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TOWARD A MORE MINDFUL PARADIGM IN ALLOPATHIC MEDICINE:

WHAT MEDICAL SCHOOLS CAN DO TO ENHANCE HUMANENESS IN THE PRACTICE OF MEDICINE

by

Marijke B. Hallberg
B. S. (University of California) 1991

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Sciences in Health and Medical Sciences in the GRADUATE DIVISION of the UNIVERSITY of CALIFORNIA at BERKELEY

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INTRODUCTION

*Education is turning things over in the mind.*

*Robert Frost*

Eric Cassell starts out his recent book, *The Nature of Suffering and the Goals of Medicine*, by saying that "the test of a system of medicine should be its adequacy in the face of suffering," and that "modern medicine fails that test."¹ He and several others corroborate the widespread perception, growing since the 1920's, that what is lacking in twentieth century medicine is an adequate consideration of the place of personhood in the patient, even though "bodies do not suffer, persons suffer."² His premise is that, although some changes have been made,

...for more than two generations remedies for medicine's dehumanization and impersonality have been a failure. Great teachers have tried, wonderful books have been written, innovative medical school courses and curricula have been established, and even new schools have been founded on ideas believed to offer solutions. For the most part, all these attempts, large and small, have been disappointments. Over these decades there have been many great teachers, more wonderful physicians, and nothing less than superb medical care to be found. But these islands of excellence remain just that, islands separated from the mainland.³

Consequently, patients are frustrated, physicians⁴ are frustrated, as are thousands of medical students. It has become a sad indication of the mutual distrust in post-modern medicine to hear doctors complain about their "selfish,

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² Ibid.
³ Ibid.
⁴ The words "doctor" and "physician" will be used interchangeably throughout.
demanding" patients, patients complain about their "egotistical, uncaring" doctors, while students are left wondering where, within this morass of stress, fatigue and mistrust, the human qualities of medicine exist.

In public surveys, physicians consistently rank poorly as trusted persons in our society. Patients, when asked about this perception often cite the impersonal treadmill of rushed, generic, technically-oriented care they receive in allopathic medicine, characteristics that are conspicuously avoided in the more "unconventional" forms of medicine such as chiropracy, faith healing, and various forms of mind-centered healing. According to an editorial in The New England Journal of Medicine, one third of all American adults may use unconventional medicine precisely for these reasons.5

As Edward Shorter puts it, "something is wrong with medicine today." Although patients are receiving far better technological medicine than at any other time in history, "medical care [italics mine] has in certain crucial ways deteriorated" creating an aura of mutual resentment and frustration; a tension that has "quite a direct bearing on whether or not the treatment is clinically successful." "In other words, medicine is currently in crisis."6

Bill Moyers recently aired a television series about this very connection between healing and the mind. His series revealed that researchers and practitioners alike are realizing the impact and importance of treating the whole person, mind-body-and-soul, rather than mere functional bits of disease. Eric Cassell calls it the "suffering" of illness, and relates how, in our present medical system, "doctors do not deal with suffering in the abstract - they treat persons who are afflicted by something that leads to suffering," and that the "separation of the disease that underlies the suffering from both the person and the suffering

itself, as though the scientific entity of disease is more real and more important than the person and the suffering, is one of the strange intellectual paradoxes of our time."7 It seems evident, then, that patients have very legitimate complaints about the way allopathic medicine continues to be practiced today, and that physicians desperately need to redefine the scope of their role in treating illness.

In 1984 the American Association of Medical Colleges (AAMC) acknowledged this problem with the publication of their recommendations for physicians in the twenty-first century. Central to the report was the expressed need to improve the level of humaneness in medical practice. The report stated that "ethical sensitivity and moral integrity, combined with equanimity, humility, and self-knowledge are quintessential qualities of all physicians."8 This report constituted the first official call for more humane qualities in the physicians being trained, and medical schools responded by actively attempting to recruit students with more humane qualities. Peter Conrad was one of the proponents who stated that "the doctors who maintain a humanistic orientation to medical care appear to be individuals who had developed this orientation before they arrived at medical school," and that, to increase the number of humanistic physicians, medical schools need to "alter" their "recruitment and selection policies."9

It has been ten years since the AAMC published their GPEP report describing recommendations for physicians in the twenty-first century. There has been much more said about the need for greater compassion in medicine

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since then, but little done. Medical schools have tried to rectify the matter by recruiting a larger proportion of students who are older, have broader and more varied backgrounds, and have undergraduate degrees in the humanities. There was little evidence to support this as the only approach to the problem. Although there is some basis for believing that medicine attracts certain kinds of people, one would have to alter the prerequisites for entering medical school to appreciably effect the self-selection of competitive academic achievers as students.

The overwhelming evidence amassed over the years shows a general loss of compassion over the course of medical education, suggesting a problem with the way that medicine is taught. Recruiting students with particular backgrounds has done little to change the tide of physician outcomes. Although far more difficult to implement, it seems that medical school education now needs to look within itself for solutions to the problem of lacking humaneness in its graduates. Even Conrad admitted that students have to struggle to maintain a humanistic or patient-oriented perspective in a social environment of medical training that "militates against humanistic doctoring."\(^\text{10}\)

Others such as Walerstein et al assert that things are getting worse as "the gap between the needs of trainees and their educational programs is widening."\(^\text{11}\)

In summary, given the transforming nature of medical education, selecting students with prior humanistic qualities does very little to increase the number of humanistic physicians produced at the other end of the process. The object of this thesis is to suggest that a more effective approach to increasing humanistic

\(^{10}\) Peter Conrad, "Learning to Doctor: Reflections on Recent Accounts of the Medical School Years," *Journal of Health and Social Behavior* 29 (December 1988): 323.

qualities in medicine might be to humanize the process itself in order to encourage and develop humanistic qualities in the physicians produced.
THE STATUS QUO IN MEDICAL EDUCATION

Where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?

· T.S. Eliot ·

Upon entering medical school, medical students quickly and inevitably become powerless victims to the fast pace, overwhelming responsibility, and rigorous demands of the curriculum. A recent article in the New England Journal of Medicine, appropriately titled Great Expectations,\textsuperscript{12} documented the hours spent on curriculum studies by second year medical students. They found that, on average, students are required to spend about thirteen hours of every day (including weekends) either attending classes or preparing for classes. An extra hour is assigned for recommended reading, leaving a mere ten hours per day for eating, sleeping, washing, commuting, socializing, and taking care of any additional activities of daily living. As LeBaron put it, "there's little doubt that we're being trained not to regard any time as a personal preserve."\textsuperscript{13}

While the knowledge base of medicine has been escalating rapidly since the Flexner model was introduced in 1910, the time allotted students to acquire and master the relevant basic science of medicine remains the same. The curriculum simply packs too many facts in too little time. Back in 1980, Anderson and Graham estimated that medical students were expected to learn 50,000 facts during the first two years of medical school.\textsuperscript{14} That was 14 years, thousands of studies, and as many publications ago. The information explosion

\textsuperscript{13} Charles LeBaron, Gentle Vengeance: An Account of the First Year at Harvard Medical School (New York: Penguin, 1952), p. 79.
\textsuperscript{14} J. Anderson and A. Graham, "A problem in Medical Education: Is There an Information Overload?" Medical Education (1980): 4-7.
remains exponential. As pointed out by Clive Taylor in his recent article in the New England Journal of Medicine, there simply are not enough hours in a week for students at most medical schools to fulfill their scheduled obligations. The information students have to memorize has become so vast that, not only is there little room left for teaching other aspects of medicine, but the information load is fast becoming unmanageable.

Taylor describes just how overwhelming such expectations tend to be, leading students to respond by skipping classes, doing far less than the required reading, and picking only the parts they find palatable. In effect, then, by overloading the students' schedule with required learning material, teachers of preclinical medicine may inadvertently be creating a situation where students cannot benefit from the guidance faculty may have to offer, and instead learn independently of the system.

Becker et al, in their landmark book on student culture, describe a similar phenomenon attributed to excessive expectations. They found that students responded by developing inter-student networks to transmit information regarding what material their instructors really wanted them to know for exams. Although this may seem to be a healthy response, Charles Le Baron discovered that portions of the material inevitably ignored are "the general theory behind the problem, historical points, social impact, cost factors, direction of future investigations, etc." Melvin Konner echoed the very same sentiment, saying that "too many facts are being taught in too short a time." Philip Reilly summed it up well in his personal account:

Topics of immense importance slipped by us with frightening speed. ...I felt as though I were standing before a conveyor belt watching information move by. The more I worked, the less I seemed to learn. Each evening the price for seriously studying one topic was to learn nothing about the other assignments. Each time I remembered that the next time I dealt with one of these subjects it would be due to the illness of a real person, I winced. The professors did little to alleviate our anxieties. Unlike the nice folks in the basic sciences, the clinicians were quick to criticize our competence. Within two weeks I must have heard my pathophysiology seminar group indicted for stupidity at least six times. These put-downs were probably intended to make us work harder, but they had the opposite effect. Attendance began to drop off, people began to admit defeat, and a few opted to spend their afternoons in the gym.¹⁹

The first two years of medical school amounted to two years of anxiety and claustrophobia.²⁰

Clive Taylor agrees that the curriculum is too broad and too overloaded, and that there is "too much emphasis on minute detail and too little on the development of broad principles."²¹ Numerous authors seem to echo what has been expressed for at least the last 60 years by various people. William J. Mayo, for example, stated back in 1933 that "one of the chief defects in our plan of education in the country is that we give too much attention to developing the memory, and too little developing the mind."²²

¹⁹ Philip Reilly, To Do No Harm. (Dover: Auburn House Publishing Company, 1987), p.84-5
The emotional onslaughts of medicine are also legendary, and has provided material for a multitude of quips, books, and anecdotes. Most medical students are still in their early to mid-twenties upon entering medical school. Being confronted with death, pain and suffering in the clinical years is the first introduction to human tragedy and misfortune for the overwhelming majority. Medical educational curricula do little or nothing to prepare students for this side of their experience. In fact, the current medical model of dealing with the rigors of medicine is almost curt in its simplicity. It could even be construed as a form of "denial" in that it continues to stress the development of an exterior shield of personal and professional toughness, without which, it is assumed, no human being can possibly face the emotional rigors of the profession.

This notion is reflected in detail in A Fortunate Man by John Berger where the protagonist, John Sassall, is initially drawn to medicine under the somewhat romantic notion that it is, like Conrad's descriptions of the ocean, "unimaginable," and that "the only men who could face the unimaginable were tough, controlled, taciturn and outwardly ordinary."23 Sassall's image at that time was not unlike the way many physicians continue to see themselves today: as persons "all-knowing, but looking haggard...in command and composed - whereas everybody else was fussing and agitated."24 What few seem to recognize is just how badly they themselves fare with the strategies learned in medical school, where caring and compassion were replaced with emotionally protective barriers, making it difficult for doctors to relate to emotional situations. Jacob Needleman describes his observations of the outcomes of such behavior in a letter to his old family physician:

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24 Ibid.
Doctor, I have seen your colleagues - many, many of them - show to their patients agreeable emotions that - forgive my crude language - are as shit compared to what I sensed in you in those days. And I have seen their coldness and indifference, their "importance," their "busyness": I have seen them all overburdened, their attention scattered or driven back by fear.  

[In the hospital] I saw only doctors solving problems, nurses carrying out orders and trying to give emotional support to the patients, and orderlies like myself doing much of the dirty work. When there was death or great suffering on the ward - as there was every day - the response was either businesslike acceptance or, sometimes, emotional reactions (when someone young or particularly interesting dies), or occasionally puzzlement. I soon found it all intolerable, young and inexperienced as I was. Every day the world of real reality was announcing its existence on the ward and people behaved as though this world did not exist, as though this world were not constantly pressing in upon us, insisting, demanding that we acknowledge it. I don't want to use the word God, but if I had to speak in religious language, I would say that every day God was thrusting his hands and legs into the ward and everyone was simply walking around them.  

There are also emotional stresses exacted by the learning environment in most medical education institutions where "pimping," negative feedback presented in belittling ways, lack of support or regard for individual needs are rife. The sense of personal sacrifice and deprivation students experience in medical school are all believed to "contribute to one's feeling of commitment - the hallmark of the medical profession" - from which it is assumed the public ultimately will benefit. Jacob Needleman offers a descriptive view of the sacrifices and suffering endured:

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26 Ibid., p.31.  
They [your teachers] demanded total dedication and you responded with total dedication. I know all about the mixture of vanity, fear, and ego that was part of their nature. They had big egos, granted. But that served something bigger than the ego and you felt that! They made you do without sleep, without money, without sex - like some burning monk seeking God. They made you give your attention to the big picture - the welfare of the patient - as well as to the tiniest technical detail, like some burning monk copying a sacred book. They rubbed your nose in your incapacities while demanding that you take it all with a quiet mind, a mind free of panic and self-love. They made you feel your responsibility - you were a doctor after all - while demeaning you in front of the real level of ability that was their standard of excellence. They made impossible demands.

The paradox seems so obvious: that an experience so much akin to a religious rite of passage can be so devoid of spiritual support. Perhaps this is why, in contrast to expectations, investigators have noted tremendous problems among students ranging from chronic substance abuse to feelings of "depression, dehumanization, anxiety, cynicism, and suicide." Studies have found that psychiatric problems are prominent in medical students, with up to twenty-five percent of first year students experiencing significant disorders unrelated to previous psychopathology. And as professionals, physicians are no less impaired.

The suicide rate of physicians is two or three times that of the general population, equal in number to the loss of about two medical school classes yearly. Alcoholism is at least as prevalent among physicians as in

30 Harvey M. Weinstein, "A Committee on Well-Being of Medical Students and House Staff." *Journal of Medical Education* (May, 1983): 373.
the general population, and under-reporting of physician alcoholics is likely. Drug addiction may be 30 to 100 times more common among physicians than in the general population... Retreat from family life is probably the most common adaptation to the demands of medical practice. A progressive emotional separation from family life in the early years of practice becomes a de facto divorce.32

The evidence points to medical education itself as "a major contributor to the development of impairment."33 Robert Broadhead also implicates the systems he talks about how medical education "delivers a jarring blow to students' private lives and sensibilities: it inundates students for more than ten years, and in this time creates enormous socio-psychological and developmental deficits."34 Impaired physicians are unable to take care of themselves, and are seriously impaired in their ability to present themselves as humane caretakers of others in need. Lacking the spiritual and emotional satisfaction they expected in their chosen profession, they often turn to the most immediate form of gratification available.

Aside from substance abuse, money, professional power and positional ego seem to be the most tangible way for graduated physicians to justify and balance the tremendous personal sacrifices that were made throughout the process of medical education. This is reinforced in medical school where students learn that physicians act as the "central character,"35 not patients. In addition, by focusing medical training on diseases in particular, and the heroism which has afforded medicine its modern renown for saving lives in real danger, an underlying annoyance for less serious, more subtle illnesses is fostered in

the process of professional socialization. Dr. Sassall, the country doctor in A Fortunate Man, for example, tells how "when a man continued to complain but had no dangerous symptoms, he reminded himself of the endurance of the Greek peasants and the needs of those in 'very real distress,' and so recommended more exercise and, if possible, a cold bath before breakfast."36 Patients, then, are gradually perceived as objective disease entities, and treated with little human compassion, and accorded as little time as possible. Robert Broadhead suggests that physicians' unwillingness to give more than the minimum amount of time allotted may represent a response to all the time that was sacrificed in training. "As every action produces reaction, ten-plus years of slavish devotion to training (called 'tyranny' by some) cultivate in students an adamancy to structure their professional practice so that they are free of such problems. A determination grows, derived from the impact of training, to plan their professional future according to their private bidding."37

If loss of compassion, psychosocial impairment, and an eventual focus on social power and financial rewards are direct consequences of an extensive process of sacrifice in the face of unyielding demands through the spiritually barren experience of medical education, it seems that steps not only could be taken, but should be taken to alleviate those factors most likely to contribute to the problems identified. But first one has to define what the goals are in order to have a clearer sense of what ends the means of education are intended to address. That is, one has to work towards a clearer picture of the humane physician and what that means in terms of the profession and its process of socialization.

MINDFUL MEDICINE

Until a man can be a physician toward himself, he cannot be a physician toward another.

- Jacob Needleman -

Much has been written on what might constitute the "good" physician, but, considering the intrinsic bond between medicine and society, any such concept is dynamic in nature. As Eric Cassell states, "what any era considers the ideal physician reflects an amalgam of the demands made by the reigning theory of medicine, the social forces acting specifically on doctors and sick persons, and the general social attitudes towards persons and their relations with each other."\(^{38}\) Changes in our society have been rapid in this century, especially over the last fifty years, and along with those changes, the concept of the ideal physician has also been transformed. For this reason, resources restricted to the last fifteen years have been employed to arrive at a current concept of the ideal physician. Ideals for the future can only be inferred.

Common to most descriptions of good doctors is the importance of the relationship between doctor and patient through which all medical care flows. Cassell affirms the relationship as mysterious, but only "because it is the foundation of the phenomenon of healing, itself obscure," but also "because it points to aspects of the connections between individuals which in a rational, essentially non-spiritual culture like ours are little known and less understood."\(^{39}\) It is precisely for this reason that medical education, which also teaches values, attitudes, and behaviors - not just facts - might do the profession better service by actively involving itself in encouraging the development of

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\(^{39}\) Ibid., p.x.
these qualities in the students it prepares for the future. "To be successful in treating the sick and alleviating suffering, doctors must know more about the sick person and the illness than just the name of the disease and the science that explains it."40 This goal cannot be attained without an intimate knowledge of the self and others, and the patterns of communication that bind the two in meaningful discourse. Such general knowledge is gained through the sharing of ideas, beliefs, and culture, and, "with skill and training even more of the person can be known, particularly when the knowledge is focused on the task of caring for the sick."41 To give historical depth to this interesting challenge, Cassell says:

Prior to the twentieth century, the body was largely a mystery. In the last century and in ours the wonders of the body have been revealed to the gaze of medicine with results that have reached far beyond medical science. Just as privacy about the body held back knowledge in the past, reticence about revealing ourselves presently retards learning about persons. Nonetheless our era has seen the beginnings. The job of the twenty-first century is the discovery of the person - finding the sources of illness and suffering within the person, and with that knowledge developing methods for their relief, while at the same time revealing the power within the person as the nineteenth and twentieth centuries have revealed the power of the body.42

Perhaps the most poignant remark Jacob Needleman makes in The Way of the Physician is that, in the end, people do not trust science, medicine, politics or religion; "people trust people."43 Themes throughout his book

41 Ibid., p.x.
42 Ibid., p.x.
revolve around the quintessential need for trust in the doctor-patient relationship; through strength, honesty, and competence. Needleman suggests that these attributes can only be forged through a process of watching, listening, and being fully attentive to oneself, to others, and to one's surroundings. That is, through being mindful. To this end, he believes that "medicine can never be taught only intellectually," being a "science of the heart" and that to be effective in teaching and in subsequent outcomes, education has to teach through an ecological foundation of concepts.

In the body there are many creatures - plants, animals, songbirds, devils and angels, and machines. Some push and pull, some run wildly after their food and sex, some raise their eyes to heaven and do nothing but sing, some spin and whirl according to mechanical law. In the sacred pragmatism of the whole of nature, all these creatures coexist in all their contradictions. You cannot meet the human organism when you yourself ride only one of them. You have to ride them all. You have to occupy the place of instinct, the animal forces of biological nature; you have to occupy the gardens of feeling and tenderness and sweet intuition where the language of the birds is spoken; you have to sit with the engines and machinery of the purely physical objects. You have to know when to pull levers, when to croon, when to shout, when to strike and kill, when to merely watch and wait, when to embrace, when to cut and separate - and through all the flesh and bones and guts you can see before you. You have to think, reason, prove - when necessary. 44

He goes on to say that "the power to do all that does not come from studying books, or from laboratory experiments alone, nor even from working with patients under the protective umbrella of professionalism and advanced technology."45 It comes from an intimate, mindful, self-reflexive experience of

the process itself. The most effective care, it is said, is given by those who have themselves experienced caring.

* A Fortunate Man * describes so very poignantly the preamble, process, and final outcome of a doctor's path to mindfulness. After his initially romanticized view of the nature of practicing medicine, Dr. Sassall begins to realize that the way Conrad's Master Mariners came to terms with their imagination - "denying it any expression but projecting it all on to the sea which they then faced as though it were simultaneously their personal justification and their personal enemy" - was not suitable for a doctor in his position. Following his realization for this deeper need in his own practice of medicine, Sassall "began to observe himself and others...to analyze many of his own character traits and their roots in the past."

It is described in the book as a painful process, but Sassall emerged with a more complex and mature outlook, having exchanged the concept of "the life-and-death emergency" for the "intimation that the patient should be treated as a total personality, and that illness is frequently a form of expression rather than a surrender to natural hazards." The importance of this lies, not in the intellectual truth of the outcome which few would deny, but in the experiential truth afforded by passage through the process itself.

What Bergen makes so vividly clear is the need to recognize and acknowledge the interaction between physicians and the persons they treat for what it really is, regardless of the context: a *relationship*. Outcome patterns in relationships are usually bound to the balance of power in the relationship, with the disempowered member most likely to feel angry, frustrated and resentful, and the powerful member to take advantage of the situation. With no other model to follow, the intimacy between patient and doctor is often compared with

that between parent and child, especially because "Illness separates and encourages a distorted, fragmented form of self-consciousness. The doctor, through his relationship with the invalid and by means of the special intimacy he is allowed, has to compensate for these broken connections and reaffirm the social content of the invalid's aggravated self-consciousness."48 It takes an enormous amount of skill and knowledge of human nature with a strong foundation in self-knowledge on the part of the healer to rise above such innate differences in advantage. There is no other way for both parties in the relationship to benefit. This is the definition of mindfulness. Mindfulness gives the physician a less biased, more receptive sensitivity to the patient, allowing for a quicker sense of the individual in his care, an immediate trust to form the foundation for treatment of the whole person and his/her illness rather than the patient's body and its disease.

There are many areas of the system to blame for the current situation, and many to target for improvement. Perhaps medical schools have perhaps been too negligent in the care. Koran and Litt voice similar concerns, particularly with regard to the way in which medical students are treated within the profession. They express this by saying that "the medical profession devotes its energies to preventing, ameliorating and curing disease. Yet, paradoxically, the profession attends inadequately to these responsibilities for its own members, particularly its newest practitioners."49

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WHERE TO INITIATE CHANGE IN THE SYSTEM

If you want truly to understand something, try to change it.

- Kurt Lewin -

The connectedness of things is the most important goal of education.

-Mark van Doren-

Numerous authors have talked about the myriad problems emerging in medical education, but most offer solutions directed at individually recognized stressors. The demanding curriculum is often cited as the primary problem, resulting in suggestions to lengthen the training required. Students' lack of coping skills and social support are also frequently mentioned as causative factors, leading to suggestions for counseling and support groups. Sleep deprivation among interns is sometimes identified as a problematic factor, as is lack of faculty support for residents, and huge financial debts. Attending physician "burnout" adds to the frustrations playing a role. Another contributive factor identified in the past was the apparent lack of interest in the humanities among students entering medical schools, which resulted in more recent attempts to attract incoming students with more humanistic attributes and broader educational backgrounds as mentioned. But, as C.P. McKegney

50 B. Mazie, "Job Stress, Psychological Health, and Social Support of Family Practice Residents." Journal of Medical Education (985) 60:935-41.
54 David Hilfiker, Healing the Wounds: A physician Looks at His Work. (New York: Pantheon Books, 1985.)
writes, "proposals that address individual students or physicians imply that the causes lie entirely within individuals and miss the role of the system as a whole."\textsuperscript{56} The problems identified and solutions that affect humanistic qualities in medicine seem to involve aspects of all levels of training and practice. Clearly a systemic approach is needed to manage what seems to be a systemic problem. Dr. McKegeney's metaphor of the family system helps to conceptualize medical education as a neglectful, abusive family, and "facilitates recognition of the dynamics within the system which perpetuate many of the problems facing teachers, students, and practicing physicians."\textsuperscript{57} In exploring the family metaphor, she uses concepts derived from family therapy literature, especially drawing on models of behavioral patterns as described by R.E. Helfer, R.S. Kemp, and B. Steele. Change needs to be aimed at the "extended" family in medical education, and the difficult task of changing a rigid system requires a long-term commitment by each generation. But who is to initiate such changes?

Students are generally not empowered to a degree where they can initiate major changes on their own. As the metaphorical children, they are the "youngest," the most nervous, and most vulnerable members of the hierarchical family in medical education, and therefore least likely to be willing to "create waves" in the system. What students can do to alleviate stress and develop the necessary characteristics has been dealt with extensively elsewhere (Virshup, Betcher, and others), and necessarily takes form from the lead shown by their peers. It is highly dependent on what the system dictates, allows, and is willing to nurture.

Au pairs are the day-to-day companions, helpers, and supervisors of the younger children. They teach what they can. In medicine, the au pairs are

\textsuperscript{56} Catherine P. McKegeney, "Medical Education: A Neglectful and Abusive Family System." 
\textit{Family Medicine}, 21 (November/December 1989): 452

\textsuperscript{57} Ibid.
probably best represented by the nurses, therapists, and ward secretaries. They are the ones who are with the house staff in the hospital on a continual basis, and at night when others are scarce. They monitor and guide students through their initiation into medicine, and teach them the fundamental procedures of the profession. But, as McKegey states, "like in many rigidly hierarchical families, this guiding is discounted by the family as a trivial task." As such, these other members of the health care team are in no position of power to initiate changes in the way medical education is conducted.

The directors, chairpersons and heads of departments who represent the "grandparents" in the system are the intermediaries between parents and children in the extended family system, but have limited contact with each group. Their influence on students is especially indirect. Given their lack of student contact and limited contact with the actual teaching environment, they are not in the best position to construct the changes needed in the process of medical education. They are responsible for carrying on certain traditions of the family, but also lend a sense of perspective for the family over time, and within the greater society. As participants in the community, their role is probably best defined as supportive in terms of community goals, budgetary issues, feedback and mediation.

Parents are more directly responsible for raising the next generation, and teaching them to become independent, but valuable participants in society. As a group they also comprise a part of the educational experience that controls much of the student body's experience, which could be far more positive than has been described in the literature. It therefore seems most appropriate to focus on them with regard to what medical schools can do curing the process of

medical education to foster a higher level of humanistic attributes among their students.
What are the purposes and priorities of teaching? First, to inspire. Second, to challenge. Third, and only third, to impart information.

- J. Michael Bishop -

It has been widely accepted that the amount of information students have to learn, memorize, and master during medical school has become overwhelming. The deleterious effect of this "overload" stress on human tolerance, patience, communication, intellectual and motor skills is well-documented. Students are continually frustrated in their inability to keep up with the unreasonable expectations placed on them, and faculty get frustrated with what they often perceive to be lack of dedication on the part of students. In their article, Facilitating Humaneness in Medical Students and Residents, Lloyd and Gately state their agreement and suggest a link to consequent behavioral patterns: "The amount of information that a student can assimilate in two preclinical years cannot escalate forever; to ignore the student's limitation in this regard is to model inhumane expectations."59 In the same way that people abused in childhood tend to become abusive parents, students treated inhumanely are less likely to become humane physicians and teachers. The flip side of this coin is that "when problems begun in an abusive childhood remain unresolved, they are more likely to be transmitted to the next generation."60 This is antithetical to the goals of medicine, and needs to be


addressed if allopathic medicine is to retain its historical commitment "to benefit human life."\(^{61}\)

A solid scientific knowledge base in medicine is important. Facts are essential because problems cannot be solved without the sequential arrangements of facts. But, as Whitman states, it is a "myth of medical education" that students have to learn so much of the "vocabulary of medicine," they have to memorize a virtual "dictionary,"\(^{62}\) especially if doing so is detrimental to a broader, more balanced understanding of the healing arts. Short of extending the length of medical training, which for most students already takes upwards of eleven years, medical educators will be forced to control the amount of information students are required to learn in the future. Many authors agree that, to begin with, the information students are expected to know is not essential to their stage of development, and that much of what they learn becomes obsolete within ten years. Many even assert that, in medicine, "there may not be a universal structure behind 'knowledge,' but rather a temporary consensus arrived at by the medical community."\(^{63}\) It is a standing joke told mirthfully over again by many physicians that, by the time they enter practice, they have forgotten half the information they had to memorize in medical school, and that the other half has since become obsolete. Most jokes have a basis in truth, and this one simply understates the need for medical educators to revise the primary goals of medical education.

It has become apparent that present expectations of students to uncritically memorize inordinate numbers of somewhat transient facts are not only

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\(^{62}\) Neal Whitman, *Creative Medical Teaching*, (Utah: University of Utah School of Medicine, 1990) p.45.

\(^{63}\) Ibid., p.44.
unrealistic, but may be irresponsible. Facts constitute the simplest and least important level of learning. And such overriding, all-consuming emphasis on mastery of information leaves little time for thinking, reflecting, or problem-solving. As Whitman stated, "the concept of learning facts to pass exams must be replaced with the concept of learning facts to solve problems." 64 Many educators recommend that teachers put less emphasis on facts and more emphasis on correlating information so that students can understand the information. 65 This would have the added benefit of lessening the load students are faced with, because the better one understands a subject, the less one has to memorize it.

Moving away from previous models of medical education where the training essentially ended with graduation from medical school, many researchers in medical education have suggested the need for a model steeped in the concept of lifelong learning. As Lloyd Smith expressed it, "The true physician never graduates from medical school; he simply transfers." 66 Continued education taken seriously would solve part of the problem: medical educators would not be as pressured to teach everything in the few short years allotted. Relieving pressure from the biomedical curriculum would offer schools an opportunity to train students in other areas such as psychosocial issues, problem solving, and critical thinking.

With increased prestige and financial incentives driving the research field, a continued explosion of information is bound to occur, some of it good, and some of it bad. It has therefore been suggested by many that, rather than attempting the impossible task of "teaching it all" in a fragmented way (the

64 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.49
65 Ibid., p.48
equivalent of the elusive "cure"), teachers should collaborate towards more meaningful, realistic objectives such as providing a solid conceptual basis of medicine, and instilling the motivation and skills for a career of lifelong learning. As Whitman asserted, true change in the curriculum itself cannot take place "until medical schools and residencies produce lifelong learners who have not been turned off by their medical education."  

The measures described above are likely to relieve only a portion of the overload stress experienced by both teachers and students. Some of the experimental curricula being implemented at various schools such as Harvard, UNM, McMaster's, and Pittsburg have already taken steps in this direction. The hope is that the traditional system of learning facts to pass exams will be replaced with one of solving problems by understanding the concepts involved, knowing where to find the facts, knowing how to evaluate the factual value of information given, and having the ability to correlate this all with compassion and understanding for each patient as a unique individual. Experience and research have shown, however, that for such systems of learning to be truly successful, teachers themselves need to be taught. This is not a formal requirement for teachers of higher education in the United States. Although some schools are training their teachers on an informal, ad hoc basis, the general lack of teacher training is a problem that needs system-wide attention.

67 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.43
Every education is a kind of inward journey.

- Vaclav Havel -

Since medical educators are not required to undergo any formal training in order to teach, their teaching styles are "derived from their personal experiences as students and teachers, and may have no basis in educational theory." Consequently, they are the descendants in what Catherine McKeegney calls the neglectful and abusive family system of medical education where, "like parents who raise their children as they themselves were raised, each generation teaches as they were taught, and the patterns are loyally perpetuated." It is important to realize that, with retraining, such patterns can be broken.

One of the six recommendations set forth in the GPEP report regarding faculty and the training of physicians for the twenty-first century states that "medical schools should establish programs to assist members of the faculty to expand their teaching capabilities." But, as has been true for much else that came out of this report, little has been done about it. Teaching in medical schools remains an erratic, sorely neglected endeavor. According to Mark Saul, a winner of the National Science Foundation Presidential Award in 1984 for excellence in teaching, bad teaching is learned in colleges and universities where good teaching is neither fostered nor rewarded. Whitman agrees, and

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68 Neal Whitman, *Creative Medical Teaching*. (Utah: University of Utah School of Medicine, 1990) p.46
exhorts medical teachers to take it upon themselves to become "connoisseurs" of teaching. He describes this connoisseur as "a person with informed and astute discrimination" who embraces the "art of knowing and appreciating what is educationally significant." The latter constitutes an important notion in the realm of information overload as discussed above. Whitman goes on to say that educational connoisseurs possess the theoretical foundation to identify the methods and techniques of teaching that match well to the instructional objectives. Training makes teachers better able to assess what works and what fails to work in various situations. This then allows them to generate their own database which becomes a "much more powerful instrument of change than are facts generated and presented by an outside expert." 

In order to break the self-perpetuating cycle of ineffectual teaching techniques in medical schools, teachers have to be offered better incentives to improve their teaching skills. Without the requisite incentives, teaching is destined to remain at the bottom of the priority pile for most faculty at research institutions. Whitman lists five ways in which medical schools can contribute to the development of medical school teaching skills:

1. Through a system of rewards, faculty will improve their own teaching because it is worth their while. Extrinsic rewards, such as money, are important because their absence is de-motivating. If faculty do not feel they are paid to teach and that better teaching can lead to advancement and promotion, then they will not be motivated to teach more effectively. Intrinsic rewards are important because a sense of ownership in the institution and a feeling of

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72 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.40
73 Ibid., p.42
pride in its teaching program will motivate faculty to improve their teaching skills.

2. If they receive assistance, faculty can learn how to improve their teaching skills. For this to work, faculty must perceive that educational assistance is available and credible.

3. Feedback on their teaching strengths and weaknesses can help faculty make the necessary adjustments to improve their teaching. We know that feedback is more useful when it is timely. ...[Questions that need to be addressed here are:] do faculty value student ratings? And, is there a comprehensive system of teacher evaluation that makes use of colleague and self-assessment?

4. Faculty can learn how to teach more effectively by developing a taste for teaching, a process known as educational connoisseurship. By paying attention to the teaching-learning process, faculty can learn about the subject of teaching every time a medical subject is taught.

5. Teaching will improve if faculty feel free to become creative, trying to be both useful in what they teach and novel in how they teach.  

Once incentives are in place, and enthusiasm has been generated, the retraining of faculty can begin. There are many theories and models of education for faculty to draw from, but some basic principals underlie the majority of them. Central to most models advocated are techniques that allow for active learning. Active learning has long been acknowledged to be far superior to passive learning, and has been shown to result in better memory and comprehension of the subject matter. In fact, it was Socrates, the father of education, who was attributed with saying that "teachers are the midwives to students pregnant with ideas." More contemporary educators agree. Carl Rogers has said that he cannot teach anyone anything; he can only provide the

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74 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.53-64.
environment in which learning could take place. Under our present system of education, perpetuated from childhood all the way through continued education, students learn passively, primarily through series of lectures. In general, the lecture format has been shown to be the least reliably effective way to teach in such a way that allows people to absorb and remember information in a meaningful way. Studies have shown that, when taught through lectures, students may do well on tests, but have trouble retrieving and applying the information they have learned. In addition, by being given the so-called "end-product," students rarely learn how to analyze and synthesize information for themselves. This is not to say that lecturing cannot be effective. Usually it becomes ineffective because the instructor is too easily seduced into presenting too many facts or ideas in one lecture. Presenting too much material in one sitting has been shown to lessen both short-term and long-term learning. For these reasons, educational researchers have been advocating a more student-centered approach to education.

Student-centered learning is a process whereby students teach themselves, guided, encouraged, and helped by the appropriate faculty. This puts a certain amount of responsibility on students themselves. But it also reduces stress by empowering students in a way that is far more appropriate to their stage of development than is possible under the current paternalistic system of education. Wales and Stager describe student-centered instruction as a system that allows students to "learn what questions to ask, what questions not to ask, and when to ask. The teacher can anticipate their problems and their concerns, but no teacher can learn for the student." This then frees teachers

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76 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.179.
to, rather than simply reciting the textbook, help students synthesize the material into higher levels of comprehension. In these ways, student-centered teaching prepares physicians for more effective self-learning, the skill that will be a necessary component of lifelong learning in the future.

For student-centered learning to be effective, teachers have to be skilled at guiding learning, but also at inspiring students in every way humanly possible. It was with good reason that Palmer called good teaching "an act of generosity, a whim of wanton muse, a craft that may grow with practice, and always a risky business." Teachers need to be made far more aware of the immense impact they have on student learning. As mentioned, they can promote learning by helping students become motivated to learn. This motivation was described by Whitman as "the interaction between personal and environmental factors, and teachers definitely influence the medical school environment." Environment is the key to student-based teaching, which itself is the key to more effective patterns of learning. Once this is understood, the ultimate importance of behavior and attitudes in the family of medical education can be fully appreciated. Educators need to be taught, not only more effective skills of teaching, but also how to provide the kind of environment that promotes motivation, enthusiasm, and a lifelong love for learning.

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79 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.103
CHANGING THE EMOTIONAL ENVIRONMENT

Truth is lived, not taught.  
- Herman Hesse -

Knowing others is wisdom. Knowing the self is enlightenment.  
- Lao Tsu -

Thomas Schwenk, in his foreword to Creative Medical Teaching, refers to teaching as a process that is concerned with "the domain of relationships, communication, motivation, and behavior." These are the factors creating the environment that either enhances or deters learning, well-being and satisfaction for both students and faculty. They are also an integral part of the cycle that is perpetuated. Teachers need to be made more aware of the fact that they do not only teach facts; they also teach attitudes and behaviors. Developing the skills necessary to enhance positive outcomes requires a broader paradigm of medical education.

With the virtual explosion of information, development of "logical-mathematical" intelligence has dominated medical educational goals. In the same way that patients have become viewed as mechanistic bodies, students seem to be viewed as virtual data banks. According to the Harvard psychologist, Howard Gardner, there are at least six other major areas of intelligence: linguistic, intrapersonal, interpersonal, bodily-kinesthetic, spatial, and musical. A broader paradigm of health care that aims to acknowledge and address psychosocial aspects of health and illness to a greater extent would at least seek to develop the first three to a degree equal with logical-mathematical intelligence. As stated by the Pew-Fetzer Task Force on Psychosocial Health Education, "these competencies reflect the complexity of contemporary health

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80 Thomas L. Schwenk's foreword in Creative Medical Teaching, Utah: University of Utah School of Medicine, 1990) p.
care in their attention to both population and individual perspectives, and allow for a more integrated approach to health care. They also allow for a more integrated approach to medical education.

It is common knowledge that the most important factor allowing for successful relationships is effective communication. But before therapeutic intervention can take place, denial has to be overcome. With an almost complete lack of formal training, inadequate feedback, and little else to compare themselves to, most physicians/teachers can only assume that they are doing just fine by coping in the only way they know how. Catherine McKegeaney provides a very vivid description of medical education when she says that, like neglectful and abusive families, the medical education system is often characterized by "unrealistic expectations, denial, indirect communication patterns, rigidity, and isolation." Denial is an inherent component of the problem, and needs to be addressed for training and faculty development to be fruitful. McKegeaney’s suggestions to teachers are as follows:

First...remember our experiences—particularly the ones we would like best to forget. Second, we need to tell our stories and listen to each other’s. Traditionally, we tell “war stories,” dwelling on circumstances and consequences. We must move beyond this mere description of events and acknowledge the feelings evoked during our training and the meanings our experiences hold for us. Sharing the secrets will be painful, both as we experience the pain we have denied and as we face the response of our patients who are frightened by the implications of the our self-neglect. The neglectful and abusive behavior patterns we learned are continuing to harm us as “parents” in this family, and are harming our students and residents.

81 Carol Tresolini and the Pew-Felzer Task Force on Psychosocial Health Education, Health Professions Education and Relationship-centered Care, unpublished draft of a document in progress, by permission of the author.
As with neglectful parents who were themselves abused as children, the process of healing will involve more than simply relearning communication patterns. First, we need to let go of the responsibility for having been hurt and recognize that the problems are systemic, not individual failings of our teachers. Because of the scars of our training we must then take responsibility for "reparenting" ourselves as we begin to change our behavior as teachers. We must treat ourselves as we know to treat abusing parents: addressing attitudes, understanding, and behavior with patience and persistence.83

Once this process has begun, teachers will have a far stronger understanding and foundation upon which to build a new educational environment.

There have been multiple documentations of poor communication skills among house officers, attending physicians, and other primary care physicians previously judged as competent. Platt and McMath found, after observing several hundred clinical interviews, that many actually impeded the establishment of rapport and the collection of an accurate data base from their patients.84 Duffy et al. concluded from their observations that clinician's interpersonal skills were "exceedingly underdeveloped."85

Interpersonal skills cannot be developed from a chaotic perception of self; strong intrapersonal skills need to be developed. This occurs through a process of self-reflection. For interactions and responses to be looked at in any meaningful way, participants have to be aware of their own beliefs and biases, and feel comfortable with self-reflection and critique from others. That is, the ability to reflect on one's own interpretations, thereby becoming open to

different ways of responding to the experience of patients and students, has to be nurtured. The need for this stems from the fact that teacher and student, or doctor and patient "are not separate and independent units. Each is an observer of the other: each interprets and constructs a subjective world, and these worlds are modified by the dialogue between them. Both healer and sufferer are changed in the process." \(^{66}\) Also, "to be therapeutic, the relationship should have as its foundation a shared understanding of the meaning of illness. This requires in the healer a capacity to respond to the experience of the patient." \(^{67}\) "Without self-knowledge, a practitioner's own emotional responses to patient needs may act as a barrier to effective care and can result in harm to the patient." \(^{68}\)

A wonderful passage in A Fortunate Man describes how John Sassal, the country doctor portrayed in the book, finds himself changing to become more self-reflective. These changes begin to take place after his realization that, by simplifying his patients' needs, "he was also simplified himself, because the chosen pace of his life made it impossible and unnecessary for him to examine his own motives."

After a few years he began to change. He was in his mid-thirties: at that time in life when, instead of being spontaneously oneself as in one’s twenties, it is necessary, in order to remain honest, to confront oneself and judge from a second position. He became aware of the possibility of his patients changing. They, as they became more used to him, sometimes made confessions for which there was no medical reference so far as he had learnt. He began to take a different view of the meaning of the term crisis.

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\(^{67}\) Ibid.

\(^{68}\) Ibid.
He began to realize that the way Joseph Conrad's Master Mariners came to terms with their imagination - denying it any expression but projecting it all on to the sea...which they then faced as though it were simultaneously their personal justification and their personal enemy - was not suitable for a doctor in his position. He had done just that - using illness and medical dangers as they used the sea. He began to realize that he must face his imagination, even explore it. It must no longer lead always to the unimaginable as it had with the Master Mariners contemplating the possible fury of the elements - or, as in this case, to his contemplating only fights within the jaws of death itself. He began to realize that imagination had to be lived with on every level: his own imagination first - because otherwise this could distort his observation - and then the imagination of his patients.89

The same quest for self-knowledge in the name of more effective communication skills should also be true for teachers in their relationships with students. Who teachers are as persons impacts directly on their ability to teach, and on the quality of the relationships they are able to form. This calls for a "profound change in medical education, from a curriculum dominated by abstractions and intellectual analysis to one balanced between intellectual analysis and the depths of human experience."90 Strategies used to encourage introspection and reflection to encourage self-awareness and self-knowledge "include counseling, journal writing, peer monitoring, wellness programs, and support groups" to allow participants opportunities "to optimize individual and professional growth."91 Borrowing from the Pew-Fetzer Task Force for Psychosocial Health Education's term of "relationship-centered care," one can begin to think of medical education as relationship-centered teaching.

90 Carol Tresolini and the Pew-Fetzer Task Force on Psychosocial Health Education, Health Professions Education and Relationship-centered Care, unpublished draft of a document in progress.
91 Ibid.
Relationship-centered education assumes that teachers and students are treated and cared for as individuals, with individual strengths, weaknesses, and therefore individual needs, but a collective community goal. It is synonymous with student-based education, and represents a collaborative environment for learning - a team effort - with teachers guiding learning rather than dictating the learning. Goals and objectives of learning and teaching are dynamic, and mutually established by the community of educators and students. This requires entirely new skills on the part of medical faculty, involving education in inter- and intrapersonal skills, but in addition, the knowledge, skills, and values related to the working dynamics of teams, groups, and organizations. Towards these goals, the Pew-Fetzer Task Force on Psychosocial Health Education suggests drawing from the largely ignored, immense body of knowledge available in the social sciences, where information abounds regarding the "dynamics that revolve around issues of membership and leadership, norms, goals, problem-solving, and group behavior."\textsuperscript{92}

A specific effort needs to be made by faculty to build genuine, meaningful relationships with students. The apprenticeship or preceptorship is one way of doing this, and creates an excellent opportunity whereby the care of patients and the care of learners become models for one another.\textsuperscript{93} It allows teachers and students to work as a team, allowing each to learn from the other, and giving each a forum for discussing stresses encountered in their respective experiences. This in turn allows for greater cross-generational contact and understanding. Informal contact outside the classroom, however, is an equally important way of forming meaningful relationships, constituting a low-stress

\textsuperscript{92} Carol Tresolini and the Pew-Fetzer Task Force on Psychosocial Health Education, \textit{Health Professions Education and Relationship-centered Care}, unpublished draft of a document in progress.
\textsuperscript{93} Ibid..
opportunity for building trust by acknowledging and validating aspects of students' lives outside of medicine.

To allow such relationships to be truly effective, teachers need to recognize the potential for abuses of power and be aware of and address threats to the integrity of these relationships such as power inequalities. The inequality of power inherent in the traditional system is made most apparent through grading or evaluative procedures.

Although evaluations are a necessary part of education, there are many ways to make them a more comfortable part of the process for both teachers and students. To begin with, they should include a two-way dialogue between teacher and student. That is, each gets to evaluate the other, rather than the traditional "top down" version. After all, "if the learner didn't learn, the teacher didn't teach." The most negative feedback should be expressed in private, and never in a belittling fashion. Feedback should be timely to be effective, and should consider "meaningful positive as well as negative performance." Trust can be built up around the issue of testing if teachers make requirements explicit and specify the criteria by which judgments will be made. According to Neal Whitman, faculty often write trivial objectives because "objectives that describe more important learning are harder to write." But, when thoughtfully written and periodically reviewed, objectives help teachers and learners connect the educational process to its intended outcome. Students should be encouraged to assess themselves. This allows for dialogue, and enables students to develop criteria. "Becoming insightful about one's own performance

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94 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p. 60.
95 Ibid., p. 69.
96 Ibid., p. 114.
97 Ibid., p. 115.
and developing the ability to self-assess performance is critical to producing the lifelong learners we want practicing in the twenty-first century.\textsuperscript{98}

For student-faculty relationships to be meaningful, teachers need to understand and respect a diversity of needs and perspectives among students, and know how to be non-judgmental. In this regard, teachers should always remain willing to learn, and be proficient in communication skills, especially listening. Strategies to promote these skills include feedback by students and colleagues, role-plays, explorations of literature, and discussions of cross-cultural value systems to develop knowledge of others and a positive regard for them within the context of their lives. An integral part of learning communication skills should include conflict resolution and an understanding of the potential for conflict.\textsuperscript{99}

Perhaps most important of all, teachers need to care about students as persons and learners, show them the same compassion accorded any patient. They should actively put aside personal and departmental agendas that may be incompatible with these goals. "A philosophy that values enabling and empowering others, as well as the autonomy of self and others, is essential."\textsuperscript{100} In addition, teachers need to maintain a creative and open mind, and "must be prepared to respond to the moral and ethical challenges that arise in the process of the relationship."\textsuperscript{101} To this end, educators need to remain honest, "open to others' ideas, display an attitude of humility, and value the mutual trust, support, and empathy of all participants." In addition, they "must exhibit a

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\textsuperscript{98} Neal Whitman, \textit{Creative Medical Teaching}, (Utah: University of Utah School of Medicine, 1990) p.70
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\textsuperscript{99} The suggestions made here have been adapted from \textit{Health Professions Education and Relationship-centered Care}, an unpublished draft of a document in progress by Carol Tresolini and the Pew-Fetzer Task Force on Psychosocial Health Education.
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\textsuperscript{100} Carol Tresolini and the Pew-Fetzer Task Force on Psychosocial Health Education, \textit{Health Professions Education and Relationship-centered Care}, unpublished draft of a document in progress.
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\textsuperscript{101} Ibid.
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capacity for grace, which represents an attitude of decency, thoughtfulness, and generosity of spirit towards others."\textsuperscript{102}

These same supportive relationships should be pursued between all members of the family/community of medical education and represent a more mindful model of medicine. This paradigm based on relational roles allows for the development of more humane attitudes and behaviors, which in turn allow for more effective and collaborative relationships with patients, peers, colleagues, nurses, and other members of the health care team.

\textsuperscript{102} Carol Tresolini and the Pew-Fetzer Task Force on Psychosocial Health Education, \textit{Health Professions Education and Relationship-centered Care}, unpublished draft of a document in progress.
CONCLUSION

*When patterns are broken, new worlds can emerge.*

· *Tuli Kupferberg·

The question of inadequate humaneness in allopathic medicine has been acknowledged for over a decade. In spite of unparalleled achievements in health care, numerous "critics have described medical education as narrow, doctor-centered, technology-bound, and indifferent to both its overall mission and its changing context."103 Doctors have less time to care for their patients, causing their relationships to suffer, and too little time for themselves, causing an unacceptable level of physician impairment. These states seem entirely antithetical to the goals of medicine. The AAMC acknowledged the need for greater humaneness in its GPEP report back in 1984, and reaffirmed the goals of medicine by stating that "every physician should be caring, compassionate, and dedicated to patients - to keeping them well and to helping them when they are ill."104

Medical schools in recent years have made an effort to resolve the problem by recruiting students who already display a sense of compassion and altruism, but this tack seems to have had little impact. Critics from various fields have argued that, although students entering medical school may bring many desirable attributes with them, they are not nurtured, and the brutal process of medical education itself inflicts 'battle scars' that soon drain students of the very attributes they were selected for: caring and compassion are ultimately replaced.


with emotionally protective barriers called "professional toughness." The end result seems to be a cadre of physicians, competent perhaps in the scientific or technological aspects of medicine, but lacking in psychosocial skills and the art\textsuperscript{105} of healing.

There seems to be something intrinsic to the 'brutal' process of medical training that needs to be addressed. Students applying to medical schools in the last several years have been made acutely aware of the general desire for a broader sense of the humane dimension in their chosen field. But they soon realize the paradoxical lack of such dimensions in the curricula offered. They find themselves inundated with overwhelming demands and are forced to make substantial sacrifices in terms of time, money, and social development. The monastic quality of this long process is exceedingly difficult to cope with emotionally, especially given the lack of spiritual support endemic within the system. The subject of coping strategies in preparation for what is, in essence, a very peculiar profession in terms of its breadth, depth, and discipline, is rarely even mentioned in medical schools. This is why Catherine McKeegney so aptly called medical education the "neglectful and abusive family system."\textsuperscript{106} Until there are substantial changes in the way the participants in medical education are trained and cared for, the care they ultimately give will always be limited and fragmentated according to the education they receive.

It is not that medical schools negate the need for greater compassion and understanding of patients. They simply have no system in place for teaching or learning these aspects of medicine, and the "majority of programs do not

\textsuperscript{105} Art here is used to encompass the more intuitive, non-technical, non-scientific, non-objective skills that allow for a broader role and perspective in the whole realm of healing.

require any training in the humanistic/psychosocial aspects of care."¹⁰⁷ There appear to be three more commonly cited obstacles to changing the way medical students are trained: time, money, and expertise. But resistance to change may, in the end, prove to be the most intractable of all the obstacles playing a role.

Change has to begin somewhere in the self-perpetuating loop where the dysfunctional coping mechanisms of one generation feed those of the next. It therefore seems most appropriate to initiate change through those who are responsible for teaching the next generation, while at the same time remaining acutely aware of the systemic nature of the problems at hand.

To begin with, schools need to make meaningful commitments to teaching, rather than relegating this task to a lower list of priorities. Teachers need to receive formal training and need to be encouraged to keep expanding their teaching capabilities. There are essentially three ways in which medical school faculty can influence the level of humanistic behavior in their students: through their own example as role models, by including communication skills as an integral part of what they teach, and by doing what they can to reduce stressors in the educational process. In the end, the curriculum is there to benefit students in their process of learning. Minimizing the scientific information students are required to master while retaining a superior level of clinical competence may be the most important challenge for medical educators in the future. But it may also be the simplest way for medical school faculty to impact the environment allowing for a higher level of humanistic behavior in students by reducing stress in the system.

More effective teaching enhances learning, thereby lessening the amount students have to spend memorizing material. But it also prepares teachers for

the difficult task of helping to change the present system of education. If the quantity of what students are being asked to master is to be replaced with qualitative changes as has been suggested, those difficult decisions have to be made by teachers who are qualified to do so by virtue of their "connoisseurship."108 As Whitman stated, it requires a connoisseur, intimately informed regarding the goals and processes of education to know and appreciate what is educationally significant.

Part of the problem here involves the fact that schools have traditionally been funded through research. Although faculty ostensibly have only a fifty percent position as researchers, research has become competitive enough to require one hundred percent attention. Consequently, most faculty have little time left to focus on the needs of students to any meaningful degree. Some schools have become particularly aware of an imminent split between clinical and research faculty, and are looking for ways to offer faculty the choice of committing to only one track which would ameliorate the problem of split commitments.109

Training faculty in the art of teaching effectively breaks the present dysfunctional patterns of education, allowing new patterns to emerge. Learning to teach requires training in communication skills, and learning to communicate requires self knowledge, which in turn requires self-reflection as a foundation. These are the same mindful skills necessary for effective clinical practice, but, without the requisite incentives, such goals are unlikely to be realized. Teachers need to receive the full assistance of the system in this endeavor. They also need constructive feedback and a meaningful system of rewards.

108 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p. 40.
109 Interview with Floyd Rector, Chief of Medicine, U.C. San Francisco, San Francisco, California, 1993.
The question of funding is always cited as the greatest deterrent to change in the system of education. But even Stanford University has come to realize the financial importance of practicing mindful medicine after discovering that doctors who have good relationships with their patients are far less likely to get sued. It has also become apparent that hospital teaching clinics can be lucrative undertakings. One could surmise that faculty dedicated to teaching could not only impact those they teach, but also improve the clinics they jointly serve and help make them more effective, efficient and lucrative. These clinics could then provide students with working role models of collaborative interpersonal styles of working.

Whitman, in summarizing good teaching practice, said that it included "encouraging student-faculty interaction, cooperation among students, and active learning." Others have called this student-centered learning, or relationship-centered teaching. Part of the importance of this type of relational learning environment is the fact that, with the decline of the solo practitioner, health care professionals are increasingly finding themselves in a position of having to work more closely with others. As Len Duhl and others have stated, people trained separately and as individuals in a competitive setting for in excess of twenty years find it extremely difficult to participate effectively in a cooperative environment. More importantly, perhaps, is the fact that collaborative, relationship-centered teaching provides the kind of emotional environment that is most conducive to the growth and development of humanistic, qualities in the participants. What doctors need to do to become more mindful and humane in their relationships with patients is perplexingly

110 Neal Whitman, Creative Medical Teaching. (Utah: University of Utah School of Medicine, 1990) p.189
111 Len Duhl, lecture given on UCB campus, 9/24/92.
simple: they need to care. And, as with family systems, those who are most caring tend to be those who were themselves well cared for.
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