Viewpoint: Reflections on a Well-Traveled Path: Self-Awareness, Mindful Practice, and Relationship-Centered Care as Foundations for Medical Education

Sharon Dobie, MCP, MD

Abstract

Medical students enter medical school hoping to have good relationships with their patients. Along with residents, however, they are exposed to a hidden curriculum that places the acquisition of biomedical knowledge above and at times at odds with development of the awareness and relationship skills important to the patient–physician relationship. Seasoned clinicians often enjoy the capacity for rich, healing relationships that are marked by reciprocal influence between them and their patients. The author argues that it is not necessary to relegate this recapturing of the human side of medicine to a midcareer epiphany, and the author calls for educational measures to encourage development of the communication and relationship-building skills throughout the medical education process. This will require a paradigm shift to a culture where teachers and learners are willing to consciously attend to their relationships and to work on self-awareness and mindfulness while they also master the biomedical knowledge required of the profession. Medical educators can facilitate and support continuous development of these skills throughout medical school and residency. Within the curriculum, there are many opportunities to teach how to reflect and to guide those reflections in ways that enhance our students’ and residents’ understanding of themselves as individuals and in the relationships they form with their patients. Using examples from narratives gathered in workshops and on work rounds with students and residents at the University of Washington School of Medicine, the author explores the concepts of relationship-centered care, self-awareness, and mindfulness as proposed cornerstones of a new foundation for medical education.


Editor’s Note: A commentary on this article appears on page 321.

It was my first patient interview in Introduction to Clinical Medicine (ICM) as a first-year medical student. I remember how I felt: humble, privileged, actually in awe that someone was going to share their story with me just because I asked. It was a gift, because what did I have to offer this person? They were giving me their time, opening their lives and, in fact, develop the gratitude and, in fact, develop the gratitude and wonder that students bring with them at entry to training? If empathy is the capacity to accept, to try to understand, and to connect with another’s experience, then greater empathic capacity is what many students and residents want to learn; losing it is what they fear. Whether we call it empathy or something else,1 how we demonstrate this professional behavior is critical to a healing relationship, dependent on the nature of our relationship with our patients—and it should evolve, not diminish, during training.2–8

Despite early losses, many of us find our way back to the place where we experience relationships with our patients that are rich and healing. Epstein9 describes how exemplary physicians use self-knowledge and mindfulness to be able to really hear the patient and distinguish what they hear from their own perspective (empathy) and to respond in a caring and useful way (compassion and altruism). Many of

Dr. Dobie is associate professor, Department of Family Medicine, University of Washington School of Medicine, Seattle, Washington.

Correspondence should be addressed to Dr. Dobie, Department of Family Medicine, Box 356390, University of Washington School of Medicine, Seattle, WA 98195; telephone: (206) 543-9425; e-mail: (dob@u.washington.edu)

*The hidden curriculum comprises those processes, policies, pressures, and influences that lie outside of the formal curriculum and that are often unexplored and unexplained. They can and do affect the attitudes and behaviors of learners in the environment.
us may hesitate to reflect on what we gain from this work or to note a connection between our patients and our self-awareness. Even if we do reflect, few of us speak clearly about these gifts. Yet, they are real and sustaining, enhancing our self-awareness and feeding our capacity for empathy and compassion in our clinical practices and in our personal lives.

Today’s students contend with an increasingly complex and problematic American health care system. Kassirer’s study of physician discontent identified rising health care costs and restrictions on physicians and patients alike. Patients have access to more information. They are expected to navigate our complex system and to be willing to partner with their physicians. Providers are expected to respond efficiently to the demands and constraints of these institutions and regulatory bodies, managing exponentially increasing information while providing evidenced-based, compassionate, patient-centered care that responds to the beliefs and culture of each patient in the context of community and population health concerns. The stress on the doctor–patient relationship is understandable. It is challenging to receive care in this environment. It is challenging to practice in this environment. It certainly is challenging to learn in this environment.

To help future physicians to contribute to the profession and maintain personal satisfaction, can medical education nurture learners’ connection with patients and resilience to the stresses of training and practice? It is time to direct more attention to relationship-centered care. The presentation of a patient’s narrative, its modification in the milieu of the encounter, and its reflection back to the patient is influenced by the beliefs, values, resources, limitations, and strengths of both the patient and the physician. In the past decade, medical educators have taught patient-centered care, using humanism, ethics, and cultural humility as basic constructs. The next step is to teach a deeper understanding of the relationship between patient and doctor. In this article, I will discuss relationship-centered care and two important components of successful relationship-centered care: the emotional work of self-awareness, and mindful practice. Both skills aid us in being open, which is necessary to both patient centeredness and appreciation of reciprocal influence, where patient and provider each give and receive. Both increase patient satisfaction and physician resilience. Both are healing and both are teachable.

There are many ways to teach these skills. One is the intentional incorporation of reflection and discussion throughout the curriculum. The tradition of medicine is a rich, narrative tradition; the narrative is the substance of what a patient brings and is what physicians and patients encounter together. Charroin suggests that narratives lead those engaged in them from the specifics of the story to contemplate more universal themes. In this article, I will use students’ and residents’ reflections to illustrate the concepts discussed and to suggest ways to incorporate these practices into educational experiences. These narratives were elicited in a variety of settings: second-year medical students’ ICM small group, a fourth-year medical school capstone course, and a behavioral science seminar for third-year family medicine residents. All students and residents whose narratives I present here have consented to the use of their comments and have reviewed the manuscript.

The ideas I express here are core values in my practice and teaching. I believe it is important to find ways to develop a new platform for medical education that centers on the self-awareness of the emerging physician in relationship with her and his patients. I am grateful for the opportunity to develop my thoughts and to share some of the narratives here.

Relationship-Centered Care

In 2001, the Institute of Medicine listed “a continuous healing relationship” as the first tenet for improving the quality of patient care. This was echoed in a call for the educational system to promote a humanistic approach to medicine by the ad hoc committee of deans speaking for the Association of American Medical Colleges (AAMC). This report came almost a decade after Stewart and colleagues’ early work on patient-centered care. During that decade, a whole generation of students and residents were exposed to varying degrees of attention to the concepts of patient-centered care. Patient-centered care, however, is enhanced by attention to relationship-centered care. Beach and colleagues have defined four principles of relationship-centered care. First, “all health care relationships occur in the context of reciprocal influence.” Second, we must explore our own world; in so doing, we can grow more self-aware, allowing the dimension of personhood (in addition to roles) into the relationship. Third, the acceptance of affect and emotion alongside cognition are fostered as important dimensions that enhance the empathetic capacity of the provider. Fourth, the work of the physician and the patient has moral value.

Learners who are introduced to patient-centered care often believe that it asks them to only attend to the needs of the patient. They perceive their job to be learning communication and clinical skills to use effectively in future interactions for the benefit of their patients. Despite the theoretical writings of Stewart et al., Mead et al., and others, learners often miss the fact that they can do this best when they know themselves, when they are truly present in the encounter, and when they are attentive to the collaboration between the patient and themselves. With every patient, a physician establishes a relationship. Whether longitudinal or in a single meeting, whether deep or superficial, and whether acknowledged, fostered, or ignored, the connection contains mutuality, giving and receiving between patient and provider.

As members of a profession, physicians seem uncomfortable with the notion of mutuality, but recognizing and identifying what we gain from connections with patients can further facilitate the development of self-awareness and the capacity for mindful practice. In a behavioral science seminar with residents, a colleague and I asked them to reflect on themselves in a relationship with one patient. One resident said, “This is really hard! I am so used to thinking about the patient. . . . I am not sure I can even think about myself.” The patient-centered focus clearly helps define the roles within the relationship, but this resident experienced it only as inquisitiveness about the patients.

Relationship-centered care orients us to the importance of self-awareness and mutuality, which enrich us beyond our clinical practice.
In small groups of students or residents, or consulting with a single resident about a patient, there are opportunities to draw attention to reciprocal influence. In a variety of settings, we ask students and residents to identify something they have received through a particular relationship with a patient, specifying that it be something they are carrying into their life outside of medicine. The examples below illustrate awareness of the first three of Beach et al's² principles: reciprocity, exploring our own world, and the acceptance of affect or emotion.

P.J. was a woman in labor with her second child. Her primary care physician [a family physician attending] and a second-year resident were present. The resident had told the patient she was six centimeters dilated, but the attending later told her she was four. The resident was quite embarrassed, yet she noted that the patient was careful to tell her not to worry, that exams were subjective. A year later this resident reflected on her awareness of and gratitude about how this patient had taken care of her. [Paraphrased from a conversation with a third-year resident]

A second-year medical student shared that he came from a very conventional white middle-class community and he worried about the level of judgment he might bring to an encounter with a homeless person or person with an intravenous drug history. After a completing an interview and exam with a homeless addicted man, the patient thanked him for listening, caring, and not judging. Seven months later, the student expressed gratitude for the man’s openness and credited this encounter as his most important. He felt this patient had given the gift of believing in his capacity to step outside the bounds of his upbringing. [Reflections of a second-year student shared with the author, his clinical preceptor]

L.J. was a seven-year-old with a chronic illness who died. He was an angel . . . who shared smiles and love and made me happy and allowed me to share my fun times with him. He made my life and others’ lives better. He was magnetic, although he could not speak. He taught me about quality of life even if a person cannot talk or contribute in a usual way that we are preconceived to seeing. I miss him. [Excerpted from a writing by a third-year resident]

As the stories above illustrate, responses to this directed process suggest that a single question can turn students and residents inward to explore and then express what they have received through relationships with patients. In asking learners to return to the experience, we can also teach concepts of self-awareness and mindfulness. Using narratives, educators can be explicit about these dimensions and practices and teach how these practices enhance compassion, empathy, trust, and mutual satisfaction.

Self-Awareness

We are not empty handed when we walk into a room to meet with a patient. We carry our own culture and beliefs, conscious and unconscious assumptions, needs, emotions, expectations, and skills as physicians or trainees, as well as our level of presence or distraction on that particular day. The more we know about ourselves, the better able we will be to listen to and accept another’s narrative.²,⁴,⁵ Self-awareness is what differentiates us from others, providing a key to the possibility of actually knowing another while giving us the matrix for healthy boundaries in the relationships we form. Our relationships with patients provide us with many opportunities to learn about ourselves. Most of us know this, even if we do not speak about it. Educators now face the task to intentionally teach this insight and to expect that learners will actively work on self-awareness at the same time that they learn and practice their other medical skills. A narrative from working with one resident and a hospitalized patient illustrates this principle well:

All week, the two residents and I were open with the patient about the possible diagnoses being considered. Now it was the day before discharge and it was time to meet with the patient to explore her insight into her symptoms, to sum up the evaluation, and to recommend next steps. Accompanied by the intern and a behavioral scientist, the second-year resident took the lead. The resident and the patient discussed her symptoms. There appeared to be excellent rapport because the patient was willing to hear and accept the diagnosis of somatization or conversion. The team discussed the interaction afterwards. In addition to all that the resident did well, our behavioral scientist noted that when the patient spoke of fears, the resident was quick to soothe them and suggest management ideas. We asked the resident to reflect on what was happening inside during those moments. He shared that he likes to be in control, in part because he fears losing control of an interaction. He expressed fear that loss of control might have allowed her fears to take over and be unmanageable by the team. He spoke of origins in his role in his family and parallels outside of medicine.

In the story above, the resident had not thought before about how the exploration of feelings might enhance his practice and personal life. The first educational tool was simple: asking the learner to reflect on what he was feeling at the time of the interaction when the patient mentioned her fears. The second, discussed by Epstein⁶ and Connelly,⁷,⁸ was allowing time and permission to explore his contribution to their interaction and to hypothesize possible outcomes had the patient been allowed to express more about her fears. The behavioral scientist and I talked with the residents about trust and risk in relationships, and the second-year resident came to a realization about himself that was new. In a future situation, armed with this understanding, this resident might manage his response to his own internal dynamics differently.

To students and residents, self-awareness is often abstract, and they miss the link to patient centeredness. Their initial focus is to understand the patient’s beliefs, needs, desires, and hopes so that they might provide better care. Also, if the stated reason for self-exploration is only so they can serve better, the personal enrichment and joy this work brings to the life of the physician is hidden. Again, an anecdote is telling:

One of our residents recalled an encounter with a patient where they both expressed anger. Through processing this apparently failed encounter with the patient and through personal reflection in our group, the resident came to understand that this was a seminal moment in her development as a person. She now knows how her anger rises behind feelings left untended, and she is working on this in many relationships in her life. As a side note, she and the patient continue to work effectively together. [Paraphrased from reflections of a third-year resident in behavioral science seminar]

It was important for the resident to apologize to the patient and to accountably process her inappropriate response. It was equally important she was open to learning that this encounter had taught her something about herself. Working on how she accepts and manages her feelings continues to have positive repercussions in her work and in her personal life.
Mindfulness

Mindful practice asks us to enter into an encounter with our focus on the relationship at hand, attending both to the patient and to ourselves, seeing and feeling. Epstein discusses the four habits it requires: (1) attentive observation of the patient, ourselves, and the patient’s problem, (2) a critical curiosity that includes the courage to see one’s own weaknesses in the situation, (3) looking with a fresh eye, without preconceived ideas, and with tolerance of contradiction, and (4) presence, or the undistracted attention to the person and task, accompanied by compassion and connection. We can teach that our role is varied: sometimes partner, sometimes time manager, sometimes educator, sometimes advisor, sometimes a simple presence. As DaGupta notes in his writing on narratives, we cannot shift gears and fill any of the shoes appropriate to the patient’s needs and desires unless we are fully present and attending to the patient, to the narrative they brought with them, and to ourselves. This scenario was a good opportunity to practice mindfulness:

It was his third patient in second-year ICM where he was to do the complete history and physical exam. Although the patient had a clear expressive aphasia, she was alert and agreed to the interview. Wondering if this would be appropriate for a second-year student, I decided to let him proceed. We later met his five classmates to present his patient and discuss the patient’s clinical case. This patient was not available for a bedside presentation, so we went to our ward classroom and took a detour from usual practice.

I asked the student how he felt throughout the time they spent together. He reflected and said he first felt frustration with the unfairness of such a hard patient. Then, he felt self-critical for his feelings. As he proceeded, he feared that he lacked the skills to interact with her. Midway, he noted that the patient seemed to be enjoying the interview, and he noticed he was feeling pleased with himself. At the end of the interview, he was aware that he felt very touched by noticing how loving this patient’s husband was to her.

With this student, we shifted from relaying the patient’s history and physical exam (telling her narrative) to one of relaying his internal narrative. By voicing my curiosity and giving the student the time to reflect, his cascade of different feelings and thoughts were examined and not lost amidst other tasks and responsibilities. His ability to recreate his internal dialogue and his perceptions of the patient and her spouse demonstrated Epstein’s tenets of mindfulness: presence in the encounter, his critical curiosity, his attention to the patient’s needs and his own sometimes conflicted feelings, and his willingness to look with a fresh eye on what was transpiring. His technical task of interviewing was accompanied by emotions that, in turn, provided a context for learning. The exploration brought those factors to the surface. With another second-year student, I asked her to identify how she wanted to be present in the encounter and to observe herself and her patient throughout the interview. The subsequent discussions modeled their mindfulness for their small-group classmates, and throughout that year, we looked for other examples to encourage the practice of mindfulness in real time and in later reflections, such as this:

This resident chose to manage himself more consciously, and he acknowledged both that he was more successful in satisfying his patient and that he enjoyed his clinic more. He shared how he was now able to approach his clinics with attentiveness and to be less reactive. This new attitude resulted in clinic sessions where he was happier.

Clinical practice demands that we process quickly and that we think on our feet. It usually is a complex mix of the biomedical and the psychosocial. It often is challenging to stay attuned to the dynamic interplay among one’s own beliefs and feelings alongside those of the patient and the subsequent shaping of the patient’s narrative. Teaching mindfulness happens best when even
The social influence of teachers is to be more receptive to embracing medical students and residents are likely. There are predictable times when trained faculty will be essential. Currently, at the University of Washington School of Medicine, students are asked to reflect on what they experience and what they learn about themselves after a variety of experiences in their first- and second-year ICM courses, in their preceptorships, and in their experiences doing their community-based projects. Prepared in advance, they are asked to be aware of themselves during the experience. In ICM 2, students are observed at the bedside weekly for a year and participate in a number of dedicated small groups where this work continues. As faculty, our own mindfulness positions us to reinforce concepts, to share experiences, to encourage, observe, and respond to students and residents, and to notice and respond at teachable moments, even in the brief relationships of ICM.

These concepts are also appropriate for the didactic sessions of several clerkships where the hidden curriculum needs to be revealed, examined, and replaced by alternative strategies for approaching clinical work. Students’ fear of making mistakes is heightened just before graduation, and they worry about the effects of training on their personal lives. “Capstone” or exit courses can use reflection and discussion to strategize techniques for self-care, growth, and preserving the capacity to relate authentically with one’s patients. Until these concepts are part of the practice within residency training and are modeled by residency faculty, we will do little to shift the paradigm toward relationship-centered care. The curriculum for this work is really a continuum supporting lifelong learning of the self in relationships.

As Haidet discusses, the teacher–learner relationship remains critical in a new model for medical education. Faculty development would target those who teach clinical skills and professionalism, along with attending clinicians and most senior residents. Residents’ role modeling exerts perhaps the most powerful influence on clinical students, and so we must acknowledge this central teaching role and include residents in training. Additionally, basic science faculty would be encouraged to participate to promote integration of these ideas throughout the curriculum. Faculty development would foster the same “dual intelligence” to be developed in learners, with skills in reflective and mindful practice and relationship-centered care in addition to the biomedical aspects of clinical care.

Conclusion
Our students and residents feel the challenges of our health care system most acutely. From published work on patient-centered care, we know some of what promotes satisfaction for patients and physicians. The Institute of Medicine and the AAMC are calling for medical educators to teach curricula quite differently. Seasoned clinicians who still love their work know that there is a path. It is well worn, if quietly traveled, by those of us who know that relationships with patients do have mutuality. Our patients and we know that they add to our lives. We both know that we have grown in self-awareness, in part because of the lessons learned in relationships with our patients. We both know that our interactions go best for both of us when we are mindful, coming to an encounter fully present and attending to the dynamic process happening around the narrative presented by the patient. The path is there. It is time to show it to our students and to teach them how to walk it, instead of simply trusting that they will discover it after some frustrating years of fearing they are lost.

Acknowledgments
The author acknowledges the works and theoretical developments of Epstein, Charon,
Novack, Candib, and others that have preceded this article. The author thanks the residents, students, and patients for many years of wonderful relationships, for their teaching and giving, and for willingly sharing their narratives and learning. In addition, thanks are due to four colleagues who challenged the author’s thinking during preparation of this manuscript and who share the author’s commitment to relationship-centered care: Valerie Ross and Larry Mauksch, both behavioral science faculty in the Department of Family Medicine at the University of Washington, and Leora Fishman (Boston) and Ron Schneeweiss (Department of Family Medicine, University of Washington), both family physicians.

References