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2004 Winter Course

“Putting Winter into the Winter Course: Finding Beauty in an Adverse Environment” is the theme of AAPP’s 2004 Winter Course.

The Winter course is specifically for American Academy on Physician and Patient Faculty and Faculty In Training (FITs).

We are excited to have four proven facilitators for this activity. Those of you who have experienced working with any of these individuals will be glad to know that Amina Knowlan, Charlie O’Leary, Joanne DeMark and Gerald Boyd will be facilitating this year.

The Winter Course will be at the beautiful Mt. Olivet Retreat Center in Farmington, Minnesota, very near Minneapolis, Sunday, January 25 - Friday, January 30. Participants may arrive Saturday afternoon, January 24.

Please Save These Dates!

For more information on the location of the Winter Course visit
www.mtolivetretreat.org.

Save the Date!

2004 Annual Faculty Development Course

Teaching Doctor-Patient Communication Across the Life Cycle,
The 22nd Annual Faculty Development Course

WHEN?

Sunday evening, June 13 - Friday, June 18, 2004

WHERE?

Pittsburgh, Pennsylvania

Medical Encounter

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Articles

Caring for the Patient With Functional Illness: A Route of Explication

Frederic Platt

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We who have a special interest in doctor-patient communication may occasionally be asked to help other physicians with specific communication syndromes.

I was recently asked to speak with two groups of physicians who claimed to be having particular difficulty working with patients who had “functional illnesses.” The physicians said that their difficulties stemmed from several factors:

a) These patients had nothing wrong with themselves. They had no illness.

b) These patients seemed to demand that the physician find a disease to fit their symptoms and that the physician cure them of it.

c) These patients seemed to come back over and over, refusing to leave the physicians who wished they would just go away.

I was puzzling about what I might best do to help this group of troubled doctors and began with a sample case:

Ms. X is a 40 year old woman who comes to you with the complaint that she “hasn’t been well for the last five years.” She says she suffers from terrible pain throughout her body and from constant overwhelming fatigue. She offers several diagnoses that have been made by other clinicians: chronic fatigue syndrome, fibromyalgia, chronic yeast allergy, and sick-building syndrome. She has been treated with many medications including analgesics and antidepressants to no avail. On examination you find a worried woman with normal vital signs. There are no physical abnormalities discernable. All your routine laboratory tests are normal.

The physicians present agreed that they were often asked to care for such patients. They even thought that they were singled out in having such patients and that perhaps someone

sent them those patients as a sort of punishment for unknown crimes. Several voiced the thought that not only did they get an inordinate number of such patients, but that their colleagues all knew that about them.

I thought that it might help to direct these troubled doctors to some of the literature that dealt with the problem of functional illness and somatization. I provided six articles from the many that discuss these syndromes, and we read excerpts from the articles aloud. This approach seemed to work particularly well and I thought it might be helpful to other members of the AAPP if I shared it.

The articles and the excerpts were as follows:

1. “The Care of the Patient” by Francis W. Peabody. First published in the JAMA in 1927 (1), Peabody’s classic article has been often quoted, though perhaps seldom read. Its most quoted line is its last: *One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.* Peabody hinted at this theme earlier in the article when he said, *The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal. The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it, and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients.*

But what was Peabody talking about? Consider: *if teachers and students are liable to take a limited point of view even toward interesting cases of organic disease, they fall into much more serious error in their attitude toward a large group of patients who do not show objective, organic pathologic conditions and who are generally spoken of as having "nothing the matter with them."* Aha! Peabody's main concern in this classic article was the patients with functional illness and note his very words, "nothing the matter with them," the same as my troubled doctors in year 2002 used. And what of these patients? *Medically speaking, they are not serious cases as regards prospective death, but they are often extremely serious as regards prospective life. Their symptoms will rarely prove fatal, but their lives will be long and miserable, and they may end by nearly exhausting their families and friends.* And we might add, their physicians and caretakers. About these patients with functional illnesses, Peabody noted that *many a student enters practice having hardly heard from them except in his course in psychiatry, and without the faintest conception of how large a part they will play in his future practice.* How large a part is that? Some have suggested that patients with functional illness are only ten percent of our patient load but provide 50% of our work and 90% of our heartache. They have symptoms aplenty but we are unable to define the disease at work and unable to provide any effective therapy. Worse, they keep coming back! They are the "Familiar

Face Syndrome" and are often viewed by physicians as "sent especially to torment me" as if there was some sort of supreme power that dealt out patients to doctors and that dealt this particular physician a particularly bad hand.

So how common are patients who have symptoms but no definable disease? Kurt Kroenke has been writing about SYMPTOMS for years and recently edited a supplement to the Annals of Internal Medicine dealing with just that phenomenon. In "Studying Symptoms: Sampling and Measurement Issues" (2) he says *An exact medical diagnosis that explains the symptom is often not established; at least one third of symptoms lack an adequate physical explanation and are referred to by various labels, including 'functional,' 'idiopathic,' 'atypical,' 'somatoform,' or 'unexplained.'* Symptoms are ubiquitous and most persons with symptoms never report them to a physician so the more important question may be "Why did this patient decide to bring his symptoms to a doctor?" After all, everyone has headaches but we don't go to the doctor with our headaches, perhaps not until we have become convinced that we might have a brain tumor.

When doctors are unable to find a diagnosis for the patient's symptoms, what do we do? If we are subspecialists, we might be content to simply categorize the symptoms by what it is not. "noncardiac chest pain" might relieve the cardiologist of his worry and his task. I recall a gynecologist who used a stamp to impress on emergency department

records that the patient had "no gynecological disease." Of course there is usually some clinician with whom the buck stops and then it isn't enough to label what is not present, but one must come to terms with what is present. Kroenke says that *Salient health outcomes have been referred to as the "five Ds" – death, disease, disability, discomfort and dissatisfaction.* He proposes a sixth, *destitution (economic consequences for the patient and the health care system.)*

Reading Kroenke, one must come to the conclusion that symptoms are often present without definable disease and that, as physicians, we must come to terms with that fact and must come to some sort of an approach to help us with these patients who will make up at least one third of our population and perhaps more of our practices.

There are many good summaries of the syndrome of somatization in the literature. I turned to McWhinney, Epstein, and Freeman's article in the 1997 Annals of Internal Medicine (3). They quote Lipkowski's definition: *somatization is a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them.* They noted four components: *experiential (the patient's experience of distress), cognitive (the patient's attribution of the distress to physical illness), observational (the physician's negative findings), and behavioral (the patient's decision to seek care).*

The cause of somatization or

functional illness is clearly unknown. There are however many entertaining theories. We might consider some of them:

a) Psychosomatic. This view suggests that the physical symptoms (such as abdominal pain and sensations of bloating, alternating constipation and diarrhea of the functional bowel patient) are caused by emotional or psychic distresses. This theory believes that anxiety, unresolved decisions, depression, and other mental distresses have become translated or transformed into physical symptoms. At one time, perhaps 50 years ago, it was much believed that specific personality types were likely to develop specific physical syndromes. There were “ulcer personalities” and “coronary personalities” and even “ulcerative colitis personalities.” This specificity has been largely abandoned but many of us physicians and perhaps most of our American patients today tend to ascribe physical symptoms to a nebulous psychic “stress.”

b) Altered somatic awareness. Perhaps patients with chronic pain syndromes simply have a lowered pain threshold. Nobody knows what a pain threshold might consist of or where it might reside in our nervous system or elsewhere, but we do know that some people can tolerate more pain than others and that all of us have days when we can tolerate more pain than on other days. I find it useful, as a demonstrative example, to call attention to the pressure of one’s shoes on his feet. Until mentioned, the person is usually unaware of the presence of the shoes, unaware that they are surrounding his feet and

compressing them. After a minute or two of focusing attention on the shoes, one feels oppressed and cannot escape the awareness of their claustrophobic presence. Perhaps our somaticization patients with chronic pain suffer from a heightened somatic awareness. Similarly, perhaps our patients with persisting fatigue suffer from an elevated effort sensitivity. I don’t know where our “effort meters” are located or how they work, but surely we all can speak to how hard we are working, to how much effort we are putting out. Perhaps our tired patients have their effort meters turned up!

c) An intriguing notion is that our somatization patients are infected with MEMES, a set of virulent and contagious ideas. Which brings us to:

“Memes’ as Infectious Agents in Psychosomatic Illness” by Stephen E. Ross. (4) Ross suggests that *A virulent idea, a maladaptive social construction of disease, can be found at the core of these diverse disorders.* He notes that because *ideas can replicate through communication and mutate (as they are altered by their hosts) and are subject to selective pressures (enduring only if they are useful or compelling), they, like genes, are subject to Darwinian evolution.* This infectious quality can account for the ubiquity and long liveness of such concepts as “chronic fatigue syndrome”, “fibromyalgia”, or “gulf war syndrome.” The disorder might be simply not yet adequately understood or may be a fantasy, but if the idea catches on, is propagated by the media (including the internet), and satisfies our patients’ needs to have a

name for their suffering, it will remain with us.

d) Metaphors? I have two patients who seem to suffer from metaphorical disease. But this explanation seems relatively rare in my practice. One patient, for example, an elderly poet with chronic dysphagia and attacks of dyspnea, often feels dissatisfied with her life course and says that she “cannot swallow it.” When the political situation in her residence building changed, her dyspnea attacks ceased and she explained the change by noting that “the atmosphere had changed.”

e) Of course, one of the greatest problems for physicians is that we are never sure. We are never certain that there is “no disease present” or even “no disease that we so far recognize is present.” We are always tormented by the possibility that we have missed something. Uncertainty remains with us. Our patient may really have some outlandish rare entity such as Acute Intermittent Porphyria that we rarely think of and haven’t thought of yet in this case. Or, perhaps our patient is in the shoes of the English king, George the Third, who DID have AIP at a time when that disease had not yet been invented. Perhaps our patient with functional bowel disease will be much better understood and diagnosable in the future. Even I can remember a time when Lactose Intolerance had not yet been invented and our cramping gassy patients who complained about milk were viewed as “just another patient with functional disease.”

If we cannot say what disease our

patient has, if our patient has symptoms but no findings, if we cannot come to a diagnosis, is there anything we can say for sure? I think there is. I think we can say that our patient is suffering.

Eric Cassel surely brought the nature of suffering to our attention in his NEJM article and then in his book of the same title. (5) He made several points that we must keep in mind: *Suffering is experienced by persons. Suffering occurs when an impending destruction of the person is perceived. Suffering can occur in relation to any aspect of the person—in the realm of social roles, group identification, the relation with self, body, or family, or the relation with a transpersonal transcendent source of meaning.* It becomes clear that to understand suffering we have to understand what makes up a person. We must realize that the person is not just body, not just mind, but all the ways we define ourself. And then suffering can occur when any of these defining parameters are threatened or damaged. Physicians' work includes the recognition of suffering, the "empathic witnessing" of its presence, and even the relief of suffering.

This all leads me to the view that when confronted by a patient with "functional illness", a patient who has plentiful symptoms but no clear organic diagnosis to explain the symptoms, a reasonable route for us to follow is to attempt to understand how the patient is suffering. To do that we have to explore the patient's person, trying to learn who he is, what his concerns are, what his life is about, and where it has been threat-

ened or damaged. So finally we must shift from our disease-centered interviewing to a more patient-centered interview.

How lucky that I can end with an article that I was privileged to help with. "Tell Me About Yourself": The Patient-Centered Interview." (6) We think that physicians need to know a lot about the person of their patient and that the sort of data we need usually falls into five zones: *Who is this patient? What constitutes that person's life? What are the patient's interests, work, important relationships, major concerns?* How to find out? We like asking the patient to tell us about himself. Then, what does this patient want from the physician? And how does this patient experience the illness? How is it affecting him functionally? (*Is there anything you cannot do since you developed this illness that you used to be able to do?*) Or in terms of relationships or even his own view of himself? (*Has it affected your relationship with anyone adversely? Do you think of yourself differently since this happened?*) Then what are the patient's ideas about his illness? What is his Explanatory Model (What happened, why it happened, and what should be done about it?) Finally, what are his main feelings? Is he mostly sad? Frightened? Angry? What?

Thinking about the difficulty of caring for the patient with functional illness, perhaps we can extend the conclusion of "Tell Me About Yourself": *In the end, the two most useful physician qualities may be curiosity and patience—curiosity to ask questions such as "tell me*

about yourself," and patience to wait for the answer. Perhaps we should add that these two qualities may be even more important in caring for the functional illness patient—curiosity to really understand how this patient is suffering and patience to stay with him despite our eagerness to flee from the difficult interaction.

To my surprise and pleasure, physicians led through these quotes from the literature seemed comforted and enthused. I offer the route map to all of us.

Suggested Reading

THE FUNCTIONAL PATIENT: Our Most Difficult Challenge.

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Using Portfolios to Promote Medical Student Reflection

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Abstract

Educational portfolios are purposeful collections of evidence that learning has occurred. They are also used in some professions to promote reflection. Medical educators, also interested in promoting reflection by medical students, have used specific writing techniques and small group interventions, but these are variably integrated into the students' daily experiences. We describe how we used educational portfolios in a third year medicine clerkship to enhance student reflection about their experiences and to promote self-reflection in a way that is integrated into their daily, practical experiences. Lessons learned and the resultant changes are also described.

Introduction

"The practice of medicine is an art, not a trade; not a business, a calling in which your heart will be exercised equally with your head."
Sir William Osler

As medical educators, we often struggle with how best to teach our students this art of medicine in a medical system that increasingly promotes and even rewards "unreflective doing". (1) Many medical schools use critical incident reports as a formal means to encourage medical students to reflect about seminal experiences during their medical training. (2) Rita Charon moved this type of reflection closer to the bedside and daily patient care activities by introducing parallel charting to her medical students at Columbia. Students were encouraged to record

aspects of the patient-student interactions that were important but did not belong in the official medical record. (3) Recently, Baernstein and Fryer-Edwards compared strategies to promote reflection by medical students. They found that one-on-one interviews with faculty may be more effective than written critical incident reports in eliciting reflection on professionalism.

At the University of Florida, we too have introduced reflective writing into the clinical years. Third year students rotating in the medicine clerkship meet in small group discussions to share narratives that they have written and that follow a similar format to critical incident reports. However, they also receive explicit instructions to include reflection on how the experience they selected may affect their professional development and future practice of medicine. These sessions are both popular and highly valued by students as evidenced by consistently superior anonymous evaluations and comments. Yet, despite their value, these sessions did not address the other key aspect of reflection in medical education, namely, students' ability to reflect on their own performance, educational needs, and progress. Thus, in 2002, we introduced educational portfolios into the medicine clerkship as a means to promote and expand reflective learning beyond the competency of professionalism.

Description of the Educational Portfolio

Educational portfolios are *purposeful* collections of evidence that learning has occurred.(5) When

executed properly, they require the learners to reflect and self-assess in order to select the best evidence that highlights their progress and current level of competence. In fact, they were developed in the school system to enhance reflection.(6) Portfolios also offer tremendous flexibility in content, which enables them to address multiple competencies in an individual learner while accommodating a variety of learning styles. However, for the experience to be maximally effective, the learners need to have skill at self-assessment and insight into their optimal learning styles. However, studies show that less competent learners tend to overestimate their abilities while the most competent learners underestimate their abilities.(7) Therefore, to counter this, we assigned each student an experienced faculty mentor to act as a portfolio advisor to help students learn and improve these skills. This advisor-student relationship has been one of the most successful aspects of the portfolio experience.

The original content of the portfolio was selected both to address some of the clerkship goals and objectives and promote more active and reflective learning while minimizing additional work requirements. (Table 1) For example, students always have been required to write a comprehensive history and physical for every patient they admit, and the attending physicians were expected to give them feedback. In the context of the educational portfolio, students also now shared these write-ups with their portfolio advisors who would provide consistent feedback over the two-month rotation. Using this feedback,

students reflect on their work and progress and select which four write-ups they think represent their highest level of achievement. Formal goal setting and the logging of scholarly activities are additional examples of portfolio content added specifically to help promote active and ongoing student self-assessment and reflection on the students' progress.

Table 1. Elements of the Initial Educational Portfolio

Goals/Learning Contract	- Reassessed every two weeks and revised as needed
Reflective Writing	-One written submission and participation in a group discussion required
Reading/Scholarship Log	-Optimally a daily record of reading, educational talks given to the team, morning report presentations, and other scholarly activities
Patient Write-ups	-Student selects four best write-up for formal evaluation
Observed Physical Examination	-Complete physical examination checklist completed by an attending physician each month
Evidence-Based Medicine Report	Approximately one-page critical appraisal of an article directly related to the care of one of the student's patients

Results

We found that students viewed the new write-up experience very positively; as it did not increase their workload, and they appreciated

seeing their improvement so concretely. This and the reflective writing sessions were singled out by students as the most valuable part of the portfolio experience in their anonymous evaluations, as exemplified by the following comment: "The process of turning in multiple H&P's for feedback and picking the four best at the end allowed me to see improvement week to week."

Yet not surprisingly, responses were quite mixed regarding elements of the portfolio that were perceived as added work to the "usual" clerkship responsibilities. Some students particularly resented the documentation requirements inherent to a portfolio. "I don't believe students at our level need to record their work daily" is a representative response from a subset of the students. Yet, other students found value in the very portfolio elements labeled as busy-work by others, "I do all the things listed in the portfolio already, this just made me more conscious of them." Interestingly as this initial cohort of students has moved past their medicine clerkship, a third group of students is emerging who have developed a delayed appreciation of some of the more controversial portfolio elements.

During the routine midyear clerkship debriefing with the course directors and deans, a class representative made the following observation, "At the time I hated keeping track of my reading but now that I have been on other clerkships, I realize I am not reading as much as I did on Medicine." (Comment paraphrased from notes taken by the author at the meeting.)

Curricular Revisions based on Lessons Learned

Though our initial experience with portfolios was an overall success based on student and portfolio advisor evaluations, there was room for improvement. With this in mind, we made changes to the portfolio that would enhance the flexibility in content with the idea that this would also promote even more active self-assessment, reflection, and self-directed learning. (Table 2) The revised structure of the portfolio is competency-based using the six core competencies defined by the Accrediting Council of Graduate Medical Education. On the first day of the clerkship, students receive information about the competencies along with clerkship-specific descriptors of student behaviors required to meet and exceed competence. Students are instructed to reflect on where they fall within these descriptors, and based on that assessment, create goals for the clerkship to help them address weaknesses and maintain strengths. They meet with their portfolio advisor within the first two weeks of the clerkship to review these goals and select elements of the portfolio that will best help them meet these goals. They are encouraged to meet with their advisors at least every other week for feedback and reassessment of their progress.

It has been said that "assessment drives learning" and the evaluation of the portfolio is also designed to promote reflection and self-assessment. The portfolio is criterion-referenced so that students can keep submitting entries in any of the competencies until they have demon-

strated the highest level of competence. The overall number of required submissions was reduced and students were encouraged to document activities that promote achievement of their goals. Portfolio advisors evaluate the portfolio using a set of written guidelines and the portfolio contributes 20% to the students' overall clerkship grade. However, as further incentive for students to accurately assess themselves, seek frequent feedback, and improve their weaknesses, documented progress and goal achievement in the portfolio may be used to help students who have a borderline grade. To date, only one cohort of students has completed this new portfolio format, and their ratings of the value of the portfolio have increased along with their USMLE shelf examination scores. It remains to be seen whether this improved acceptance of the portfolio and student performance will be sustained and significant.

Table 2. Elements of the Competency-Based Revised Educational Portfolio

Professionalism

- Reflective writing***
- Journaling
- Parallel charting
- Written formative feedback from attendings

Patient Care

- Write-ups (Four best submitted)**
- Progress notes
- Observed complete physical examination**

- Mini-CEX
- Procedure log
- Use of interactive teaching modules on ECG and x-ray interpretation

Medical Knowledge

- Conference preparation

Practice-Based Learning

- Goal setting/learning contract**
- Evidence-based medicine report
- Lead a journal club discussion
- Reading/scholarship log
- Prepare a self-study guide
- Educational talks given to the team

Interpersonal and Communication Skills

- Entries at students' discretion

Systems-Based Practice

(One submission of student's choice required)

- Identify and analyze a systems error
- Spend half a day with a nonphysician member of the healthcare team
- Make a home or rehab visit
- Interview and compare perspectives on a patient's care by all members of the healthcare team (RN, PT, social work, etc.)

* Items in bold are required of all students.

Conclusion

Portfolios are one way to integrate previously successful methods of promoting reflection on professionalism into broader self-reflection and assessment that, in turn, may promote

more reflective medical practice and continuous professional development. It will be important to track these students to see whether such a short-term intervention has sustainable effects on future behaviors. We also have plans to expand the use of the educational portfolios to encompass all the clinical years, which may achieve an even greater influence on long-term student development of reflective practices.

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Reflections on Total Care For the Cancer Patient and Family

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Ed Rockwood MD is a glaucoma specialist at the Cole Eye Institute, at the Cleveland Clinic. He recently lost his wife to cancer and wrote this article for physician colleagues and all people who care for dying patients and their families.

-Mariana Hewson

Introduction:

Being a physician offers the ability to help others by improving quality of life, reducing pain and suffering, and saving lives. These goals are not possible in every patient. It is upsetting to be unable to help a patient, and worse, to be unable to save their life. However, this becomes a part of every physician's experience and can improve our ability to deal with future patients. Even the best general or medical education can never adequately prepare one for some of life's greatest trials and tragedies or prepare others for how to assist someone going through such events. Everyone has at least some expectation of medical or personal calamity usually in the more remote future, however, there remains a peculiar sense that such tragedies only occur to others.

The shock of a diagnosis of cancer can occur at any point in life, although more probably later in life. Some patients are affected in the prime of life or in childhood. A cancer diagno-

sis is difficult to accept at any age, though more so at a younger age. Cancer patients of all ages usually, at least initially, feel both shock and an eerie, unreal feeling after the diagnosis of cancer, or worse still, after being told they have cancer and their condition is terminal. Properly dealing with these feelings is important for the physician or other health care worker who treats cancer or other potentially fatal conditions.

Medical School Education:

Medical school education has traditionally been very strong in teaching the areas of the basic sciences, the pathological basis of diseases, and in the medical and surgical methods of treating diseases, especially in a hospital-based setting. In the last few decades, there has been a much-needed, increased focus on outpatient and primary care in medicine. Other areas such as office management and learning about the costs of health care have received little, if any, attention in medical school or postgraduate training. More importantly, the art of communicating with patients and families, and especially the communication of bad news, has not been given adequate time in medical school curricula or in residency training programs¹. This too is changing. Even the best communicators are uneasy in dealing with these tense situations. A solid self-confidence combined with compassion, understanding, and a wish to help those experiencing severe stress can help patients and families experiencing the grief and emotional stress of a cancer diagnosis.

Learning the human dimensions of

care in medical school and residency may occur from positive role models², recollection of special memorable patient interactions, and active, participatory learning skills with patients and patient surrogates³. For practicing physicians, continuing medical education programs can improve the quality of physician-patient communication⁴. Unfortunately, one study of general medical and surgical patients showed that only 46% of senior clerks agreed that their medical teachers displayed humanistic characteristics such as sensitivity and concern about how patients adapt psychologically to their illness⁵. Good communication can lead to improved outcomes and decreased malpractice claims⁶.

Though possessing many of the basic skills for effective communication, the communication of bad news, and dealing with the patient's depressed or angry reaction to the news, provides special challenges to the physician, physician-in-training, or other health care professional. Before addressing ways to deal with these difficult situations, general comments on approaching the cancer patient can assist the health care professional in discussing their patient's cancer diagnosis and therapy and, perhaps just as important, in dealing with the patient's and family's reaction to the diagnosis of cancer and possible terminal illness.

Be Authentic:

The physician should be polite, respectful, warm, professional, and show a genuine interest in, and empathy with, the patient and their problem or problems. At any stage of

the illness, it is important to respect the cancer patient's dignity, privacy, and personal wishes. The treating physician should always be truthful and unambiguous⁷, not aloof or evasive, and answer the patient's questions to the best of his or her ability⁸. Many patients and families want the "whole truth" but can readily accept an honest "I don't know" or "I'm not sure" when discussing sensitive issues such as prognosis and longevity. Be honest, but don't clobber the patient with difficult-to-accept information, and be sensitive to how much information the patient can handle at one time. Some patients need to "digest" bits of information and details rather than hearing it all at one time.

After the initial diagnosis of cancer, some patients and families are lost and hear little else that is told to them. Later, further discussions may be necessary to outline future therapeutic plans. Talk to the patient's level of understanding but do not talk down to them. Consider the patient's ability to comprehend possibly complex medical discussions. For example, patients with lower education levels and lower literacy present with more advanced stages of prostate cancer⁹. In the other direction, some physicians become very technical when having discussions with better-educated individuals and health care workers and their families and risk failing to successfully communicate with them. Patients' and family members' questions may give clues to their level of understanding and acceptance of the diagnosis and therapy.

Patience, compassion, understand-

ing, and a caring relationship are all important for the development of good patient-physician bonding. Similar traits in the cancer victim's spouse or other caregivers will assist the patient through treatment. The treating physician and other health care workers should be in tune to the patient's family relationships and ability or lack of ability to assist in the cancer patient's home care.

Treating the health care professional or family member can provide both special opportunities and challenges for physicians and other health care workers. Certainly, health care workers and their family members are generally more knowledgeable about cancer and cancer therapy. While this greater awareness can facilitate a patient's care, this greater knowledge may also cause these patients to have a heightened anxiety, particularly with respect to possible complications, adverse effects of therapy, and medical errors. Additionally, treating physicians may have a tendency to be more self-conscious and defensive when treating other physicians, health care workers, and their families. Some physicians preferentially discuss significant findings directly with the health care-employed spouse, or health care-employed adult child of an affected, older adult rather than with the patient directly, which can heighten the patient's anxiety about the possibility of withheld information or worse-than-actual prognosis.

An upbeat approach to the cancer patient can be uplifting to the patient and family. Direct eye contact and a simple smile, and hand shake from the treating physician can ease the anxious patient and can convey better

than many spoken words that the physician really cares for the patient. Ask how the patient is doing. This can be an easy way to enter into a discussion of how the patient is handling their diagnosis and current therapy. Allow the patient to express his or her concerns, and try to achieve this without interruption. Repeated interruption of the patient conveys that you have your own agenda and may not be personalizing appropriate and necessary standard care to the individual's needs. Remember your chief concern (eg. falling white blood cell count) at the moment may be quite different from that of the patient or family. Try to take the time to address both the patient's and your chief concerns.

Avoid expressions that may, even remotely, be perceived as judgmental by the cancer victim or family. A simple "Why didn't you notice that lump earlier?" or "You should have gotten in here sooner than you did!" can, at best, evoke feelings of guilt and cause greater stress and, at worse, provoke an angry reaction from the patient. Often the patient has already heard this from well-meaning family and friends. Certainly patient education and early detection is the key to increasing the survivability of many patients with cancer, and future efforts in this direction will continue to pay off in greater cancer survival. However, once detected at whatever stage, the physician can best focus attention with a forward-looking attitude to establish further necessary diagnostic testing and treatment planning rather than second-guessing a patient's delayed attention to potential earlier signs of cancer.

Be aware of you own values, beliefs, attitudes, and defense mechanisms. Physicians often fail to understand reasons why a patient may choose to refuse treatment. Some, particularly the elderly, may have decided that they have already lived a full life and do not wish to pursue aggressive therapy, even if it can be life-saving. It is important to be sure that patients understand all the options and the most likely outcome of their choice of a given option.

The angry patient is unsettling to the physician but should not evoke a reciprocating expression of anger or avoidance. Many times, a verbal expression of anger by the cancer victim or family is expressed at the cancer, or other stresses resulting from the cancer and its treatment, and *to* but not *at* the physician. It takes tremendous fortitude to endure a patient's or family's barrage of questions and occasionally challenging accusations after the diagnosis of cancer. Lessons learned from a physician's own personal good, and especially tragic, or other difficult experiences in life can be used to empathize with the patient and assist in providing the emotional support needed by the patient to face the diagnosis of cancer and possible terminal illness.

Total Patient Care:

Patients want, and expect, the best diagnostic, medical and surgical care of their illness. They want a cure, and that, with the least possible side effects. It is, of course, not possible to deliver this in all cancer victims. Unfortunately in this, what is often their most difficult time of life, the

cancer patient and family need so much more than just the highest quality care from physicians. Physicians, nurses, social workers, clinical research coordinators, psychologists, pharmacists, hospice workers and others involved with the patient's care should work together to provide comprehensive and coordinated health care and support for the cancer victim and family.

Cancer and other terminal patients often seek alternative care in special diets, vitamins, minerals and other supplements. Yoga, Reiki, aroma therapy, massotherapy, spiritual care, and music therapy may each provide relaxation, comfort, diversion, and a method to reduce stress and better tolerate the side effects of cancer and cancer therapy. The cancer victim will hopefully not choose these in lieu of standard cancer therapy. However a nonjudgmental approach by the physician to these alternatives may help the patient accept and continue necessary, traditional anti-cancer therapy offered by the physician in addition to alternative health care options.

The cancer patient may fear losing time at work and possible loss of employment and loss of income. Financial concerns can be severe for many cancer patients and families. Some families with a patient facing terminal illness reported that they had to take out a loan or second mortgage, spent their savings, or obtained an additional job to pay medical bills¹⁰. In addition to acutely facing the serious illness of a parent, spouse, or child, many families must rapidly adjust to an enormous change in family routine. Young children may be

bewildered by these family changes. Ill parents may no longer be able to play with children and engage in previous family activities. Social interactions, family outings and trips may be drastically changed after cancer strikes a family. Some children become quietly depressed and others may act out aggressively. Performance in school may suffer and children may become withdrawn or show a lack of interest in previously interesting hobbies and activities.

External Support:

Immediate and extended family can provide tremendous physical and emotional support to the cancer victim and family. Loving and caring family, neighbors, and coworkers may offer assistance to the cancer patient and their family during difficult times and to the surviving family after the death of the cancer patient. National and local support groups can provide valuable information, counseling, mutual support, and other services for the cancer victim and family. Many patients and family members can be expected to surf the Internet for information about cancer and both conventional and alternative therapeutic options. The physician can proactively provide 'a lists' of a few of the better information sources and Internet sites to guide the patient and family to more reliable and accurate information.

The physician must never underestimate the power and value of a deep religious faith. Religion may affect patient choices about therapy¹¹. Even though not previously overtly religious, many cancer patients and families find great inner strength in

prayer and in the church community. Faith and a feeling of purpose in life can provide the inner strength necessary to get the cancer patient through a long and difficult therapeutic course. For the terminal patient, faith can ease the acceptance of, and reduce the suffering from, their inevitable demise.

External Pressures:

Family and friends frequently offer unsolicited opinions and advice to the cancer patient and their family. Some may be helpful, such as advice on how to handle a similar difficult situation. Unfortunately, not all advice is helpful. The cancer victim and family may also be exposed to sometimes strong recommendations to seek second and third opinions, often from well-meaning family and friends, or to seek alternative care locally or overseas for some wonderful new cure, only available in Mexico or elsewhere. Formerly supportive family members or friends may become very critical of the cancer victim's immediate family or physicians if there is a perceived lack of courageous effort performed on behalf of the cancer patient. Education of the family can alleviate these concerns.

Patient and Family Concerns:

Cancer patients are suddenly forced to face a myriad of issues: the diagnosis of cancer, possible mortality, radiation and chemotherapy and their side effects, and the possibility of disfiguring surgery. Many do not initially realize that their course of treatment may be a long and arduous course, even if successful. Many hope for a one-shot, quick treatment of

their cancer with a lumpectomy or some other easy cure. Some may express seemingly inappropriate concerns or requests such as breast-conserving surgery for advanced breast cancer or extensive surgery to eradicate multiple distant metastases. Patience and appropriate education may help the patient and family come to a more realistic understanding of their situation.

Patients are fearful of pain and other symptoms that they may experience either from either the cancer itself (pain from bone metastases) or from surgery, radiation, and chemotherapy. Reassurance of the patient about the large number of excellent options to control pain and nausea may help ease these concerns. As trivial a complication as it may seem to the physician, hair loss is no small side effect to the cancer patient. One female physician with breast cancer indicated that she was very upset about losing her hair from chemotherapy and stated, "I felt naked without my hair!"

Terminal patients face a host of additional burdens including preparing a will, making funeral and burial arrangements, and, particularly for younger adults, preparing their spouse and children for life after their death. Other factors important to quality of life in terminal illness can differ by role and by the individual¹².

During cancer treatment, some patients face other severe stresses such as spousal estrangement, divorce, or abuse. Marriages and families, possibly already under stress for other reasons before the cancer diagnosis, can easily be pushed beyond the breaking point. The

cancer patient may have to face the disintegration of their family at a time they are most in need of family support.

Outpatient Cancer Care:

The increasing move to outpatient care, outpatient surgery, and shorter inpatient stays has had many benefits, not the least of which include cost savings, reduced risk of nosocomial infections, and keeping the patient in the midst of their supportive and beneficial family milieu. However, this shift comes with some cost to the patient and their family. Complicated outpatient oral chemotherapeutic regimens, postsurgical wound and Hickman catheter care, and even subcutaneous injections are now commonly left to the already burdened and stressed cancer patient and family¹³.

Education and training of the patient and family can ease concerns about their ability to provide care previously provided by physicians and nurses in an inpatient setting. The patient and family may have a confusing array of oral cancer chemotherapeutic agents, corticosteroids, antibiotics, pain relievers, antiemetics, antidiarrheals, and antipyretic agents that can be difficult even for a physician or nurse-spouse of a cancer victim to properly manage! Family members may not be informed of all the subtle nuances of effects and side effects of home medical and postoperative care. Important side effects and new problems may not be recognized until relatively late by the cancer victim and family. Visiting nurses, home health care, hospice, and detailed written patient education

brochures can be invaluable to the patient and family in this matter.

Cancer Clinical Research:

Many cancer patients have a decidedly mixed view of participation in clinical research. Often cancer victims eagerly express interest in the "latest available" potential cancer treatment or cure but then, are hesitant to participate in clinical trials with placebo or comparing older to newer therapeutic regimens. They want the best treatment and may be eager to accept the newest therapeutic option or vaccine as the best hope for a cure. An honest presentation of the options, and the offering to assist in the procurement of a second opinion may help the patient and family feel more secure in the chosen therapeutic options or clinical research participation.

After Death of the Cancer

Patient:

After the terminal cancer patient dies, physician and support staff commitment to the patient is obviously over. Such is not true for surviving family. The abrupt disappearance of the physician can leave the family feeling abandoned. While families do not usually expect the physician and health care workers to attend the wake or funeral, physicians can oversee efforts and inform families of options administered through hospice and other organizations. Surviving adults may benefit from support groups. Children may benefit from art and music therapy and child-oriented support groups. Important as it was while the cancer victim was alive, the need for outside support of family,

friends, and others can become even more critical after the death of the cancer patient. The family that was handling cancer stresses poorly before the patient's death may have even more difficulty after the cancer victims' passing. Even the strongest of families can benefit from various family and support services.

Summary:

A total medical care and patient and family support care approach is needed for the cancer victim and family. Helping the patient physically, emotionally, and spiritually can provide benefits far beyond that possible with just a narrow focus on the most up-to-date and highest quality medical and surgical care (14). Cancer patients and family will be forever grateful to physicians and health care workers who attempt to address all these important needs.

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Simulated Teaching Experiences - A Teaching Tool

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In order to train young professionals in various skills (such as communication), we describe an innovative teaching method for professional education, which we refer to as a simulated teaching experience (SIMTEX). Consistent with the principles of adult education, SIMTEX allows learners to learn in a clinically relevant learning climate, learn according to their needs, be involved (at least, to some extent) in planning the learning experience, participate actively in learning experiences, and receive feedback on their performance (Knowles, 1975). SIMTEX is a method of teaching professional skills using tailored instruction, in which the teaching is responsive to and based on learners demonstrated or elicited needs (Hewson, 1992).

SIMTEX offers a combination of micro-teaching (a method for organizing instruction on a single, elemental idea or strategy) (Merrill in Reigeluth, 1983), case-based teaching, role-play (Cohen-Cole et al, 1995) and simulations (Hoppe, 1995). In addition, the SIMTEX approach can be organized to utilize multiple stations, allowing the possibility of teaching large groups at one time. In this respect, the organization of SIMTEX is similar to that of Objective Structured Clinical Exams (OSCEs) (Hardern, 1975).

The SIMTEX structure involves a case-based approach to teaching how to teach (Shulman 1992), and is an

adaptation of the use of standardized patients for teaching medical students how to handle medical situations (Simpson et al, 1992). SIMTEX focuses mainly on teaching issues instead of medical ones, but can be used for both. The approach is characterized as follows:

1. It utilizes trained persons representing a student or resident with an interesting learning problem that provokes the learning group to focus on an important issue or strategy. For example, how to teach a student who is defensive or lacking important information. Or how to teach a student who needs to learn how to interview a rambling patient.*

2. Each learning group consists of a facilitator, and a group of 4-8 learners

3. Persons in the group elect to simulate characters such as the student, resident or faculty (they may play out a role or may play themselves) and respond to the presentation for a given amount of time (usually short, eg, 1-5 minutes)

4. The group then engages in facilitated discussion about the performance and the issues raised..

5. The facilitator brings each SIMTEX to conclusion by asking for a group summary, and may use checklists or published materials to summarize the topic.

6. The SIMTEX stations are timed and at the end of the designated time the group moves on to the next station, or the simulated patient or learner moves on, which can be more efficient, especially when the group is large.

* In some SIMTEX cases there can be two nested interactions that

form the focus of conversation: a student interviews a patient, and a faculty works with the student by giving feedback. In this situation, the facilitator organizes both levels of the simulation, and negotiates which players will be asked to give feedback.

The Role of the Facilitator

The facilitator does not teach overtly but helps the learning group to reach their own conclusions about how to respond to a given scenario. The facilitator's responsibilities include:

1. **Orientation:** The facilitator introduces the teaching topic and describes the purpose and mechanism of the SIMTEX process. The facilitator explains that as many people as possible will have a turn to encounter the issue/case being presented. The facilitator assures the group of confidentiality, establishes a friendly, non-judgmental, non-threatening learning climate by emphasizing collaboration and mutual support. The facilitator encourages the group to relax and be informal. We recommend that the group sits in a circle (without a table, if possible). In preparation for the simulation, the facilitator describes exactly how the simulation will take place and how the debriefing will occur.

2. **Elicitation:** The facilitator elicits the group's ideas on the general topic and invites them to share their recent experiences with the issue in their own life. When a range of problems, examples, or scenarios have been elicited the facilitator narrows the field by helping the group decide where to focus. The facilitator encourages the

group to explore several factors relevant to the issue. Based on this discussion, the facilitator selects a scenario for a role play. If the topic has been clearly delineated *a priori*, the facilitator will provide a prepared case relevant to the topic, and will be accompanied with an actor trained to simulate the particular role.

3. **Discernment:** The facilitator advises group members that they will be asked three questions about the simulation: What went well? What could be improved? How would you do it differently?

4. **Instruction:** The simulation proceeds and the facilitator stops it at an appropriate moment (when events have become worthy of discussion). The facilitator first invites the person in the hot seat to reflect on his or her performance and feelings about the experience, followed by the actor, and then the group members contribute their ideas. The facilitator follows up the discussion and may add his or her thoughts (if appropriate). It is NOT necessary for the facilitator to teach the group but may add his or her comment and relate the points made to the theoretical premises or guidelines concerning the issue. However the facilitator should warmly thank all the people who take on roles and give positive feedback wherever appropriate.

5. **Application:** The facilitator invites the group to suggest how to improve the simulated behaviors and invites the group to apply them to a follow-up simulation. This should engage as many people as possible with the simulation by inviting different people to be in the hot seat. The simulation can roll back to start at

the beginning, can start where the previous role play left off, or can fast forward to a future moment. This allows for discussion of several contingencies (variations on the theme).

6. **Summary and Review:** The facilitator invites the group members to share their insights and take home learning points. The facilitator may provide materials pertinent to the discussion topic (eg, published papers, screening tools, check lists), and may invite group members to follow up the event with a homework assignment.

The SIMTEX approach has been used successfully in faculty development courses at the Cleveland Clinic. In one course, we invite medical students to take on specific roles (eg, a student who has problematic performance and needs feedback, or a student who is new to ambulatory medicine and needs to be oriented to the clinic and to the faculty's expectations of the student. It is important to note that the students give excellent feedback that is highly appreciated by the physicians who play the faculty roles, and that the simulated students themselves learn how to behave appropriately in the clinical settings and how to deal with specific learning problems.

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Fit Column

A FIT Reflection on the Winter Course

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We spend years learning how to be a doctor and being taught how to be a doctor. And somehow, as soon as we acquire our degree, we are also expected to teach with really no attention at all having been paid to the skills and needs of the teacher we need to become. As PGY-1's we are expected to teach medical students and as PGY-2's to teach interns and students. As senior residents and attendings we teach all of the above. Sometimes we work with individuals; at other times in pairs, small groups, or large conferences. We teach formally or on the run, but usually with no prior care to our personal development as educators.

Through its annual summer and winter courses, and through the Facilitator-in-Training (FIT) program, the Academy offers educators at all levels the opportunity to discover their strengths and weaknesses. It invites us to identify our learning needs and goals in that arena, and then offers supportive opportunities for us to accomplish those goals. The winter course for FIT's and faculty of the academy, held this year in Pittsburgh, is now long past. Near the end of the course, the FIT's gathered to describe for each other the kinds of

skills, teaching as well as facilitating, that they felt they had learned during the course this week. Following is one example of the learning that occurred.

One FIT wanted to better engage a resident around the issue of motivational interviewing with regards to patient nonadherence. The FIT roleplayed the resident. Faculty and other FIT's would participate by roleplaying in quick succession the attending in a precepting encounter with this resident. While setting up and executing the role-play, this teaching situation clearly exemplified at least three important parallel processes. First, we wanted the resident to experience with the attending the same qualities of interaction that we wished the patient to experience with the resident. The resident would thus experience motivational interview as part of the precepting encounter.

Second, the techniques of motivational interviewing applied to the attending-resident interaction as well as to the resident-patient interaction. In other words, the attending could experience "letting go" his desire, to some degree, for the resident to change a practice behavior. The rolling role-play technique then allowed us to hear and to experience the interchanges of three "attendings" with the resident and to identify which approaches and which language seemed most effective in achieving the desired goal.

Third, the role-play became a vehicle for the group to understand itself more deeply as group members encountered inter- and intrapersonal conflicts before and during the role-

play. Who was heard and who was not? Some members seemed more engaged than others, and some people were hurt. All of these dynamics had been present for the preceding two or three days, but the experience allowed us to learn more fully about the microcosm in which we were enacting a role-play but playing out our very real personalities and behavior patterns.

Much of the learning that occurs at Academy courses comes in surprising and unanticipated forms. Learning exercises become more deeply meaningful than originally intended. As a result, we hope to become more mindful of our roles as physician-teachers at home so that we can better recognize our impact, even sometimes what is unintended, on our learners. ■

Behavioral Science

Introduction to the Behavioral Science Column

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The behavioral sciences have much to contribute to the practice of medicine. It is estimated that at least half the symptoms for which patients seek primary care consultations are not accounted for by clear organic pathol-

ogy. Rather, psychiatric disorders such as depression and anxiety, psychosocial problems such as family violence and abuse, and everyday stressors such as work and relationship problems often manifest with physical symptoms. These symptoms bring the patient to the physician's office. A relationship-centered approach to care encourages the patient to share some of these concerns. But how best to address them? There are many treatment options and intervention models that focus on increasing the patient's sense of self-efficacy, managing symptoms and addressing underlying disorders. Familiarity with the range of treatments available enhances the physician's ability to provide optimal care, to address psychophysiological symptoms and to refer the patient to appropriate mental health clinicians when necessary. Classical theories from the psychological literature on transference, personality styles, and attachment theory can help inform physician-patient interactions, influence patients' ability to cope with illness, and even affect medical outcomes.

This new column will provide information from the behavioral sciences on relevant theories, diagnostic tools, clinical interventions and research data. Please send ideas for future articles, submissions for possible publication, and other thoughts or ideas to: alyce_getler@hms.harvard.edu I look forward to hearing from you! ■

Pediatric Perspectives

Inaugurated in 2000, Pediatric Perspective is a column devoted to work with children, adolescents and their families. I invite you to submit narratives, , essays, research, editorials, and other pieces along with any ideas you have about topics that you would like to see in Pediatric Perspective. E-mail submissions and ideas to: elizabeth_rider@hms.harvard.edu.

Howard King, MD, MPH is a pediatrician with training in child psychiatry and public health. He is the former chair of the subcommittee for mental health of the Massachusetts Chapter of the American Academy of Pediatrics and has organized programs on childhood and family depression and strengthening the partnership between doctors and their patients. Dr. King is an associate medical director for the Medical Delivery Organization for Newton-Wellesley Hospital, Newton, Massachusetts. He has had pediatric practice for many years. Dr. King's article applies to all clinicians who work with children, adolescents, and their families.

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The Psychosocial Assets of the Pediatrician

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Pediatricians sometimes think they will be "starting from scratch" if they address the mental health issues of children. They don't realize how much they are already doing that can help them in this area.

Although you may feel you lack the training of a mental health clinician, that seeming deficiency is balanced by your natural intimacy with many mental health concepts. You make use of this knowledge all the time in your work with children and families, often without realizing it.

By reminding yourself of the following attributes of your relationship with parents, you may feel even more confident when you work with families.

The pediatrician as historian

Over time, listening to parents discuss concerns about their children, you can often understand the ways in which certain families may be vulnerable. You may be able to use their history to discover why a particular family member may have evolved to become the representative for the family conflict.

What you hear may seem initially confusing. However, your observations over time will make increasing sense and may suggest potential opportunities for intervention.

The development of trust

It takes time for parents to form a trusting relationship with a therapist. In contrast, family members have

usually known you for a long time. If they believe you are willing and able to intervene at the right time, parents may be ready to be engaged, psychologically, when the need arises.

Furthermore, you have developed credibility and trust through previous successful interventions involving illness and physical health problems. The transition to viewing you as an ally for emotional crises may frequently seem very natural to parents.

Crisis intervention

As a pediatrician, you play a unique role as witness to all the developmental stages from birth to adulthood, not to mention the various joys and sorrows to which families are exposed over time. On such occasions, a host of complicated feelings emerges between family members. Relationships change and require new adjustments. With your understanding of the family history, you may be very helpful by suggesting opportunities for more constructive attitudes and choices when they confront such issues.

A reflective attitude

A psychologist studying two groups of children, one with anorexia and one without, speculated that one factor, among others, might account for the difference. She suggested that a characteristic of the parents in the control group was the existence of a "reflective attitude." Those parents seemed to have an introspective but not guilty nature, a striving for healthy dialogue between parent and child. They seemed to be working to understand their children's behavior but not be so preoccupied that they

failed to give their children the space and direction they needed to grow as separate human beings.

You use your well-child visits, without realizing it, to encourage this reflective attitude. You ask questions like, "How is your child doing?" "What are you pleased about?" "What are you concerned about?" "What do you think it means?" "How are you doing?" "How are you and your spouse (or partner) doing?" These questions, and others, stimulate parents to reflect, constructively, with you. Such parents, in turn, are often able to adopt a similarly reflective attitude with their child.

Steering the family through a morass of experts

There is the danger that, by asking such questions, parents may wonder if you are being judgmental. Not so. You are merely trying to help them articulate how they feel. You are not just being supportive but are also encouraging them to use their intuition and healthy gut-feelings.

There are many issues about which "experts" write and lecture. The point is that for such issues there are no right answers, only right answers for *some* people. Your task is to help parents come up with a solution, in a logical way, that reflects their own feelings and what is appropriate *for them*. Ideally, you are not just helping parents deal with a problem today, but rather with how they and their children cope with problems for the rest of their lives.

One of your objectives, therefore, is to protect parents from feeling guilty as they encounter a variety of experts who tell them that there is only one

way of doing things.

The concept of the "right-lower-quadrant"

What do you do when you try to decide if your patient has appendicitis? You start your exam in the left upper quadrant and gradually work towards the area of greatest discomfort, i.e. the right lower quadrant.

Similarly, when you are dealing with a family in pain, you try to understand what is going on with the family as a whole, what their strengths are as well as what they are worried about. Gradually you discover the real issues. You don't avoid those issues because you fear you may, temporarily, bring pain or sadness to the surface. If you have the family's permission to do so, your investigation may bring a secret problem to the attention of all concerned and, by so doing, may bring relief.

Searching for strengths

The evaluation of a family problem means exploring the total functioning of a child and his family. Problem areas may be discovered that need attention. But, just as likely, investigation can bring to light many areas of mastery and competence for both the child and parent.

It is important to discover these strengths. Helping parents remember what they have accomplished may give them the esteem and confidence to deal with issues that remain to be resolved.

The child as an agent for change

As parents help their children through the stages of emotional growth, they inevitably encounter

experiences that may bring to mind troubling memories and feelings of their own that may have become repressed. Sometimes their coping methods have been successful. Often, however, they have not.

As children go through these different stages, the parents' old adaptations may be disturbed. It can be like when a scab is peeled off, revealing a poorly healed wound. At such times, parents have the opportunity to reexamine such wounds and contemplate how successful, or not, they have been in resolving such hurts. In short, children, without realizing it, give parents a second chance to revisit their past and the opportunity to resolve some of their old problems.

When parents express thoughts and feelings about their children, their defenses against thinking about themselves may be less rigid than at other times. If you have a good alliance with parents, you can help them clarify such issues. In that sense, the child may do as much for the parent as the parent does for the child.

System theory

It is common, in a well-child visit, that you may end up considering several family members simultaneously. A parent comes in to talk about one child who has a rivalry with another sibling. This may remind parents, in turn, of how they interacted with siblings when they were younger and how their parents dealt with it. So, unlike other physicians, you may be involved, consciously or unconsciously, with systems.

Systems theory as it pertains to families takes into account not only

how individual members relate to each other but also how the family as a whole develops and changes over time. Thinking about families this way may help you understand causality in regard to childhood problems, and may even suggest useful ways of intervening.

Parenting, the archetypal way to gain competence

Regardless of how people are raised, regardless of their education or status in work or marriage, all of us are given a fresh start when we become parents. As potential allies to the parent, pediatricians have a great opportunity to help nurture that sense of competence.

The parent who acquires competence in *this* role can usually master most of the other challenges in life.

The routine office visit as a corrective experience

As a pediatrician, you shouldn't feel you are just a source of information. You are also seen as an authority figure (although maybe less so these days). Regardless of how you present yourself, parents may view you, and respond to you, the way they responded to other authority figures in their past.

How would you characterize the ideal pediatrician-parent relationship? Might it not include patient listening, a non-judgmental attitude, permission for the parent to express a variety of feelings, and an absence of ridicule and condescension? You are always in a position to give advice. You may be most successful, however, when you help parents understand that they have choices and that they can

develop a sense of competence in making good decisions.

Furthermore, parents may use the relationship with you as a model for learning and, in turn, a model for how they can listen and intervene constructively with their children.

There are other aspects of the office visit from which parents may gain insight. For example, many of the families you see may have difficulty expressing feelings, and some may tell their child that "big boys don't cry!" But throat swabs are unpleasant, shots do hurt! It may be useful when you give an injection or take a throat culture to say, "It may hurt a little ... It's all right to cry."

Such corrective experiences for children and their parents, however trivial they may seem individually, become increasingly significant in the aggregate, helping both parent and child gain confidence and express feelings.

Working with parents where they're at!

You will be more successful in helping parents manage the emotional growth of their children if you consider starting with where the parents are.

Suppose a parent came in with a four-year-old child, concerned about tantrums and the child being "out of control." The parent wonders if the child has food allergies or could be hyperactive. You may personally believe that the tantrums are emotional in origin. Your task, then, is how to help the parent consider that possibility and manage the child's behavior from that point of view.

If that is the case, you will have a

number of tasks. You may ask yourself (and, ultimately, the parent) why the parent would consider the unlikely possibility of food allergy or hyperactivity. At the same time, you want to convey respect for the parent who has shared that belief. At some point, you will express your own contrary, even though tentative, point of view. Still, consider offering parents the choice (e.g. temporarily exploring food allergy) and leave it to them to follow their own initiative.

Double- and triple-identification

You may be the first person to hear inappropriate labels attached to a child, e.g. the one-month-old infant who has a “terrible temper” or who is “high-strung.” (Is she talking about her spouse or her siblings?) Or you may hear about the six year old with a “binge for crackers” (reminiscent of an alcoholic grandfather?).

You don’t know if these things are true unless you think about listening, not only to the parent but also to *your own* senses as you become aware of an inappropriate label applied to the child. At that point, ask yourself whether the parent is really thinking about some individual either in her present life, or in her past, to whom she is attached by an important unconscious conflict.

In short, you may wish to consider that parents may identify the child with people from the parents’ past. How you verify that intuition and how you share it with compassion is another matter, but it is important for you to recognize it.

Combating the self-fulfilling prophecy

How many times have you heard parents say such things as, “I’m going to have a lot of problems with her when she is a teenager” ... or ... “He is a high strung kid!” ... or “He’ll never change!”

You will have many opportunities in your pediatric visits to constructively confront parents, at the appropriate moment, when they express such ideas and ask why they contemplate such outcomes.

The longitudinal benefit of psychosocial pediatrics

Pediatricians need to remember that the emotional growth of parents occurs over time. It is an evolutionary process that occurs during the entire span of their children’s lives.

Each crisis, each developmental stage of a child, in fact, each child in a family provides parents with opportunities to gain insight and acquire mastery over a variety of unresolved life experiences.

The relationship between you and parents is like a book with many chapters. If you have a collaboration with parents based on trust and mutual respect, the outcome would seem salutary for the child and the *family*.

Additional articles by Dr. King can be read at his website: <http://www.drkingsoffice.com> ■

Poetry Encounter

“The Number” by Mary Ray Worley, like all good poetry, reverberates with meaning. At one level “The Number” is a wry and well-crafted response to our cultural obsession with weight and body image. Weight loss, or at least the quest for it, is big business. And self-esteem teeters precariously on “the tiny platform / with the fateful dial.” However, I almost immediately slipped into reading “The Number” a different way, reflecting another cultural phenomenon; that is, with regard to doctor-patient relationships and patient care. This is the patient speaking: “I have no face, / I have no voice...” Unfortunately, too many patients experience their medical care in this way. “I am reduced to this / number... This number / carries more weight / than I do.”

- Jack Coulehan

This Number

Mary Ray Worley

Stripped bare,
I take one heavy step
and then another
onto the tiny platform
with the fateful dial.
The number, the number
spins across the dial
Until its judgment is settled.
The number decrees
whether I am good.
All I have done,
all I have taken in,
all I have become

comes down to this,
 this number, this number.
 Each calorie of love,
 each morsel of pleasure,
 each nugget of sweetness
 bears down and down,
 and I am roundly condemned.
 I have no face,
 I have no voice,
 no mind, no thoughts.
 I am reduced to this,
 this number, this number.
 I am only
 this number.
 This number
 carries more weight
 than I do.

You are cordially invited to contribute your work to Poetry Encounter. Please send your poems for consideration to Jack Coulehan, Medicine in Society, HSC L3-086, Stony Brook University, Stony Brook, NY 11794-8036.

Special Addition

In Memoriam - Lorenzo Bignamini, M.D.

William H. Salazar
 Kathy Cole-Kelly

Memories:

That cold, winter afternoon Lorenzo told me, "William, it is great to share the room with you and to know that you are Catholic. We can pray at night. You can pray in your

own language and I can reply in Italian!" Indeed, for Lorenzo prayer was an integral part of his daily life. During the Pittsburgh Winter Course in 2003, every night, Lorenzo and I found each other in deep meditation before going to sleep. We prayed for our families, for the AAPP, for peace, for our patients, for the poor and for the rich.

Lorenzo and his family had just finished vacationing in India. He was astonished by the socioeconomic imbalance and the poverty of India. So often he told me how lucky he and his family were to have all the luxuries they had, and he continually reflected on how lucky many people were in the United States, especially health care workers.

We also laughed together a lot, and we made plans for the future. We shared pictures of our families and we talked about the love we felt for our wives and children. Lorenzo made me remember those wonderful college days when you formed those wonderfully strong relationships with those who were going through a journey similar to yours.

Tragedy:

Lorenzo Bignamini, 41 years old, died on August 10th when he was

stabbed to death by a former psychiatric patient. His wife writes:

"Dear Friends,

I am very sorry to tell you like this, but I need you to know that Lorenzo has been killed last Friday by a devil of a beast patient he had. He is dead as a hero and a martyr of his profession, but for me is just a wonderful partner and spouse and father missing. This is what I can say now, but

maybe you all can pray for him. With my tears and faith,
 Donata

Work:

Lorenzo was a true force in Italy in the field of Doctor-Patient Communication. He had established a network within the country and was a major influence in the dissemination of doctor-patient



communication work in medical schools as well as other health professional institutions.

Lorenzo was also intrigued with the relationship between spirituality, health and healing. He was authoring a special section of an Italian medical journal devoted to this topic. He was President of the Italian Society of Medical Clinical Psychology and Commissioner of the Order of Doctors of Milan.

Lorenzo came to the U.S. for the

June AAPP course in 2002. For him, the experience was life-changing. He wanted to expand AAPP in Italy and some day be able to hold a meeting there. In January of 2003, Lorenzo came back to the U.S. and participated in the Pittsburgh winter course. Again, he was delighted with what he experienced and constantly reflected on how he could integrate what he learned into his work and his country.

Inspiration:

Our colleague Kathy Cole-Kelly had the distinct pleasure of hosting Lorenzo in this country for two weeks before the course, and then being with Lorenzo and his incredible family, in Italy, for three weeks. She writes the remainder of this remembrance:

“Larger than life. That phrase can be used casually to describe someone, but never has this description been more accurate than when applied to Lorenzo Bignamini. Lorenzo was and is larger than life. His vitality was contagious. He had the wonderful mix of a mischievous nature, of whimsy and spontaneous play, of passion for his wife, his children and his special friends and for his work. Lorenzo loved life. Lorenzo was life. He didn’t do anything half-heartedly. He dove into every experience with a vigor, enthusiasm and curiosity that made his being so powerful.”

“Everywhere we taught, it was clear that Lorenzo was a distinguished, respected leader in the field of doctor patient communication. His enthusiasm, seriousness of commitment and creative talents were well acknowledged by the multiple professionals we

encountered throughout the country.”

“But of all the images and reflections that I have of Lorenzo, the most beautiful ones were to watch him with his family. They—Lorenzo, Donata, Anita and Mathilde — had a dance that was as magnificent to watch as to watch the Bolshoi Ballet mixed with Martha Graham. They worked together, they laughed together, they played together, they explored mountains, they learned about the herbs and wildflowers, and they traveled to new continents. They learned about the people, about the struggles and about the beauty of their personal and physical surroundings. Their dance was a combination of jumps, of waltzes, of slow dance, of country fiddlers. They moved together as one yet they rejoiced in each other’s individuality. Lorenzo and Donata co-led the dance, each contributing their spirit, their balance and their zest for life and learning and living.”

Lesson:

Lorenzo had a sense of humor that was both playful and clever. The sense of play was such a central part of who he was. It was evident with his family, his friends and his patients. He took play to new heights in his therapy. He took everyone to new heights in his friendship and support.

But Lorenzo’s playfulness and sense of fun didn’t mean that he wasn’t a very deep man. He was pensive, he was reflective and he was always stretching limits:

...Stretching limits within himself to grow and understand his thoughts and his work. ...Stretching the field of

psychiatry to incorporate the world of doctor-patient communication and of spirituality.

...Stretching to be as creative as he could in his very serious work with his patients.

Sorrow:

We will all miss Lorenzo beyond comprehension. Lorenzo’s death is a tragedy to all of us who knew him, to the fields of Doctor-Patient Communication and Psychiatry, and most importantly to his inspirationally strong wife Donata and their beautiful children, Mathilde 10 and Anita 12.

We will believe that Lorenzo’s vitality has not been extinguished... that he is here with us, spurring us all on to savor life as he did — with such total pleasure, generosity, desire for connection, sense of justice and spirituality.

So much love we send to Donata, Mathilde and Anita knowing the ache you must feel. May we all strive daily to continue the life-affirming approach that Lorenzo showed us. We hope by doing so, it can ease the pain a bit for each of us who will sorely miss Lorenzo.

To Lorenzo, with so much love and respect.

We are hoping to establish a fund in honor of Lorenzo that would allow other Internationals promoting healthcare communication to be able to participate in AAPP. The possibility of a scholarship fund that would allow AAPP to sponsor an international guest each year, in Lorenzo’s name, is under discussion.