratic expression of the person *through* the profession that determines the level of humanism. We then examined the insight that "intention" to be good is not enough. Several students resonated to the part of the reading in which the doctor sets out each morning to be nice and good, but after exposure to a few difficult patients and bureaucratic demands, ends up irritable and nasty.

A used this point to initiate a discussion about the importance of practice. We identified students who had learned to play a musical instrument or a sport, then asked them to comment on the process. We realized that people have different levels of aptitude for different activities, but almost everyone can improve on their baseline through practice. We also noted that practice often seems tedious, boring, trivial, and not worthwhile, although these are ultimately just excuses for "avoiding the work." We further commented that learning the scientific and technological side of medicine requires an enormous amount of practice over many years, to which no one seriously objects. So why shouldn't we consider devoting at least a fraction of that amount of time and effort to practicing the art of medicine?

We then returned to the algorithmic model of approaching situations and tried to apply it to our session. We did a couple of breathing exercises (breathing in whatever we might need; breathing out to let go of everything that was burdening us). B stated the breathing just made her "tired," so we practiced breathing again, this time taking in energy on the in-breath, and letting go of tiredness on the outbreath. C provided a helpful mini-lecture on the physiological and neurological explanation of why breathing promotes relaxation and releases endorphins. We discussed how processes that work on multiple levels – cognitive, emotional, spiritual, and importantly, physical – have a greater chance of being effective.

We next explored thankfulness. Although the point in the model is to express thankfulness about some aspect of the situation-at-hand, students chose to express thankfulness more generally – about having a roof over their heads (D), good health (E), being able to practice medicine (C). C also offered an example of a seriously ill patient who nevertheless radiated joy and gratitude.

We next turned to intention. F expressed his intention to learn more about how to support "artful" interactions with patients. We probed his experiences on Geriatrics to pinpoint what he was learning so far that spoke to this point. He noted patience/impatience as an important physician quality, and then mentioned "personal

knowledge of the patient." C elaborated on the importance of the ability to connect with patients. He noted his three-pronged approach of a) fixing the problem b) healing the patient c) connecting with the patient, and noted that sometimes one prong is followed with little attention to the others, while at other times all three are activated simultaneously. E pointed out that some patients don't want healing. We made a distinction between healing and expressing caring, which we agreed all patients wanted, although the form of this caring might vary significantly.

G shared an intention to remember to bring "caring" to each patient encounter, and described a clinical situation in which she thought about her grandmother, and tried to identify ways in which her grandmother had made her feel safe, cared for, and protected. She then tried to behave in a similar manner toward the patient. A noted that sometimes third year students stated that they had the time to demonstrate caring toward patients "because they didn't know how to do anything else," with the implication that once they became "real doctors" they wouldn't have time for this. We discussed the importance of retaining caring as a crucial element in all patient encounters, regardless of level of provider training.

A pointed out that part of a physician's personal knowledge of a patient had to do with the ability to "recognize" as unique individuals within a context of their lived life. H mentioned the example of his optometrist-father making notes about his patients' personal lives and interests on each chart. G objected that it was difficult to make a connection with a non-continuity patient. C provided excellent examples as a hospitalist of ways in which connection was possible, even in a limited time frame. Other students confirmed this idea. We discussed students making a commitment to practicing "connection" with patients, regardless of time or circumstances.