NARRATIVE COMPETENCE, MINDFULNESS, AND RELATIONSHIP-CENTERED CARE IN MEDICAL EDUCATION: AN INNOVATIVE APPROACH TO TEACHING MEDICAL INTERVIEWING

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ABSTRACT

Narrative Competence, Mindfulness, and Relationship-Centered Care in Medical Education: An Innovative Approach to Teaching Medical Interviewing

DMH Dissertation by

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In the last ten years, narrative competence, mindfulness and relationship-centered care have been on the forefront of the movement to humanize medical education. However, these critical humanizing models of clinical practice have either been ignored or only superficially included in medical school curricula. This dissertation is concerned with the incorporation of these models of practice into the medical school curriculum in so that medical students can graduate with the ability to provide compassionate care to their patients.

The current literature on narrative medicine, mindful medical practice and relationship-centered care is reviewed. A discussion of why these aspects of medical practice are critical to humanizing medical practice is included. The needed skills in each area are provided in detail and proven methodologies for teaching these skills are defined. A complete medical interviewing curriculum incorporating these essential aspects of practice is provided. Students who participate in this curriculum will be able to begin the process of gaining competency in mindfulness, narrative medicine and relationship-centered care.

DEDICATION

This dissertation is dedicated to the memory of my parents,
Max and Eleanor Hershkowitz,
and to my loving and supportive family,
Don, Emily and Daniel Reichman

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This dissertation would not have been possible without the support and guidance of my professors, Dr. Carol Wipf and Dr. Jo Ann Middleton.

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INTRODUCTION

In the last ten years, narrative competence, mindfulness and relationship-centered care have been on the forefront of the movement to humanize medical education. However, these critical humanizing models of clinical practice have either been ignored or only superficially included in medical school curricula. This dissertation is concerned with the incorporation of these models of practice into the medical school curriculum in so that medical students can graduate with the ability to provide compassionate care to their patients.

Narrative competence, a term coined by Rita Charon, is the ability to recognize, absorb, interpret and act on the patient's story of illness ("Narrative Medicine: A Model for Empathy, Reflection, Profession and Trust" 1897). The incorporation of narrative competence into the goals of the medical interviewing curriculum will go a long way toward educating health providers to be attentive to the patient and attuned to the patient's experience of illness. This attention to the patient's story leads to a carefully derived and accurate interpretation of the medical history and to effective medical care. Narrative competence is one answer in addressing the concern that doctors graduate from medical school without the sensitivity and communication skills that are necessary for the practice of humanistic medicine.

Similarly, the practice of mindfulness helps to develop the skills of attention. Ronald Epstein defines mindfulness as a practice that involves purposefully paying attention. "A mindful practitioner attends, in a nonjudgmental way, to his or her own physical and mental processes during ordinary everyday tasks to act with clarity and insight"(Ronald M. Epstein "Mindful Practice" 83). He describes characteristics of mindfulness including curiosity and reflection (cognitive and emotional), insight, and being available and present in the encounter (Ronald M. Epstein "Mindful Practice in Action: Cultivating Habits of Mind"). The purpose of mindful practice is to open the door to hearing the patient's story fully.

> Relationship-centered care, as defined by the Pew Fetzer Task Force, includes: organizing information about the patient and his or her care; providing comprehensive biomedical care; critically reflecting on practice to increase self-awareness; practicing from a caring, healing ethic and perspective that seeks to preserve the dignity and integrity of the patient and the patient's family; listening and communicating openly and effectively; … encouraging the active collaboration of the patient and family in decision making, care, and treatment; …" (Tresolini and Force 26-27)

These aspects of medical practice, particularly self-reflection, collaboration with the patient, listening, and open communication are not emphasized enough in typical medical school curricula.

When schools do offer courses in these areas, they are usually marginalized. Most often courses that focus on narrative medicine or mindfulness are included as electives rather than part of the core curriculum. The placement of these courses outside of the required coursework indicates that the content taught in such courses is not valued as necessary for professional proficiency. I contend that, while medicine has made great technological/scientific strides in the past quarter century, the capacity to listen, to be present and to collaborate with the patient on their health care decisions have not advanced. I will show how these abilities, which involve the skills of narrative competence, mindfulness and relationship-centered care, can improve diagnosis and treatment as well as a patient's overall well-being. As such these concepts need to become mainstreamed in the medical school curriculum. I will show how the skills needed to realize these competencies can be brought into the medical interviewing curriculum. I will propose a new medical interviewing curriculum that recognizes and values these skills which are necessary to humanize the clinician/patient interaction and graduate compassionate clinicians.

Beginning with the study of narrative techniques, one goal of this curriculum will be to translate the skill of close reading into the skill of careful listening. In this course which promotes narrative competence, students learn to analyze and interpret narrative in order to read and understand the patient's story in the context of their illness and their life. Close reading promotes careful listening by teaching the student to "hear" the

narrative in the patient's discourse. When applied to the clinical arena, these enhanced listening skills augment the student's understanding of the patient which leads to empathy, accuracy and a more therapeutic relationship with the patient.

To have a full understanding of the role of narrative medicine (medicine practiced with narrative competence) in the promotion of humanism in the clinician/patient relationship, I will review the work of many medical educators and scholars and examine the current state of the art of teaching medical interviewing (teaching medical students how to communicate with patients) by reviewing medical school curricula. The skills necessary for narrative competence contain the skills of mindfulness and relationship-centered care. These include practicing compassionate presence, mindful listening, self-reflection, expressing clinical empathy, reading and interpreting complex stories, and writing clinical stories (Engel 170). These skills are not included in these traditional texts and courses and I will argue for the need for reform. The proposed model will demonstrate how students can take these skills necessary and apply them in the clinical arena.

Chapter One will examine how medical education curricula have begun to incorporate learning outcomes that address compassion and empathy (medical humanism) in patient care. It will focus on how narrative, mindfulness and relationship-centered care have become a means to this end. In the 1960s, reform in medical education formalized the technical/scientific parts of medicine previously taught in an apprenticeship model. However, the humanistic aspects of medical care were left to be learned in the hospital by watching the performance of more experienced clinicians. The chapter will discuss how medical humanities curricula have begun to legitimize the study of the mindfulness, empathy and compassion in health care and argue that these need to be mainstreamed in order to demonstrate the value of this curriculum. These aspects of medical care must be formalized in the curriculum in much the same way that the technical/scientific components were formalized in the 1960s.

Chapter Two will fully examine narrative competence, mindful medical practice and relationship-centered care. This discussion will include an analysis of the work of

Rita Charon and her colleagues at Columbia University's College of Physician and Surgeons who have the nation's only program in narrative medicine. I will review the literature that describes this new discipline and explore why studying medical narrative works to facilitate physician – patient communication. I will analyze the work of Ronald Epstein and other leaders in the medical mindfulness movement. I will show how the skills of mindfulness intersect with the skills of narrative competence. Finally I will show how these skills can be used to promote relationship-centered care. I maintain that narrative competence, mindfulness and skills in relationship-centered care should be formal learning outcomes of medical education and that the skills needed for these should be taught in a mainstreamed medical interviewing course.

Chapter Three will discuss the unique skills needed for narrative competence, mindfulness and relationship-centered care. It will focus on the work of Rita Charon and and Martha Montello who each describe the skills necessary to gain narrative competence. Charon talks about the skills of close reading, attention, representation, and affiliation. Montello calls them departure, performance and change. I plan to address unanswered questions about how these skills are acquired in narrative training. I will argue that narrative competence significantly impacts on the clinician/patient relationship and contributes to health care that is humane and effective. I will also review the work of Jon Kabot Zinn and Ronald Epstein in the field of mindfulness and discuss how compassionate presence is essential to the patient encounter and forming a therapeutic relationship. Finally I will relate all of these skills to those necessary for relationship-centered care and show how taken together, these skills promote meaningful clinician-patient relationships.

Chapter Four will review the current state of medical interviewing courses in American medical schools. A discussion of a sample of medical school course descriptions will provide an overview of the current content of medical school courses in medical interviewing. I will show that the expected outcomes of these courses and the content they include fall short of teaching the skills needed for narrative competence,

mindfulness and relationship-centered care. This chapter will include recommended teaching methodologies to best present these skills to students.

Chapter Five will propose a new medical interviewing curriculum. It will include content covered in the traditional medical interviewing course and teach the skills necessary for narrative competence, mindfulness and relationship-centered care. This curriculum will utilize patient and clinician narratives as teaching tools and encourage students to use the skills of narrative competence in the clinical arena. It will include exercises to encourage mindfulness and it will rely on the principals of relationship-centered care as part of the core curriculum.

My dissertation will contribute to scholarship on medical education, specifically in the areas of medical interviewing, the clinician/patient relationship and the growing body of work that describes the use of narrative, mindfulness and relationship-centered care in medical education. This call for formalizing these competencies as goals of the medical school curriculum can contribute to the transformation of medical education. This transformation would further move the medical school curriculum to one that recognizes and values the empathy, compassion and humanity in patient care.

CHAPTER 1
MEDICAL HUMANITIES IN MEDICAL EDUCATION

In the twenty-first century we find ourselves confronted with a health care system that is more mechanized and technologically advanced than ever before. In this sophisticated and complex health care system, compassion and empathy are rare commodities. The implementation of medical humanities programs is medical education's response to this sense that there is a need to open the hearts of our clinicians–in-training. The medical humanities is an interdisciplinary field that includes the arts, philosophy, bioethics, literature and other areas in the social sciences. The objective of medical humanities curricula is to teach the "art" of medicine: that is moral reasoning, empathy, communication and other skills that contribute to healing. Although the medical humanities movement has been underway for the last forty years, in many medical schools the medical humanities are not fully integrated into the curriculum. It has neither the respect nor status of the technical science - based curriculum. The failure to integrate the medical humanities has prevented it from having a significant impact on the practice of medicine.

This chapter will look back at the early humanities programs and describe the curricula that were common in the first programs. I will also describe the curricula that are common in today's programs. The chapter will explore the historical rationale behind teaching humanities in medical school and discuss the controversy regarding teaching empathy to medical students. This controversy impacts the value that medical schools place on the medical humanities curriculum. I will argue that three specific areas of the medical humanities: narrative competence, mindfulness and relationship-centered care provide the skills needed to create empathic medical students. The chapter will look at the status of the field of medical humanities within the medical school curriculum and argue that this discipline is not valued or emphasized as it should be by the medical school establishment. Finally, the chapter will address the unique ways in which a medical humanities curriculum that emphasizes narrative competence, mindfulness and

relationship-centered care can contribute to graduating physicians who are knowledgeable in the caring aspects of medical practice.

In a brief history of the field of medical humanities, Thomas McElhinney and Edmund Pellegrino, early reformers of medical education, describe a movement that emerged in the 1960s as medical academics and theologians began to question the way medical education was increasingly emphasizing the technical aspects of patient care. This new emphasis, coupled with growing depersonalization in health care, was a cause for concern for medical academics at the time and eventually led to the formation of the Society for Health and Human Values. The group's goal was to respond to the changes in medicine and medical education by introducing the humanities into the medical curriculum (McElhinney and Pellegrino 291-317). Pellegrino wrote extensively on the need to add a humanistic ethical element which acknowledges human interdependence and the need for mutual respect to the medical school curriculum. The addition of this ethic would protect "the humanistic elements of medical care against the erosion by its increasingly technological character" (Pellegrino 253). The focus of medical education in the 1960s was to teach specific medically focused skills and knowledge. At this time, medical educators were just starting to consider the critical thinking, analytic and reflective skills that would be necessary in the new more technological field of medicine. The new technologies of the sixties and seventies brought with them social and ethical dilemmas that require physicians to have skills in problem-solving and reasoning that were not necessary before that time. The medical humanities, with its focus on critical thinking and self-reflection, provided a means to that end.

In an autobiographical essay, "The House Officer's Changing World," Joseph Hardison provides a narrative of the evolution in medical practice that created the call for humanities programs. In this essay, Hardison writes about his experience in the early 1960s as a medical resident and house officer. He describes the enormous difference between his medical training and the experience of medical residents today. He recognizes that the growth of technology and advances in medical knowledge has led to an entirely different set of expectations and stressors for young physicians. Hardison

describes the early 1960s as a time when "the fund of medical knowledge was manageable … it was possible, if we worked hard … to diagnose and treat most of the diseases we would encounter … without ever photocopying a single article. There were no ICUs … no cardioverters or pacemakers" (332-33). Before the 1960s, medical technology was simple: physicians knew a lot less about medicine and disease, and the expectations for heroics were minimal. Very sick people died and that was expected. Physicians were permitted, even expected to withhold bad news from the patient. With the emergence of new technologies, this kind of medical practice came to an abrupt halt. The focus of medical education became more and more technical and the humane aspects of care took a back seat to the new science of medicine.

Ann Hunsaker Hawkins describes the first program in medical humanities that was established in 1967 at the founding of the Pennsylvania State University College of Medicine in Hershey, Pennsylvania. This medical school began with a focus on family and community medicine. The humanities department was among the first to be established in the school. This department pioneered the idea of integrating medical humanities into the heavily science laden medical school curriculum. The initial course offerings were in the form of small-group seminars on a variety of topics including religion, history, philosophy and literature for first and second-year students (Hawkins, Ballard and Hufford 1001-02).

Since that time, there have been additions to the offerings of medical humanities at the school. Today the Pennsylvania State University College of Medicine is still offering weekly seminars to first-year students and in addition they require students to make monthly home visits to patients whom they follow throughout the year. The purpose is to give students an opportunity to learn from the patients' experiences of illness. The final assignment for these students is to write an enriched patient history that includes many of the psychosocial issues not usually included in a typical medical history. This enriched history helps the student to see the patients in the context of their lives. The second year of the program utilizes a small-group format and focuses on ethics and professionalism. In the third year, while on clerkships in the hospital, students attend

weekly ethics case conferences. In the fourth year, students must participate in one of several four-week humanities seminars that focus on a particular area of patient care such as palliative care, medical ethics or children with HIV. This final requirement allows students to bring their clinical experiences into perspective using their knowledge of the humanities (Hawkins, Ballard and Hufford 1003-05).

This type of curriculum, threaded through the four years of medical school, is the way many medical humanities programs are structured. The differences between programs are primarily in the variations of how and where courses are integrated into the curriculum. Some programs have unique course offerings such as spirituality and medicine, literature and medicine, and/or history of medicine. Some offer a general humanities course such as the one described by Sharon Krackov at the New York University School of Medicine called "Physician, Patient and Society." This two year course includes content in the areas of ethics, communication skills, behavioral medicine, preventive medicine, health care policy, cultural competence, chronic illness and pain management, and domestic violence (978). Medical humanities programs across the country include course offerings that have the potential to improve medical education by including the humane aspects of patient care. Unfortunately only some of these courses are required. Most are electives or selectives (a group of courses, one of which must be chosen by the student). Medical students are now getting some minimal education in medical humanities but these courses are not part of the required essential elements in medical education.

In part due to the precarious position of medical humanities programs within the medical school curriculum, the October 2003 issue of *Academic Medicine* was devoted to a description of medical humanities programs across the country and abroad. The editor writes that this thematic issue of the journal was important in order to document the place of medical humanities education in the medical school curriculum but also to recognize the ongoing struggle of humanities programs to maintain their validity and status within medical schools (Dittrich 951-52).

The issues in medicine in the 1960s that led to the creation of medical humanities programs are the same issues that medical educators struggle with today. In fact, they are now magnified by continued technological advancements that are moving at enormous speed and overwhelming the medical school curriculum. One example is the recent breakthroughs in genomics. Medical schools are now obligated to offer advanced level courses in genetics that were not necessary a few years ago. Technology continues to influence the medical school curriculum and medical practice. Medicine is now evidence-based; every local family doctor has a PDA (personal digital assistant) that allows him to tap into the internet to find the best treatment for a particular ailment or check on a drug dose. The vast fund of medical knowledge is not manageable. To compound that fact, the expectation that medical care will cure even the most dire illness has reached an incredible peak. For young physicians, this burden is enormous. It has moved the focus of their training and daily activities from caring clinician and healer to scholar and technician.

When there was little to offer patients in the way of diagnostic tests and cures, the importance of compassion and empathy as integral components of healing were well recognized. Today, physicians are physically separated from their patients by diagnostic tools and computers. Physicians literally see their patients through medical instruments and diagnostic machines. Before these tools were available, the patient's story was the major contributor in making a diagnosis and listening was the key to success. Physician and educator, Stanley Reiser, recognizes that young physicians need to become expert in the new technologies available but he also recognizes that "technologic knowledge creates a portrait of a being. Empathetic knowledge creates a portrait of meaning. Linked together the two views recreate as nearly possible the person who is the patient" (130). If we agree with Reiser then it follows that the humanistic dimensions of health care in medical education are as important as the science-based factual knowledge. Despite this obvious conclusion, teaching the humanistic aspects of medical care has lagged far behind scientific and technical teaching in medical schools. In order to have an impact on medical education, medical humanities must be formalized, further

integrated and accepted by the medical establishment in much the same way that the technical aspects have been.

In addition to technological advancements, economic pressures add to the strain on physicians and the lack of empathetic care experienced by patients. In a recent essay in the *Journal of the American Medical Association*, physician and writer/poet, Raphael Campo discusses this issue. He blames the larger society for the plight medical educators find themselves in today. He discusses pressures on young doctors that force them to focus on moving patients quickly through the revolving office door. Managed care and insurance reimbursements systems that reward volume of patients seen prevent even the most caring physicians from spending the needed time with their patients (1009-10). Today, the time to express empathy and talk to the patient is minimal and not supported by the health care system. Medical educators have instinctively turned to the humanities for answers. Although Campo does not propose that this is the only answer to this crisis in healthcare, he maintains the clear message that medical humanities is part of the solution and a place to begin.

Campo's analysis of medical humanities programs does not directly address the status of these programs within the medical school. The minor role played by humanities courses may also be to blame for the lack of impact noted by Campo. In most schools these programs are separated from the required curriculum serving as a source of enrichment. This placement of the humanities curriculum outside of the traditional/required curriculum devalues the content. If medical schools send the message that these courses are not important enough to require, students will get the message that the skills offered by these courses are not important enough to develop. Medical humanities programs exist precariously at the edge of medical education. Although programs have been in place since the late 1960s, most of the offerings are electives. The advocates of medical humanities programs are still trying to convince administrators, educators and students of their value. While the medical education establishment has acknowledged a need for these programs, they do not give them the time in the curriculum they require. In 2005, Beth Lown and colleagues surveyed

associate deans and curriculum leaders in American medical schools in order to determine the perceptions of these educators about teaching caring attitudes (often done through medical humanities courses) in their schools. Lown concluded that while a majority of the respondents recognized the importance of teaching this value, they were inconsistent when it came to implementing this curricula element. She notes that senior educators commented on significant barriers to the implementation of teaching caring attitudes including the lack of integration of this value into the broader curriculum and the dominance of the hidden curriculum that undermines values of caring and humanism (1514-19). Medical humanities needs to be integrated into medical education in a new way. Moving the humanities curriculum from an elective to the core curriculum would legitimize humanities education and value its significance. In addition, the inclusion of "humanistic" competencies such as narrative competence, mindfulness and relationship-centered care expands the expectation of medical school current competencies of empathy and communication. Shapiro and colleagues call for a curricula change from what is currently defined by adherence to a topic list, to one that identifies "analytic and reflective habits of mind in students so that they are better able to think from the perspectives of others, move toward a greater humility and focus on the values and vision that they brought to medicine in the first place" (195).

The problems in medical education are a concern of the society at large. Issues of empathy in medical care are not just the stuff of journals for medical educators. Patients are continuing to tell medical academics that they need to do better in educating physicians who are humane and empathetic. Many of today's consumers of health care have an expectation of respect for their wishes and want a say in the type of care they receive. They are more knowledgeable about medicine and disease than the patients of the 1960s. They often expect discussion of treatment and negotiation of a management plan. The therapeutic relationship between doctor and patient is a partnership. It may not be an equal partnership in terms of medical expertise but it must be a partnership of respect.

Two recent articles in non-medical publications demonstrate this point. A May 2006 article in *Time*, "Teaching Doctors to Care," reports changes in medical school curricula in response to patient demands for more compassion in medical practice. Similar to the Pennsylvania State Program described earlier, educators at Harvard Medical School developed a medical humanities program that brings medical students closer to their patients by pairing each student with a patient who is seen weekly for a period of five months. During this time, the student has the opportunity to get to know the patient and all of their health care needs. The student gains an understanding of the frustrations that the patient experiences in the healthcare system and learns to listen carefully to the patient's concerns (Thornburgh). This article in *Time* was written not just to report on this innovative program, but to comment on medical practice. In an era when medical technologies save lives daily, medical practice is still highly criticized for its lack of compassion.

Similarly, in September 2005, *The Wall Street Journal* published an article entitled "Teaching Doctors to Be Nicer." The article describes the experience of medical students as they see first-hand the callous behavior of health care professionals in the clinical setting. In this article, Landro discusses an array of efforts by medical educators to include empathy and communication skills in the curriculum. Unfortunately, these efforts are undermined by what students see when they enter the clinical arena (D1).

In clinical practice, it is not unusual to hear interns and residents talking about "the head trauma" in room 212 or "the ovarian cancer" on the sixth floor rather than talking about patients by name. Without names, it is easier to maintain emotional distance from patients. These detached physicians are the role models for medical students. Role modeling is a significant educational modality in medical education. If physician mentors do not display the qualities of compassion and empathy that are necessary in patient care, students will not learn to model that behavior. The callous behavior of physicians in practice, particularly young residents who are treated badly and work excessively, is often blamed on what has been called the "hidden curriculum." This curriculum is a culture that underlies the formal coursework and clinical studies. This

culture encourages students to remain detached to protect themselves from the emotional trauma of dealing so closely with illness and death. A medical humanities curriculum can counter these underlying messages by demonstrating an alternative to detachment in the form of empathetic care. It can help students to gain the skills needed to cope with their emotions rather than suppress them.

In the academic literature, Frederic Hafferty and Ronald Franks from the University of Minnesota, Duluth School of Medicine are the first to identify this culture that models callous behavior and erodes compassion in medical practice. They coin the term "hidden curriculum" and describe it as the curriculum that teaches students about attitudes and values in medical practice including "the 'dangers' of becoming 'too' involved, 'too' reflective or 'too' introspective" (856). The message to stay detached is a long standing tenet of medical education. The term "detached concern" describes the advice given to medical students and residents since the days of William Osler who proposed "equanimity," a notion of the cool, calm and always in control physician. Osler believed this clear-headed, unemotional physician would be able to provide the best care for the patient (Carr). Perhaps the pressures and technological advances of the decades since Osler have pushed this detachment to a crisis point. Medical humanities programs are attempting to respond to the cry for more empathetic practitioners.

The belief that the process of medical education itself erodes empathy and compassion is supported by Paul Haidet's 2002 study which examined the attitude of medical students toward the doctor-patient relationship. Inspired by the movement in medicine towards patient-centered care, Haidet and his colleagues at Baylor College of Medicine in Houston, Texas, used a survey instrument to measure: 1) student attitudes toward sharing the control of patient care with the patient and 2) the value students placed on the caring dimension of health care such as warmth and support in the relationship. Haidet refers to the sharing and caring attitude as patient-centered and the more paternalistic, controlling attitude as doctor-centered (571). The study found that the attitudes of the students changed as they moved from their first year of school to their fourth year. Students in their later years of medical school were less willing to share

control and regarded the caring dimensions of patient care as less valuable. The authors conclude that medicine and medical education share a culture that wears away patient-centered attitudes. They suggest that educational interventions to promote patient-centered care need to be implemented (571-73). Similarly, in 2004 Hojat et al. used the newly developed Jefferson Scale of Physician Empathy (JSPE) to evaluate empathy in third year medical students and noted statistically significant declines in items related to attitudes of empathy based on pre- and post-testing students before and after their third year of medical school. The attitudes evaluated in this study included the importance of asking patients about what is happening in their lives, the place of emotion in patient care, and the need to be attentive to the patient's personal experiences (938-39). The fact that these are third year students is of particular importance because it is in this year that students start clinical rotations and are exposed to the culture in the hospital.

The medical humanities can respond to the hidden culture in medical education. It offers students an opportunity to see their patients as more than the hosts of disease. It allows them to reflect on their role in patient care and to explore the impact they might have on their patients. Studies suggest that the value of empathy in patient care goes beyond issues of patient satisfaction. In a 2002 study, Hojat and colleagues found that higher empathy scores correlated with higher ratings of clinical competence (525-26). If we follow this connection between compassion and clinical competence it can be argued that the next measure we expect to see improvement in would be clinical outcomes. This link is crucial to the argument that the humanities in education is much more than a means to make doctors nicer. It can impact medical outcomes for patients.

Giving value to the competencies of care and compassion in medical practice and offering students an opportunity to learn the necessity of empathy is the only antidote that medical educators have. Proponents of the medical humanities believe that we can teach students the skills necessary to become caring and empathetic health care providers.

However, the question of whether or not is possible to teach empathy has been long-debated in the medical education and psychology literature. If empathy is something innate, something that a person is born with, can it also be taught as any other

skill? At least some medical educators believe in the possibility of teaching empathy or there would be little need for medical humanities programs.

A definition of empathy is important in any discussion of whether or not empathy can be taught. Psychologist and author, Carl Rogers, describes empathy as the ability to "sense the client's private world as if it were your own but without ever losing the 'as if' quality . . . (229). Howard Spiro, director of the Program for Humanities at Yale University defines empathy as "what we feel when we see a picture that moves us … empathy feels [like] 'I am you' " (843). Spiro goes on to say that empathy requires not just compassion but passion. This is what distinguishes empathy from sympathy.

Empathy plays a role in medical care beyond being kind and compassionate. It can assist the clinician in making the right diagnosis. Jodi Halpern argues that empathy contributes to the gathering of medical information in three ways. Empathy allows the physician to understand how patient's view the information they are providing in the medical history. This understanding gives the physician the opportunity to use techniques that will encourage the patient to share information rather than unwittingly discourage communication. Empathy further allows the physician to elicit the symptoms that the patient has been experiencing by offering an opportunity for the patient to fully express these subjective complaints. Finally, empathy helps the physician to have a grasp of the health care values of the patient. This understanding allows the clinician to develop a treatment plan that has the highest probability of being followed (Halpern "Empathy: Using Resonance Emotions in the Service of Curiosity" 160-72). Ultimately empathy contributes not only to how the patient may feel after the encounter, but also to the efficiency and accuracy of the diagnosis and treatment plan. In these ways, teaching medical students to become empathetic practitioners significantly contributes to their competence.

Although educators have only just begun to look for the evidence to support the ability to teach empathy, a few small studies do demonstrate ways to promote the development of empathy through the medical humanities. In 2006, Stepien and her colleagues at the University of Washington School of Medicine examined 13 peer-

reviewed reports of educational interventions that were implemented to teach empathy. In order to better understand how these interventions teach empathy they expanded the definition of empathy by identifying four behavioral dimensions:

> (1) *emotive*, the ability to imagine patients' emotions and perspectives; (2) *moral*, the physicians internal motivation to empathize; (3) *cognitive*, the intellectual ability to identify and understand patients' emotions and perspectives; (4) *behavioral*, the ability to convey understanding and perspectives back to the patient. (Stepien and Baernstein 524)

The 13 interventions include literature and medicine courses, attending a theatrical performance, a reflective writing seminar, communication skills workshops, and interpersonal skills workshops. Six of the thirteen studies focus on the behavioral aspect of empathy and concentrate on the development of communication skills. The literature and medicine courses focus on immersing students in the emotional narratives of patients as they describe their experience of illness. This narrative approach emphasizes the emotive and cognitive dimensions of empathy and offers the opportunity for students to understand the patient in the context of his/her story. After reviewing all of the interventions, the authors conclude that these focused educational strategies can be successful in promoting empathy in medical students (Stepien 528-529).

Medical humanities, whether offered as a literature and medicine course, a communications skills workshop, or specifically through the skills narrative competence and mindfulness offer opportunities for medical students to reflect on their work, their patients and themselves. It helps them to understand the plight of the patient who is ill and trying to navigate the complexities of obtaining medical care today. I would argue that gaining these understandings is empathy.

Without the medical humanities curriculum, a student may stumble into a circumstance that allows for that "aha" moment when they connect deeply with a patient. However, that opportunity should not be left to chance. Studying literature, art, film, mindfulness and philosophy can precipitate those moments for medical students and they need those opportunities to participate fully in the healing arts. Perhaps Kathryn Hunter Montgomery expressed it best twenty years ago when she wrote,

> Here is what the humanities offer medicine . . . an understanding of texts and how to read them . . . and above all that medicine is *not only* a science . . . medicine itself has no special duty of self-examination and reflection. That is where [the medical humanities] come in . . . [the medical humanities] explain medicine to itself, to ourselves, to the world. (K. Hunter 377)

As noted earlier, the value of the medical humanities for medical students goes beyond teaching kindness and compassion. Recognition that empathy can be taught and promoted through specific activities justifies the full inclusion of humanities course in the required medical school curriculum.

Despite this recognition, calls for bringing compassion and empathy into the medical school curriculum are not always met with open arms by medical academics. Kelly Edwards from the University of Washington School of Medicine writes that empathy is not appropriate in the physician-patient relationship. She believes that because empathy requires the physician to identify with the patient, the physician will lose the ability to be objective. She suggests that rather than empathy, medical educators might look to teach something like professional responsibility (Edwards). In the essay, "…And the Least of these is Empathy," Richard Landau, professor emeritus at the University of Chicago Medical School, argues that empathy disables the physician, crippling him with emotion that will interfere with his ability to do what is best for the patient. He acknowledges that physicians need to be sensitive and take time with their patients but ultimately "the patient regards the physician as an authority and wants the opinions and the decisions of a scholarly, experienced expert" (108). Landau's warnings against empathy and Edward's call for professional responsibility are what underlie the hidden curriculum. Adherence to this ideology would bring medical practice back to the days of the authoritative, paternalistic physician and the patient who takes on the dependent "sick role." Medical education has come too far to ignore the need to teach empathy. It is time to move on from goals that support an unbalanced and unsatisfying relationship for both the patient and the physician.

Although the medical field has only recently begun to talk about empathy and balance in the physician-patient relationship, therapeutic empathy is a construct long used

in psychological counseling. Empathy is a major subject of the writing of psychologist Carl Rogers, founder of client-centered therapy. He began writing about empathy and the therapeutic alliance between patient and practitioner in the 1950s. This client-centered alliance or relationship between the therapist and patient is the subject of hundreds of studies in the psychology literature (Feller and Cottone 56-57). Psychotherapists recognize that within this relationship, empathy helps the patient to feel understood. This aspect of the therapeutic relationship is linked to better outcomes for the patient (Greenberg 382-83).

In the 1990's, medicine, following the lead of the psychotherapy community, started to talk about a similar relationship between the doctor and the patient called patient-centered care. This concept became a focus of the family medicine literature and made its way into an Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health Care Delivery System for the 21st Century* in 2001. This report cites six aims for improving health care, one of which is patient-centered care. The IOM report defines patient-centered care as "providing care that is respectful of and responsive to the individual patient preferences, needs, values, and ensuring that patient values guide clinical decisions" (3).

Relationship-Centered Care (RCC) arose from patient-centered care when clinicians began to realize that ensuring that the patient's values guided clinical decision making left no room for the clinician's values or negotiation of the treatment plan. By reinstating the values of the clinician, relationship-centered care is able to emphasize the importance of authenticity and genuineness in the relationship. Like patient-centered care, relationship –centered care acknowledges that respect and the willingness and ability to listen to the patient's story are the first steps towards empathy.

Medical humanities promotes relationship-centered care because it not only emphasizes the patient as a unique person who requires an individualized approach to care, but it also values the relationship between the patient and the clinician. Medical humanities has much to offer medical students in reaching the goal of practicing relationship-centered care. In an article that shares his reflections on the medical

humanities movement, Thomas McElhinney looks back at the early work of Edmund Pellegrino that describes the capacities developed though an exploration of the humanities:

> The capacity for critical thinking,
> The capacity to listen and read intelligently,
> The capacity to make judgments about the beautiful,
> The capacity to make judgments about morals,
> The capacity to comprehend the notion of continuity – that is history. (270)

The physician who embodies these capacities will be able to provide relationship-centered care by taking in and responding to the needs of the patient. Doing what is best for the patient is not only a basic tenet of relationship-centered care it is also one of the four basic ethical principles in biomedical ethics called beneficence. At its core, beneficence is relationship-centered. Beneficence requires that the physician understand the patient well enough to make decisions in his/her best interest. It is through courses offered in a medical humanities curriculum that a student will gain the skills they need in order to understand their patients.

The Association of American Medical Colleges (AAMC) is the professional organization that recommends educational standards for medical schools. In 1998, the AAMC issued "Learning Objectives for Medical Student Education." These objectives are critical for medical students to master in order to graduate from medical school. The rationale behind the initiation of the project is explained in the report accompanying these objectives.

> For more than a quarter of a century the medical profession and the society at large have perceived the goal of medicine to be largely the cure of disease; to a great extent, all other aspects of medicine have been subordinated to this purpose. This view has had a major impact on the way doctors have been educated and on the culture of the institutions responsible for their education. Our society now recognizes the need for a broader view and wants doctors who can and will attend equally well to all aspects of health care . . . a consensus was reached among leaders of the medical education community on the attributes that physicians need to meet society's expectations of them in the practice of medicine. (AAMC 4)

The attributes set out by the AAMC are as follows:

1. *Physicians must be altruistic.* Physicians must be compassionate and empathetic in caring for patients . . . In all of their interactions with patients they must seek to understand the meaning of the patients' stories in the context of the patients' beliefs, and family and cultural values.
2. *Physicians must be knowledgeable. P*hysicians must understand the scientific basis of medicine and be able to apply that understanding to the practice of medicine…They must engage in lifelong learning to remain current in their understanding of the scientific basis of medicine.
3. *Physicians must be skillful.* Physicians must be highly skilled in providing care to individual patients. They must be able to obtain from their patients an accurate medical history that contains all relevant information . . . Physicians must be able to communicate with patients and patients' families about all of their concerns regarding the patients' health and well-being.
4. *Physicians must be dutiful.* Physicians must feel obliged to collaborate with other health professionals and to use systematic approaches for promoting, maintaining, and improving the health of individuals and populations. They must . . . promote healthy behaviors through counseling individual patients and their families . . . " (4-9)

Of these four attributes, three can be addressed by the medical humanities curriculum, in particular, narrative medicine, mindfulness and relationship-centered care. The objectives associated with physician's being altruistic, skillful and dutiful include the ability to provide compassionate patient care, the development of strong interpersonal and communication skills, and recognition of the team approach to care. These are areas that the technological aspects of the curriculum cannot address. It is remarkable that most of what the AAMC considers essential for graduation is in the area of the humanities. Given the percentage of the curriculum devoted to the humanities and the fact that much of it is elective in most schools, it becomes evident why most medical schools cannot fully address these domains of competence.

William Branch and his colleagues, representing medical schools across the nation, examine a number of questions with regard to teaching medical humanities. Included in their 2001 study is a review of the appropriate educational content for

teaching the human dimensions of medical care. The following content areas are recommended:

1. Social amenities including greeting the patient and attending to the patient's privacy.
2. Verbal communications skills such as gathering information using open-ended and closed questions and obtaining psychosocial information.
3. Nonverbal communication skills including facial expressions and eye contact.
4. Observational skills such as noting the patient's dress and interactions with others.
5. Humanistic care including attending to the patient, showing respect for the patient as a unique individual.
6. Self-awareness such as being aware of the emotions evoked by the interaction with the patient. ("Teaching the Human Dimensions of Care in Clinical Settings" 1070)

The first four skills listed are taught in most traditional medical interviewing courses. However, few medical interviewing courses offer more than a cursory examination of humanistic care or self-awareness. Teaching these skills is a challenge for medical educators and is much of the reason for adding a medical humanities curriculum to complement traditional coursework. In 1998, University of Connecticut, School of Medicine, studied the medical interviewing skills of their students. They found that although students gained some skill in obtaining a medical history, they were particularly weak in the area of the social history. The social history is the part of the history that allows the patient to be seen in a social and cultural context. Additionally, skills in communication and rapport showed an interesting pattern, these increased until the third year (when students start clinical rotations) and then declined. Students were learning how to communicate effectively but these skills were lost beyond the second year. The authors offered a number of explanations to account for these findings. One reason involves the "hidden curriculum" which de-emphasizes the need for interpersonal skills. They hypothesized that students were taught to focus on their technical skills and not worry about their interpersonal and interviewing skills. Another possible explanation was that students may be preoccupied with making a diagnosis rather than attending to

the patient's social history or establishing rapport. A third explanation provided by the author's was what they referred to as "getting rid of patients' perspective" so they can have more time to devote to their technical education (Pfeiffer 287). Narrative medicine, mindfulness and relationship-centered care provide strong counter-arguments that would address each of the explanations of why the students at this medical school performed so poorly.

The role narrative competence in medical care is discussed by Garro and Mattingly in their work on narrative, illness, and healing. They recognize narrative as a fundamental means of human expression. Within that, narrative acts as a go-between for the inner thoughts of the patient and the outward expression, i.e. the story told. It is our natural means of communication. Through the ages, stories have served as a medium for learning and gaining insights into the world of others (1-37).

The work of psychologist-psychoanalyst Roy Schafer also addresses some of reasons why narrative and mindfulness are so important in the clinician-patient encounter. Schafer talks about specific actions including attending (being present) and empathizing that are critical in listening to the patient's story. He describes attending or paying attention to the story as a "narrative action" that allows the health care provider to process and reformulate the story for therapeutic purposes (244). Empathizing requires the transformative action of taking the other (the patient) into the self and then restoring separateness so that the clinician can "know" how the patient feels. In this way the clinician recontextualizes, that is, takes into account "much of the patient's *experienced life-historical background . . .*" to enhance their therapeutic connection (246).

The work of sociologist Arthur Frank asks clinicians to think *with* stories rather than think *about* stories. Thinking with the story lets the listener or reader experience the story rather than analyze it (23). This allows, as Schafer suggests, the transformation of the listener/reader to an empathetic partner of the patient. Frank finds, as do the principals of relationship-centered care, that there is a moral imperative to thinking with stories, to witnessing the illness narratives of patients and retelling them (24).

The skills of narrative competence, mindfulness and relationship-centered care not only enhance the clinician's ability to understand the patient's story but also offer opportunities for healing. The skills needed to listen effectively to the patient's story also allow the patient an opportunity to tell his/her story. In telling these stories of illness, patients have an opportunity for healing. The telling of a story gives the patient a chance to reframe, clarify and tell, not only the clinician, but also him/herself this very important story. As Arthur Frank explains, "Illness is a crisis of self in the specific sense of an uncertainty that one's self is still there . . . the reaffirmation of this self as 'available' is crucial" (56). The experience of serious illness is often transformative. The well person becomes an ill person, whether it is visible to the outsider or not. Acknowledgement of this new self, the ill self, is difficult and uncomfortable, like wearing a heavy coat that is bulky and too big. Telling the story is asking for a witness to the experience of illness, asking for someone to see and help carry the ill-fitting coat. Most importantly, asking the listener to recognize that story teller is there, struggling to restore the well person again. The story, shared with the clinician, informs and heals simultaneously.

Equipping medical students with the tools needed for narrative competence, mindfulness and relationship-centered care will undoubtedly improve the chance that they will grow into practitioners who can truly listen to and interpret the stories their patient's tell them. Over the last fifty years, medical education has been slowly moving toward embracing a more humane model of medical care. The medical humanities movement has been at the forefront of this transition. Adopting skills of narrative competence, mindfulness and relationship-centered care as expected educational outcomes for medical students will lead to the graduation of doctors who are capable of providing empathetic care.

CHAPTER 2
NARRATIVE MEDICINE, MINDFULNESS AND RELATIONSHIP-CENTERED CARE

The physician in the 21st century is immersed in a healthcare system that is focused on technologies and efficiencies and not on the patient and the therapeutic relationship. Calls for better communication between doctors and patients continue to be supported by health care consumer polls **(**Adams**)**. We have long seen how technology has intervened between the doctor and the patient. The emphasis on diagnostic outcomes has left us with distant clinicians focused on getting the right diagnosis rather than making a connection with the patient. In addition, medical specialization exacerbates these already impersonal relationships by requiring patients to be seen by many different providers for a single problem – some of whom they see only once. There is little opportunity to develop a therapeutic relationship in this type of health care system. Without an understanding of the patient's plight, medicine is practiced in a vacuum that is dissatisfying to both the patient and the provider. Narrative medicine, mindfulness, and relationship-centered care offer an alternative model for practicing medicine that emphasizes the therapeutic relationship rather than the technology. This chapter will examine narrative medicine, mindfulness and relationship-center care as answers to the communication problems of the doctor-patient relationship. It will focus on the intersection of these practice models and show how, when taken together, they can create an evolution in the therapeutic relationship. It will also explore some of the educational programs that are beginning to embrace these concepts.

Medicine itself is a narrative enterprise. It is filled with the patients' stories. The ability of the clinician to make sense of these stories is what leads to ordering appropriate diagnostic studies, making accurate diagnoses and effective treatments. Narrative medicine utilizes the patient's story and depends on the narrative skills that can help connect doctor and patient through this story. From the first moments of the medical encounter, there is narrative. The patient tells the story of illness and the doctor listens to

that story. In medical training, the case presentation is a retelling of the patient's story by the clinician. It is a fundamental element of medical communication. The case presentation is an interpreted narrative, the clinician's version of the patient's story. Kathryn Montgomery Hunter describes these two narratives (the patient's story and the doctor's interpretation) as linked accounts of illness that cannot exist without one another (123-47). The narrative features of medicine remind us of medicine's dependence on stories. It is most obvious in the construction of the medical history – the history of present illness (HPI) but it extends far beyond this narrative section of the patient chart. These narrative aspects of medicine should guide us in thinking about medical education in new ways.

In 1995, Rita Charon, Joanne Trautmann Banks, Julia Connelly, Anne Hunsaker Hawkins, Kathryn Montgomery Hunter, Anne Hudson Jones, Martha Montello and Suzanne Poirer collaborated on an article published in the *Annals of Internal Medicine* entitled "Literature and Medicine: Contributions to Clinical Practice." Although literature and/or narrative have been discussed as a teaching tool by medical educators since the 1970s, this ground-breaking article, written by the leaders in the area of narrative as it relates to medicine, did much to enhance its value. In this article, the authors make the argument that students require explicit training in the humanistic aspects of health care as they do in the scientific areas. The authors explain that literature contributes to the teaching of the human dimensions of medical care in the following ways:

> Literary accounts of illness can teach physicians concrete and powerful lessons about the lives of sick people; 2) great works of fiction about medicine enable physicians to recognize the power and the implications of what they do; 3) through narrative knowledge, the physician can better understand stories of sickness, thereby strengthening diagnostic accuracy and therapeutic effectiveness . . . 4) literary study contributes to physicians' expertise in narrative ethics . . . 5) literary theory offers new perspectives on the work and genres of medicine. (600)

Since 1995, the exploration of the contribution of literature and narrative to medical care has exploded. Hundreds of journal articles and texts describing theories,

methodologies, and studies of implemented programs are evident in the literature. By 2001, Charon had coined the terms *narrative competence* and *narrative medicine*: "The effective practice of medicine requires *narrative competence*, that is, the ability to acknowledge, absorb, interpret, and act on the stories and plights of others. Medicine practiced with narrative competence called *narrative medicine*, is proposed as a model for humane and effective medical practice" ("Narrative Medicine: A Model for Empathy, Reflection, Profession and Trust" 1897). Reflecting back to earlier discussions of what patients are looking for in a therapeutic relationship and noting the call from AAMC for empathetic engagement in that relationship, we can see why the exploration of this area of medical education is vital today. Charon's work provides a bridge between narrative and empathy. She explains that narrative competence can lead to the ability to be empathetic through the acquisition of skills that allow the reader to learn to pay close attention to language, diction and metaphor. The skills that allow us to closely follow a plot line, also allow us to follow closely the meandering stories of our patients ("The Narrative Road to Empathy" 151).

Learning to think critically and read closely is the beginning of the path to narrative competence. Close reading skills allow readers to interpret a written passage by considering how the words, sentence structure, and imagery inform their understanding of the story or a particular character in the story. Discovering the meaning of the written passage through narrative analysis parallels the analysis of the patient's story that is required if a clinician is to accurately diagnose the patient's problem.

By contrast, in today's medical system, medicine is most often practiced without narrative competence by clinicians who do not make the patient's story a priority. As previously described, the focus on the technical aspects of medicine de-emphasizes the development of the skills of listening and interpreting the patient's story. Rita Charon describes clinicians educated without these skills as unable to "follow a narrative thread; … adopt an alien perspective; . . . [they are] unreliable narrators of other peoples' stories; who are deaf to voice and image . . . She goes on to say that "Literature thinks it can help medicine accurately interpret the stories of sickness and courageously recognize – and

thereby soften – human suffering" ("Literary Concepts for Medical Readers: Frame, Time Plot, Desire" 30).

The collaboration between the patient and physician is a critical element of the therapeutic relationship. The story exerts a powerful influence over the entire clinical encounter. It is not only the staple of medical information for the clinician; it is also the source of seeing patients in the context of their lives. Examining the narrative features of medicine provides insight into the power of the story in the clinical relationship.

In her text, Narrative Medicine Honoring the Stories of Illness, Rita Charon discusses the narrative features of medicine: temporality, singularity, causality, intersubjectivity, and ethicality (*Narrative Medicine Honoring the Stories of Illness* 131-51). Each of these narrative features refers directly to the story but also extends to the practice of narrative medicine.

Temporality refers to time, which is a critical element in the medical narrative. In medical interviewing courses, students are taught that temporality is an essential part of the patient's story. When did the symptoms begin? Has it been years of intermittent mild complaints, weeks of more significant problems, or perhaps hours of something more intense? Each of these temporal relationships reveals a completely different differential diagnosis for the clinician/listener to consider. In medical practice the chart often reveals a series of accounts that tell a story over time. How has the patient's story changed and evolved?

The story of Mrs. G illustrates this point. Mrs. G, is a 60 year old diabetic patient who first presented 10 years ago with vague symptoms of fatigue and a general sense of malaise. Laboratory tests revealed an elevated blood sugar and a diagnosis of diabetes was made. Since that time she has come in for visits every 6 months and although her blood sugar has been relatively well controlled, her chart reveals the progression of her illness over time. At first, just a few minor infections which were difficult to heal, then the numbness in her feet, and now the onset of heart disease. Over time, the natural history of her illness is recorded in the medical chart.

Singularity is the aspect of narrative medicine that provides the connection to the patient's individuality through its insistence on the unique nature of every medical narrative. Oliver Saks describes this feature well.

> If we wish to know about a man we ask 'what is his story-his real inmost story?'- for each of us is a biography, a story. Each of us is a singular narrative, which is constructed continually, unconsciously, by, through, and in us through our perceptions, our feelings, our thoughts, our actions; and, not the least, our discourse or spoken narratives. Biologically, physiologically, we are not so different from each other; historically, as narrative- we are each of us unique. (110)

Narrative singularity teaches us that every story is matchless and distinct. Each patient offers us his/her story, the medical history, the singular truth that belongs only to that story, to that patient. Understanding that each patient is an individual is an essential aspect of the therapeutic relationship. Singularity echoes the medical ethics principle of autonomy which states that patients are unique individuals who must share in medical decision making. Singularity also connects to relationship-centered care which recognizes not only the individuality of the patient but also the individuality of the clinician. The therapeutic relationship is based on acknowledgement that two unique human beings, the clinician and the patient, work together to ensure the best medical outcome.

The concept of singularity can be generalized to other aspects of medicine. Most recently cancer treatments have been tailored to individual patients by examining the DNA of their own cancer cells and targeting treatment to those unique cells. The recognition of individuality in medicine has been documented in the JNC (Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure) report on the treatment of hypertension which describes the preferred treatments for elevation of blood pressure. In this document, the patient's age, sex, race and underlying medical conditions are considered in order to make the best treatment decision (National Institutes of Health). There is no doubt that medicine is moving more and more toward the recognition of the individual.

Causality is very familiar to any student of medicine. It is the stuff of everyday practice and what is tested in the standardized examinations that certify a practitioner's ability to provide medical care. Given a set of symptoms and/or diagnostic studies – What is the cause? For the clinician, each day, patients arrive asking that very question. Why am I ill? What is causing this problem? Physicians spend years honing their skills of diagnosis and causality. They study the symptoms, the sequence of events as the illness progresses. Much like the plot of a narrative, a story unfolds as the clinician listens to the patient. The story leads the clinician to the cause of the illness. Charon describes it this way:

> Diagnosis itself is the effort to impose plot onto seemingly disconnected events… The plot-strong clinician will not stop with obvious… but will keep looking… hopefully in collaboration with the patient – to construct a wide and varied differential diagnosis. This is narrative medicine in practice. (*Narrative Medicine Honoring the Stories of Illness* 50)

Intersubjectivity is the situation that arises when two subjects meet. Both medicine and narrative bring two subjects together. In narrative it is the reader and writer, in medicine the physician and the patient. Tellers and listeners enjoy a unique personal connection. The clinician has a duty to listen carefully and with the patient co-construct the story and give it meaning. This joint assignment of meaning unite the two allowing a certain intimacy, and adding to the exceptional quality of this particular relationship. In the world of medicine the teller and the listener create an intersubjective narrative based on what is entrusted to the clinician by the patient. The following story by David Watts illustrates this connection.

> *The Girl in the Painting by Vermeer*
>
> Ten o'clock Monday morning and she's waiting for me, my new patient, a woman who looks younger than her age of 35. She almost curtsies as she shakes my hand. She wears a light tweed suit that reminds me of Easter Sunday in Central Texas.
>
> She has a quick laugh that juts into conversation with surprising speed and at unexpected places, as if she's embarrassed to be speaking out loud. She's a violinist, teaches a large clutch of students and is frequently tired but blames it on her heavy concert schedule. She's lost weight. No other symptoms. Oh yes, night sweats, drenching. Another doctor found something in her liver and she wants to know what I think.

> In the exam room she reaches down and pats her belly. Do you see it? Do you see my hemablob? Your what? My hemablob. That's the name I gave it. She laughs. And there, out her side, a large bump protrudes, lifting the skin over it like a mound of soil over something buried. Holy cow, I think to myself. That thing's huge. She's looking up at me. Hemablob, I say. It's a great name.
>
> We run a few tests. She's giving a lesson when I call with an update and plan. She doesn't ask questions, just says, it's a mind boggle.
>
> I schedule a colonoscopy. Two seconds in and I find it. The nurse groans as the lens picks up the unmistakable fleshy, crumbling mass, plastered to the side of the rectum like a fungus gone mad.
>
> The room grows quiet, as if we were standing around the embers of a house burned down, kicking the cinders aimlessly. I look down at her lying on the table. She looks young and perfect, relaxed in a posture of grace like a girl in a painting by Vermeer. But I know her body's ruined, rotting from the inside out.
>
> In recovery I tell her I found it. She says it makes sense. She's been thinking there might have been a little pain, a little bleeding. I'm sorry for the trouble I caused you, she says.
>
> She decides to move back to New Haven to be close to her friends. I call her at home the next day. Her voice still has that light lift I heard the first time we met. I say I wish I could have found something nicer. She laughs and thanks me for picking up on her crazy way of communicating. I do violin all day, she says. I'm not very good with words.
>
> There came a little silence in which I could not say good luck, because I knew she wasn't going to have any. We stayed on the line a while, holding on to our silence, letting it run a few saturated seconds . . . then broke the connection as we knew we must. (45-46)

In this story the reader understands that the there is an intersubjective connection between this clinician and patient even though they have just met. She places her fate in his hands, or rather in his words. What will he find? What will he say? There is an intimacy, a connection and sense of duty and responsibility to the patient. We hear through physician's retelling, the patient's own words. The peculiar name she gave her tumor and how she is not good at expressing herself. Charon writes that the receiver of a narrative "owes something to the teller, by virtue, now, of knowing."(*Narrative Medicine Honoring the Stories of Illness* 55) The ethicality of bearing witness is part of the relationship between the clinician and the patient. Arthur Frank talks about the ethical responsibility of those who retell the stories of illness. In the retelling of the patient's

account of illness, the witness/clinician offers "testimony" to a new truth that is the patient's story (1-25). David Watt has not only an intersubjective connection to the patient; he also has a moral obligation.

At the core of narrative medicine is the belief that the relationship between the physician and the patient can be healing and empathy plays a critical role in this therapeutic relationship. Skills that would aid the clinician in recognizing suffering, perceiving the impact of illness on the patient and the patient's family, managing their own emotional turmoil as they struggle with life and death situations are ultimately narrative skills (self-reflection, mindful listening, compassionate presence, etc.). The clinician's ability to listen to the stories of patients can lead to the kind of health care we hope to achieve. In understanding these stories, the doctor will see patients in the context of their lives and their suffering. This narrative knowledge can be used by clinicians to help make sense of the mix of emotions that come up when providing medical care to the sick and dying, replacing the urge to protect oneself from the onslaught of feelings by cutting off emotion.

Narrative medicine is not just about stories of illness. As described by Charon, medical narratives may be found in a number of distinct genres.

1. Medical fiction, written by physicians and other health care providers, are fictionalized accounts that express their experiences in medicine.
2. Non-clinician essays on experiences with illness and the health care system appear in magazines like *The New Yorker* and newspapers such as the *New York Times*. Both publications regularly publish essays written by physicians about their experiences in medicine intended for a lay audience.
3. Medical autobiography is another genre of narrative. Books like the *House of God* or *A Taste of My Own Medicine,* which provided the story for the movie *The Doctor,* allow the clinician-writer to describe experiences in medical training and/or practice.
4. Stories from practice similarly tell of experiences in practice or training but in this case the intended audience is others in the health care system. *Annals of Internal Medicine* and *Journal of the American Medical Association* both have regular columns that offer physicians an opportunity to speak to their colleagues.
5. Writing exercises in medical training may take the form of prose, poetry, critical incident reports or parallel charts. These encourage

> reflection on the experience of caring for patients ("Narrative Medicine: Form, Function, and Ethics" 83-84).

Narrative medicine is one approach to helping clinicians and medical students develop empathy and compassion for their patients. New educational interventions that bring mindfulness and other non-traditional concepts utilizing the humanities are becoming more popular in medical schools in the United States and internationally. A recent literature review reported that more than 240 journal articles over an eight year period (2000-2008) discuss the value of humanities in medical education and specific programs in place or in development. (Ousager and Johannessen 988-98). This finding demonstrates the recognition by medical schools of the benefit of including medical humanities in medical education. Medical educators are looking to these alternative approaches to promote professionalism and humanism in medical students, to encourage empathy in practitioners, to increase the sense of meaning and purpose for clinicians, and to foster self-reflection, mindfulness and presence in the medical encounter[1].

The medical humanities programs utilize different curricular designs but their overall goals are the same. Humanize the experience of medical education and in so doing, promote the development of more humanistic clinicians. The model used by the Maine Humanities Council is one found in many institutions. In 1997, the Council created a program called *Literature & Medicine: Humanities at the Heart of Health Care.* Although it is a hospital-based program designed for practicing clinicians, similar programs are utilized in medical schools. The program offers monthly meetings where clinicians discuss assigned medical narratives that illustrate issues in health care. The

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[1] Examples of educational initiatives: (Arno Kumagai, "A Conceptual Framework for the Use of Illness Narratives in Medical Education," Academic Medicine 83.7 (2008), Daryl Pullman, Cheri Bethune and Pauline Duke, "Narrative Means to Humanistic Ends," Teaching & Learning in Medicine 17.3 (2005), Lewis Mehl-Madrona, "The Nature of Narrative," The Permanente Journal 11.3 (2007), Johanna Shapiro, "Walking a Mile in Their Patients' Shoes: Empathy and Othering in Medical Students' Education," Philosophy, Ethics, & Humanities In Medicine 3 (2008).

goal of the program is to offer an opportunity for a fuller understanding of the human condition and the experience of illness. The program is held over a six month period and is evaluated at the end of each cycle. Participants reported that they were better able to understand the impact of social and cultural influences on their patients and the patients' families; it sensitized them to the difficulties inherent in communicating with patients and the need to be mindful in this process; it improved their awareness of different value systems and perspectives, and it caused them to be more self-reflective about their work and their interactions with patients (Bonebakker 963-67).

These findings support the concept that the study of the medical narrative can help clinicians to develop skills in humanistic care and self-awareness which are necessary for narrative competence. Although this program was designed for clinicians in practice, the model could be easily implemented for undergraduate medical students during their clinical years.

Twice yearly, the journal *Medical Education* publishes a column called "Really Good Stuff" which was created to share emerging trends in medical education and encourage the exchange of ideas amongst medical educators. In the last few years, along with descriptions of many technological developments in medical education, programs in medical humanities have been described. These vary in format and include educational interventions such as: a film course offered to third year medical students; a physical diagnosis course that opens with a reading of a Richard Selzer essay; and a program that assigns senior students to a patient and his/her family for a six to nine month period in order to view the experience from the perspective of a "family member." In the description of these programs, the educators include a justification for their inclusion in the medical curriculum. Reasons cited for these programs include: the need to help students confront issues of human suffering and death; the need to explore the clinician's "privilege and responsibility" in performing the physical examination of a patient (Perakis 1038) and the need to step out of the role of clinician in order to better understand the patient's experience of illness (Lepicard and Fridman), (Perakis), (Amin and Rucker). In each of these examples of programs that are currently in place, narrative

is central to the learning experience. The teachable moment is created by the patient's story in films such as "Wit" and "Lorenzo's Oil" and by the doctor's story in Richard Selzer's essay "Textbook." In the program requiring a student to become a "family member" of their patient, the student's diary documents the patient's story and their own reflection on seeing the illness through the patient's eyes. The thread that runs through these programs is the recognition that medical education must offer an opportunity for students to learn the skills necessary for them to provide humanistic care in a complex medical environment. The evaluation of these programs reveals that the participants value the experiences and feel that they contribute or will contribute to their practice of medicine.

As noted in the study by Bonebakker, medical narrative can help practicing clinicians to reconnect with old ideals. Perhaps they can again connect to those intentions for practice they had as students but have long forgotten. In the current structure of the health care system there is little time for clinicians to develop relationships with their patients. The practice of medicine requires great technologic skill and expertise in a medical knowledge base that is enormous and unmanageable. It is no wonder that many clinicians have lost the capacity to find meaning in their work and to extend themselves to their patients through empathetic engagement and compassion.

Carol Horowitz and her colleagues studied stories written by physicians in order to discover what they found to be important in their work. They were able to identify three basic themes: a change in the clinician's perspective after a profound event or emotional experience; a connection made with a patient; and making a difference in someone's life. Almost all the physicians in the study wrote about a human connection rather than a technical triumph. They reported that these experiences with their patients reaffirmed their commitment to healthcare. In addition, they viewed the story writing itself as a helpful exercise for clarifying their personal feelings. This study demonstrates two important concepts. First, that clinician job satisfaction is primarily determined by the quality of the relationships they have with patients. Second, the process of writing

and discussing their writing is helpful for clinicians who are dealing with the demands of our current medical system (772-74).

In December of 2001, the *Annals of Internal Medicine* began a medical writing feature called "Physician-Writers' Reflections on their Work." In their introduction to this new feature, the editors describe the rationale behind its development: "Underlying this interest (in narrative medicine) is the assumption that careful attention to language and stories in medicine can enrich the doctor-patient relationship, improve patient care, and enhance doctors' sense of satisfaction with their work" (American College of Physicians 1012). In one of these narratives, Kate Scannell, a practicing physician in California, describes how writing is "life-saving" for clinicians in that it provides a way to recognize the meaning in their work. ". . . we are uniquely positioned to bear witness to birth, death, pain, suffering and healing . . . Consciously narrating these accounts illuminates more of our collective lives as patients and physicians, expanding our felt understanding of human frailty, compassion, strength, love, fear, hatred and ill will" (780-81).

The medical narrative has much to offer as an educational tool that can promote empathy and compassionate care. It can also provide clinicians with a means to explore the meaning of their work in order to attain better job satisfaction and to reaffirm their commitment to healing. Most importantly, with narrative competence health care providers can work alongside patients toward creating a health care system that is effective, compassionate and caring.

Educational advances are often prompted by trends noted in reports by the medical professional organizations. In 2007, the American Medical Association published *Initiative to Transform Medical Education: Recommendations for change in the system of medical education.* In their examination of the gaps in medical education, the authors of this report note a number of areas in need of improvement. Among these are the loss of altruism and the caring aspects of medicine, the expectation that the physician will be "in charge" rather than one participant of several in health care decisions and poor communication skills on the part of clinicians. (AMA) Appreciation

of the patient as a unique individual, the ability to listen to the patient's story, and recognition that the patient is part of the decision-making team can all be reinforced in a curriculum that emphasizes narrative competence, relationship-centered care and mindfulness.

These three aspects of medical practice are not often discussed together in the literature, but the three intersect in the clinician-patient relationship. The collaboration between the patient and clinician has been a major focus of both relationship-centered care and mindful medical practice. They both arise from the call to humanize the clinician-patient relationship. Few authors/educators, however, have looked at the melding of narrative, mindfulness and relationship-centered care.

Relationship-Centered Care (RCC) arose from patient-centered care which became popular in family medicine circles in the mid-1990s. The Institute of Medicine Report, "Crossing the Quality Chasm" includes patient – centered care as one of the six pillars of quality care (IOM 1). In her seminal text on patient-centered care, Moira Stewart begins her introduction by saying: "Patients are dissatisfied. Physicians are confused and may no longer enjoy their work. Their training has not prepared them adequately for the everyday challenges in practice" (Stewart xv). Pointing to failing medical education and practice as the causes of this complex problem, she introduces a patient-centered model of health care. This model of care was quite revolutionary when introduced in 1995. It introduced concepts such as: exploring the patient's experience of illness, understanding the patient as a whole person, and creating a therapeutic relationship. At this time, the focus on the patient was a new solution to the problems of the doctor-patient relationship. Stewart suggests that clinicians needed to relinquish their authority in the relationship in order to empower patients and empower the relationship itself. Although this was the beginning of a very important positive shift in doctor – patient dynamics it was this patient-centric model caused problems for clinicians who attempted to follow its tenets.

Criticism of the model includes its exclusion of the clinician as an equal member of the team. Stewart and her colleagues promoted patient empowerment to the extreme.

They went as far as labeling collaboration with patients as doctor-centric behavior. The model has been blamed for promoting an extremely prescribed clinician role that created disingenuous clinicians who act a part rather than being truly part of the relationship. These criticisms led to the development of relationship-centered care (RCC). As defined by the Pew Fetzer task force, relationship-centered care includes:

> organizing information about the patient and his or her care; providing comprehensive biomedical care; critically reflecting on practice to increase self-awareness; practicing from a caring, healing ethic and perspective that seeks to preserve the dignity and integrity of the patient and the patient's family; listening and communicating openly and effectively; . . . encouraging the active collaboration of the patient and family in decision making, care, and treatment . . . (Tresolini and Force 27-28)

In this model the clinician is an equal partner with the patient. The encouragement of an active collaboration with the patient is a very important advancement in this model. Additionally, the focus on self-reflection to improve patient relationships recognizes a new responsibility for the clinician as a partner to the patient in therapeutic relationship. In addition, RCC takes another step ahead by considering not only the clinician's relationship with patients but also the relationship with colleagues and the community. This model assures not only the patient's satisfaction and positive sense of support, it also assures the same for the clinician.

The Pew task force includes a description of knowledge, skills and values that are necessary for relationship-centered are. These are summarized in the following table:

Table 1

Knowledge, Skills and Values Necessary for Relationship-Centered Care.

Component of RCC	Knowledge	Skills	Values
Self-awareness	Knowledge of self-understanding self as a resource to others	Reflect on self and work	Importance of self-awareness, self-care, self-growth

Table 1 *continued*

Component of RCC	Knowledge	Skills	Values
Patient experience of health and illness	Role of family, culture, community	Recognize patient's life story and its meaning	Appreciation of the patient as a whole person
	Threats and contributors to health	View health and illness as part of human condition	Appreciation of the patient's life story
Effective communication	Elements of effective communication	Listen	Importance of being open and nonjudgmental
		Impart information	
		Facilitate the learning of others	
		Promote and accept patient's emotions	

Adapted from: The Pew Fetzer Task Force on Advancing Psychosocial Health Education. *Health Professions Education and Relationship-Centered Care*. Page 30, San Fransico 1994

It is easy to see from the table outline how the emphasis is shifted from the patient to the relationship. Beach and colleagues also attempt to explain RCC by defining four basic principles. These are:

Principle 1 - Relationships in Health Care Ought to Include Dimensions of Personhood as Well as Roles.
Principle 2 - Affect and Emotion Are Important Components of Relationships in Health Care.
Principle 3 - All Health Care Relationships Occur in the Context of Reciprocal Influence.

Principle 4 - Relationship-Centered Care Has a Moral Foundation. (S4)

These principles again point to the emphasis on the relationship. Principle 1 recognizes that the patient and the clinician are unique individuals with their own experiences and values. One aspect of relationship-centered care that makes it distinct from patient-centered care is that it emphasizes the importance of authenticity or genuineness in the relationship. The clinician's respect for the individuality of the patient must be real. Genuineness is a basic tenet of empathy and fosters the therapeutic relationship. As with narrative medicine, the goal is the establishment of establish an authentic relationship. Principle 2 focuses on empathy. In relationship centered care, empathy is encouraged. The patient is supported through the emotional presence of the clinician. Empathy can help patients experience and express their emotions. This principle connects directly with mindfulness which fosters presence and emotional availability of the clinician. Principle 3 recognizes that clinicians benefit and grow from knowing their patients. When the patient is allowed to have an impact on the clinician, it is a way of honoring that patient. The acknowledgement that the clinician benefits in serving the patient is unique to relationship-centered care. Principle 4 addresses the moral component of clinician- patient relationship. The authentic relationship fostered in relationship-centered care is morally desirable because it is through these relationships that clinicians become invested in the patient's experience and outcome. This investment is necessary if one is to serve others genuinely and be renewed from that serving. The honesty inherent in this type of relationship is morally desirable as an end in itself.

There are many connections between narrative medicine and relationship-centered care. Both emphasize the human interaction that is the basis of the therapeutic relationship. Narrative medicine, with its emphasis on the patient's story, opens the door to the patient as a unique individual and is a perfect companion to relationship-centered care because it also requires seeing each patient encounter as an opportunity for a unique relationship. In her text, *Narrative Medicine, Honoring the Stories of Medicine*, Charon mentions patient-centered care early in her text. She praises the concept as one that is "bound to enhance clinical effectiveness" but she misses the opportunity to make the

obvious connection to narrative (*Narrative Medicine Honoring the Stories of Illness* 27). Her discussion of the goals of narrative medicine could easily be a discussion of the goals of relationship-centered care. The four principles of relationship-centered care as outlined by Beach could apply just as well to of narrative medicine. As described by Charon, narrative medicine can be construed as doctor-centric. It is about the doctor using narrative skills to best interpret the patient's story. In her discussion of narrative skills, Charon describes clinicians who practice narrative medicine as "meaning-making vessels…we act almost like ventriloquists to give voice to that which the patient emits" (*Narrative Medicine Honoring the Stories of Illness* 132). This idea of speaking for patients is where narrative medicine leaves the path of the egalitarian relationship. Although Charon speaks at length about empathy, this is not empathy. Empathy is not about interpretation, it is about giving up the ego in order to feel another person's feelings. The marriage of relationship-centered care and narrative medicine can help to enhance and refocus the latter in order to allow for the creation of a truly therapeutic relationship.

Focusing on relationship-centered care, Norfolk and colleagues developed a model of doctor-patient communication that helps to elucidate the relationship with narrative medicine. In their 2007 study, Norfolk, et al looked at the motivation and skills that are required for the clinician to engage in a therapeutic alliance with the patient. They found that there are both innate qualities and learned skills that can impact the relationship. Clinicians who are open, curious, warm and caring are more motivated and empathetic. However, even when these innate qualities are not strong, specific skills can substitute for innate characteristics. A clinician who can pick up the clues in the interview that relate to the patient's feelings and thoughts and build a perception of the patient based on conversation and non-verbal cues are skills that can lead to an empathetic connection to the patient. Communication skills that encourage patient disclosure will add to the effectiveness of the relationship (691-93). Narrative competence requires these same skills described by Norfolk. In carefully listening to the patient's story a clinician with narrative competence is able to pick-up on clues that

reveal the patient's concerns in the context of the account. Norfolk's study, without naming narrative competence, describes the skills as necessary to establish a therapeutic relationship.

Similarly, the practice of mindfulness connects relationship-centered care with narrative medicine. Mindfulness is a practice that involves purposefully paying attention. The purpose of mindful practice is to open the door to hearing the patient's story fully. This same purpose is the major function of narrative medicine. Ronald Epstein describes the mindful practitioner as on who "attends, in a nonjudgmental way, to his or her own physical and mental processes during ordinary everyday tasks to act with clarity and insight" ("Mindful Practice" 833). He describes characteristics of mindfulness including curiosity and reflection (cognitive and emotional), insight, and being available and present in the encounter. Epstein argues that without self-awareness of core values a clinician cannot distinguish his or her reaction to suffering from the patient's experience of illness ("Mindful Practice in Action: Cultivating Habits of Mind" 12-13). If we agree with this premise, practicing narrative medicine in the context of relationship-centered care requires skills in mindful practice.

In their text Narrative in Health Care, Engel et al describe narrative skills that differ from those offered by Charon and colleagues. They include in their list of skills "practicing compassionate presence and mindful listening" (9). The inclusion of these skills recognizes the direct relationship between mindfulness and the practice of narrative medicine. These models connect because narrative competence requires the skills of compassionate presence and mindful listening. Narrative competence cannot be achieved without the ability to practice medicine mindfully.

Narrative medicine, mindfulness and relationship-centered care all utilize reflection, both self-reflection and reflection upon meaningful events. Reflective writing is a useful methodology because it has the potential to increase self-awareness. Branch and colleagues reported in the early 1990s about the experiences of third-year medical students who were given an opportunity to write about their clinical encounters. After reviewing over one hundred of these reflective papers he concluded that the papers

almost always focused on situations in which conflict arose between empathy for the patient and the culture of medical care ("Becoming a Doctor - Critical-Incident Reports from Third-Year Medical Studentd" 1130-32). This finding is very important because it emphasizes the conflicts that arise in medical students. The fact that they felt compelled to write about these conflicts represents the burden that the culture of medical care imposes on the students. Reflective writing is an opportunity for students to explore these and other conflicts that arise in medical training. It also serves as a way to process feelings that arise when dealing with patients who are ill or dying.

Interactive reflective writing is a methodology utilized by medical educators that allows them to have a conversation with the student on the page. This written mentorship can be a critical part of the professional development of health care provider. In 2004, DasGupta and Charon referred to reflective writing as an established method for teaching medical students about the clinician-patient relationship. Reflective writing offers students an opportunity to reflect on their own personal experiences of illness and in this way they are able to change their point of view from that of the clinician to that of the patient in order to gain a new perspective (351-56). In 2010, Reis and colleagues of the Warren Alpert Medical School at Brown University reported on their efforts to assess their curriculum around reflective writing and the development of a concrete tool for faculty to provide appropriate feedback to students (Reis et al. 253-59). Self-reflection is a key skill in the narrative medicine, mindfulness and relationship-centered care.

A number of medical schools have introduced narrative studies in some form, and some have moved to teaching patient-centered or relationship-centered care and one or two schools even offer an elective in mindfulness but none have put the three of these together and certainly no school has required students to graduate with competencies in these areas. Requiring these competencies should be the next step in the evolution of medical education.

Medical education has benefitted greatly from the medical humanities movement. Beginning in the 1980’s with the works of Howard Brody and Arthur Kleinman, who brought attention to the patient’s story and the importance of that story in understanding

the patient and making the right diagnosis (Brody et al. 220-23; Kleinman). Later Kathryn Montgomery Hunter and Anne Hudson Jones, among others, began the discussion of the narrative nature of medical knowledge and how literature and medicine connect (Hunter 367-78; Jones 1360-2). As this movement continued, texts were published regarding narrative- based medical practice, including Rita Charon's Narrative Medicine: Honoring the Stories of Illness. Finally, in 2008, Engel, et al published Narrative in Health Care: Healing Patients, Practitioners, Profession and Community. In this text the authors not only consider the narrative nature of medicine but they go on to include relationship–centered care and even mention mindful practice as one method of improving listening skills.

The next step is to move from theory to practice and incorporate this work into the medical school curriculum. Medical school curricula are largely influenced by the accreditation requirements set out by the Liaison Committee on Medical Education (LCME). In June 2013 the LCME published the newest accreditation standards that include guidelines for the curriculum. With regard to communications and medical ethics, the following is required:

> The curriculum of a medical education program must include specific instruction in communication skills as they relate to physician responsibilities, including communication with patients and their families, colleagues, and other health professionals.
>
> The core curriculum of a medical education program must prepare medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from other health professions.
>
> The curriculum of a medical education program must prepare medical students for their role in addressing the medical consequences of common societal problems (e.g., provide instruction in the diagnosis, prevention, appropriate reporting, and treatment of violence and abuse).
>
> The faculty and medical students of a medical education program must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
>
> *Instruction in the medical education program should stress the need for medical students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on*

> *patients' health. To demonstrate compliance with this standard, the medical education program should be able to document objectives relating to the development of skills in cultural competence, indicate the location in the curriculum where medical students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.*
>
> Medical students in a medical education program must learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the process of health care delivery.
>
> *The objectives for instruction in the medical education program should include medical student understanding of demographic influences on health care quality and effectiveness (e.g., racial and ethnic disparities in the diagnosis and treatment of diseases). The objectives should also address the need for self-awareness among medical students regarding any personal biases in their approach to health care delivery.*
>
> A medical education program must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients' families and to others involved in patient care. (11)

Although the LCME does address the need for education in communication skills and self-awareness and the need for students to have instruction in medical ethics and human values, it is purposely vague about how to go about these tasks. Educational standards such as these avoid specifics in order give schools flexibility in curriculum decisions. Unfortunately, in this case, its lack of specificity allows schools to continue to focus on the scientific/technologic portion of medical education and to spend little time or effort on the medical humanities. It certainly does not give any incentive for creating a curriculum that considers the areas of narrative medicine, relationship-centered care or mindfulness and how these might serve to meet these educational standards. As in the past, we must rely on cutting edge medical educators to bring these curricula to schools and demonstrate their effectiveness.

These three approaches to medical practice have evolved to bring the clinician and the patient together and to offer clinicians a more efficient and satisfying manner of medical practice. The goal of the curriculum described in Chapter five is to integrate these methods to better prepare medical students for the clinician-patient relationship.

CHAPTER 3
NARRATIVE SKILLS, SKILLS OF MINDFULNESS AND SKILLS OF RELATIONSHIP-CENTERED CARE

Introduction

A fundamental goal of medical schools is to graduate clinicians who can communicate effectively with their patients. I have argued that in order to do that, the student must attain several competencies. These include narrative competence, the ability to practice mindfulness and the capacity to engage in relationship-centered care. This chapter will discuss how students can be educated about these competencies by teaching the skills that are necessary to attain them. Experts in medical education have discussed these necessary skills, naming them in a variety of ways. This chapter will analyze the medical education literature and carefully outline narrative skills, skills of mindfulness and the skills needed to practice relationship–centered care. It will become very clear that although these are distinct competencies, they are interconnected and the skills required to master one can be used to master another.

Narrative Skills

Thus far I have argued that narrative competence is one of key capabilities necessary for a clinician to communicate effectively with his/her patient. The clinician who possesses narrative competence recognizes the patient as the narrator of his/her story. This recognition allows the clinician to focus on the patient's account much like the reader might focus on the narrator's account of the story in a written text. The competent clinician works in collaboration with the patient, co-creating rather than interpreting the story of the patient's illness. As discussed in chapter two, this distinction is critical because it is the relationship between the clinician and the patient that is at the therapeutic core rather than the clinician's ability to interpret the patient's story. A number of medical educators have embraced the concept of the narrative nature of

medicine and the need for clinicians to have narrative skills. Engel identifies six narrative skills that are necessary for narrative competence. These are:

1. Practicing compassionate presence and mindful listening
2. Exercising moral imagination and expressing clinical empathy
3. Reading and interpreting complex texts
4. Writing reflectively and telling complex clinical stories
5. Reasoning with stories
6. Engaging in narrative ethics (208)

Notably, within these narrative skills there is an assumption that the clinician has already mastered the competencies of mindfulness and relationship-centered care, among others. This overlap and confusion between skills and competences are present throughout the literature. The lack of clarity emphasizes the disjointed nature of current approaches to medical education and the need for a more cohesive methodology. The medical interviewing curriculum, which is the culmination of this dissertation, makes the needed connections between these competencies and offers a methodology that embraces the overlap of skills using it to the advantage of the student as opportunities to practice these needed skills. Regardless of how they are labeled in the literature, skills of presence, empathy, listening, and self-reflection are necessary for any clinician to practice competently.

As in Engel's first skill, Rita Charon also connects narrative and mindfulness when talking about the skills of narrative competence. In her discussion of the skill she calls attention, which is the ability to be present and allow the patient's story to be absorbed, Charon refers to the mindful practice movement in medicine and the need for clinicians to develop skills that allow them to "mute inner distractions to concentrate the full power of presence on the patient" (*Narrative Medicine Honoring the Stories of Illness* 132). Although Charon does not focus on mindful practice in her treatise on narrative medicine she acknowledges its importance. A more complete discussion of mindfulness will be explored in the section of this paper on mindful practice skills.

Engel's second skill, exercising moral imagination, refers to the need for clinicians to understand what they bring to the encounter; their own biases, values and judgments. Through this understanding, the clinician is able to identify which values are

his/hers and which belong to the patient. The ultimate goal is to be able to co-create a therapeutic or healing story that belongs to both the patient and practitioner. In his thoughtful refection written in the mid-1990s, dermatologist Alan Rockoff demonstrates this skill.

> Why on earth would you *want* to remove tattoos?
>
> When my colleagues discover that I remove tattoos in my practice, they are puzzled and skeptical. What motive could a physician have for doing that sort of thing, other than the obvious one, greed? Bad enough to use lasers (or other means) to rid patients of birthmarks or scars or other defects. We dismiss such concerns as "cosmetic," which is to say trivial and frivolous. In the medical construction of reality, a cosmetic problem is not "real," not something physicians consider important enough to fix, diagnose, or at least define in conventional terms. Insurers seem to validate this construction in the most potent way possible: by reimbursing only for those problems physicians count as real.
>
> Foolish enough, then, to bother with marks that, however petty, are at least acts of nature. But tattoos? Do people who deform themselves deserve anyone's interest or skill to undo the predictable results of their own folly?
>
> Some of my colleagues' questions sound faint by clear class undertones. As one put it, lowering his voice a bit (although we were alone), "Do you really want the kind of clientele that has tattoos?" That clientele is plainly not "our sort" of people. Who are these tattoo types, anyway? What motivates them? What are they after? Why do they mutilate themselves in the first place, and how will they react if treatment doesn't produce the results they expect? One never knows about these "cosmetic sorts." They may be unrealistic. Their very concerns mark them as neurotic and unhappy with themselves.
>
> *I was about 15, I guess. I grew up on the east side of town, the poorer side. Nobody paid much attention to what I was doing, so I was out on the streets by the time I was in ninth grade. You know-broken home, alcoholic father, Mom too busy trying to keep the house going to pay much attention to my sister or me.*
>
> *I don't remember exactly how it happened. Just one night a bunch of us got together and drove to a town downstate. One of my buddies said he knew a guy who had a tattoo parlor there, and we all had one put on. It didn't hurt too much. I remember the tattoo guy gave me a choice of designs. This tattoo he put here on my arm-I don't even think it's the one I picked, but it didn't matter, as long as I had one. You can see it when I wear a short-sleeved shirt.*
>
> *My in-laws have been very nice. Really, they never mention it at all, but my father-in-law did say he would pay for it if I wanted it off. He's a*

> *big attorney downtown, and he's on the board of trustees at the university. My wife grew up a lot different from the way I did. Like I said, I'm from the other side of the tracks and she's from the good part of town, where her folks still live. They have some house, you should see it. They give parties there all the time, for the attorneys in her Dad's firm and for the trustees at the university. And like I said, her family's awfully nice. They've always accepted me, ever since my wife brought me home to meet them.*
>
> *And now I have a house of my own! It's small, two bedrooms. My wife and I use one, and the girls are in the other; one's 3 and the other's 6 months. I started my own business last year. It's going pretty well, but I still do some work for my old boss to help make the house payments. Between the two jobs, we'll be OK.*
>
> *I look at myself and I can hardly believe it. Here I am 32 years old, with a wife, two kids, a house, and my own business. I don't even recognize myself. When I was 15, I never pictured myself doing any of these things. I can't even really figure out how it all happened.*
>
> *This tattoo on my arm, I guess it was a stupid thing to do, a kid thing. Whenever I look at it, it reminds me of who I was then. My wife and my in-laws look at it too, but like I said, they're too nice to say anything.*
>
> *And then I look at who I am now. This tattoo reminds me where I came from. But I'm not the kind of person who would put a tattoo on, at least not anymore. And you know, sometimes I think maybe it isn't right for me to be taking it off like this. Maybe I don't deserve to forget where I come from.*
>
> During this soliloquy the laser beats out a steady tattoo of its own, with a fluence of seven joules per square centimeter. Each second a pulse of light, wave-length 755 nanometers, carves another three-millimeter disk out of the young man's unwanted tattoo. Seventeen years ago, in a group ritual with ancient roots and complex, unfathomable meanings, he had his class and social origins inscribed in his flesh. Now, crafting a new identity, he is having the brand expunged. The completed process will leave no scar, at least none anyone else can see.
>
> His concerns, it goes without saying, are purely cosmetic. That is to say, they are airy and insubstantial, too trivial to engage the notice or warrant the attention of any self-respecting member of the healing profession. (1076)

Rockoff's reflection includes a co-created story. He has made a therapeutic connection with his patient and this is demonstrated in the story he shares. Rockoff's own thoughts, which are expressed before and after the patient's story, are filled with the

judgments of his colleagues that he has had to grapple with in order to provide care for his patients. Rockoff's reflection clearly reflects the empathy he feels for his patient.

Developing empathy is the other half of this skill set described by Engel. Chapter 1 of this paper discusses the rationale behind teaching skills of empathy and how these skills are essential to the practice of medicine. Arthur Kleinman describes the skill of empathetic witnessing as the ability to facilitate the creation of the patient's "illness narrative that will make sense of and give value to the experience [of illness]"(54). Empathy may be the key to the therapeutic relationship and the development of the ability to co-create the patient's story.

Engel's third skill recognizes the need for the clinician to be able to read and interpret texts. Scholars of narrative medicine believe that the practice of reading and interpreting complex texts can transform into the skills of empathetic witnessing and attention as outlined above. In addition to the skill of attention, Charon discusses the skill of representation. Representation refers to the ability to represent or show what has been witnessed in the interaction with the patient. The clinician must be able to conceptualize and share with the medical team what has occurred in the encounter. Charon concludes that the narrative practices of attention and representation lead to a new kind of affiliation with the patient: a more genuine connection that is fostered by these skills. This new affiliation leads to a more effective and satisfying relationship for the clinician and the patient. This is a complex process that Charon states requires skills in perception and interpretation (*Narrative Medicine Honoring the Stories of Illness* 136-51). I agree that the process is complex but again, rather than interpretation representation should involve perception and story co-creation. Conceptualizing representation as co-creation of the patient's story shifts the emphasis of the communication from doctor-centric to relationship-centric. There needs to be a sense of humility on the part of the clinician in order for co-creation to override interpretation. Humility allows the clinician to be genuinely open to the perspectives of others. In their 2012 study of the nature of excellent clinicians, Mahant, et al surveyed a group a peer-nominated physicians considered to be excellent clinicians. They found that humility

was a key part of their core philosophy. It is also notable that the study found that self-reflection was included as a "deliberate activity" in which clinicians engaged in order to maintain their clinical excellence (1717).

Reading texts and representing the story is an opportunity for students and practicing clinicians to hone skills that will be needed to represent the patient's story. By developing these narrative skills that foster tuning in to the written text, the clinician can learn to tune in to the patient's "text" or story. Close reading, an activity utilized to interpret texts, can do just that.

Close reading is "detailed, careful attention to evidence from the text itself, to the words on the page" (Parker 14). Close reading can be approached in a number of different ways. In her discussion of narrative competence, Martha Montello refers to departure, performance and change as acts of reading that strengthen the reader's experience. Departure is the skill that is needed to leave the real world and enter the fictional world of the text. We can see how this ability is similar to what might be necessary for the clinician to enter the story of the patient, to empathize with the patient's plight. Just as the reader will naturally go in and out of absorption in the text, the clinician will balance his/her empathetic response to the patient with the ability to use diagnostic skills in order to analyze the patient's "text."

Montello defines performance as the ability to shift perspective. For the reader, the perspective shifts as he/she enters the story and sees the text from the inside out. For the clinician, performance is the ability to shift perspectives to that of the patient (185-95).

Change is familiar to anyone who has read a great work of fiction and has had the sense of being changed by that experience. This is also true for a clinician who has entered the world of his/her patient only to be changed by that experience. The change occurs as the reader or clinician starts to value new ways of thinking and being, such as understanding the suffering of others. When a clinician is affected by a patient in this way, it is a moving and rewarding experience. This new insights reinforces the clinician's openness to change in their approach to future encounters where

circumstances are similar. Clinicians can learn from the clinical encounter and grow in their ability to relate to patients.

The skills of close reading are also described by Charon as the reader's ability to discern frame, form, time and plot in the text and to understand desire in the context of desire to read. Her approach to close reading is more concrete than Montello's. Charon discusses close reading as method of parsing the text rather than a means to being transformed by a text. It is included in this discussion because its practical approach is useful in curriculum development.

Charon describes framing the text as considering where the text comes from and how that influences the meaning of the text. In this process the reader questions the author's intention; where is he/she coming from and where is he/she going; what's been stated and what's been left out? The close reader tries to answer these questions (*Narrative Medicine Honoring the Stories of Illness* 114-16). Similarly, the clinician must frame the patient's story to give it perspective. The clinician must consider what is being shared and what is being left out of the patient's account in order to assure the best outcomes for the patient. The patient who arrives at the Emergency Department at 10pm with a problem that has been plaguing them for days will tell the clinician all about the sore throat or backache that brought them in. But unless the clinician frames this complaint, it is likely that he or she will miss the context. This patient probably has little to no access to regular healthcare. Perhaps they have no insurance and/or a job that doesn't allow for daytime doctor's appointment. These facets of the patient's story are critical for the clinician to understand in order to develop a treatment plan that will be achievable for this patient.

Form, as defined by Charon, includes genre, visible structure, narrator, metaphor, allusion, and diction. Genre refers to the type of text such as a poem, short story, novel, etc. The visible structure is how the text is presented in chapters, verses or some other structure. The narrator is the story-teller. Every narrator has a specific relationship to the characters in the story. The identification of metaphor assists the reader in understanding the writer's meaning or intent. Allusion is the way a text refers to other texts.

Identifying allusion requires that the close reader be familiar with many texts. Finally, diction is the nature of the language used and the style of writing, such as conversational, formal or some other style of writing (*Narrative Medicine Honoring the Stories of Illness* 116-20). Form can also be directly related to the patient encounter and the medical record. Who is the patient (genre); what is the story teller's relationship to the patient; is the storyteller the patient, a parent of a child, a child of an elderly parent or companion of a disabled patient (narrator)? Does the story-teller or patient speak in a straight forward manner or is there the need to interpret the language and understand subtle meaning (metaphor)? The written patient record is a very clear example of the need for a clinician to have skills in medical diction. The style of medical writing in a chart follows very specific rules and conventions. Experience with close reading is an opportunity to practice the skills needed to recognize these elements of form in the patient encounter.

In Charon's definition of close reading she refers to time. Similar to discussed in Chapter Two, this relates directly to the readers ability to discern time in a narrative (*Narrative Medicine Honoring the Stories of Illness* 120-22). The timing of events in the patient's story is critical to making an appropriate diagnosis. Being familiar with narrative time prepares the clinician in training to be aware of illness time. Illness time reveals much to the clinician when it comes to diagnosis and treatment. The differential diagnosis of abdominal pain for two hours is vastly different from the differential diagnosis for abdominal pain for two months. Understanding temporal relationships is a skill that when mastered, enhances the clinician's diagnostic skills. However, timing is only one aspect of symptomology that a clinician must master. The sequence of events can be equally important.

Charon defines plot as the story itself, the sequence of events (*Narrative Medicine Honoring the Stories of Illness* 122-24). In medicine it relates to the sequence of symptoms and concerns. Any clinician must be able to listen carefully to the patient's story. Reading carefully for plot allows the clinician to hone the skills needed to "hear" the story.

Finally, Charon describes desire as the fulfillment experienced by the reader in the reading of the text. It refers to our appetite to read and derive satisfaction from what we read (*Narrative Medicine Honoring the Stories of Illness* 124-26). This desire is very similar to what I read regularly in the personal statements of applicants to medical programs. Statements like: "I can't imagine doing anything else with my life . . ." or "I've known for years that I belong in medicine . . ." Clinicians often feel "called" to the medical profession. Their desire to be part of the medical field propels them through the rigorous training and the difficult moments because they experience a deep satisfaction in their clinical role.

The skills of close reading relate very directly to the skills that are needed by the clinician in his/her encounter with a patient. Training in close reading prepares the clinician for medical practice and enhances the possibility that the clinician will be able to develop a truly therapeutic relationship with the patient.

The utilization of techniques such as close reading aid the clinician in the ability to tune in to the patient which is essential for effective medical practice. Equally important is the clinician's ability to turn inward and tune in to him/herself. Engel's fourth skill includes writing reflectively which is one way that clinicians can engage in the process of self-reflection. Reflective writing offers the clinician the opportunity to process everyday experiences in order to recognize what went well and what challenged them to do better. It offers an opportunity to ask: what was meaningful and what was not important? It helps clinicians to gain perspective and insight. Examples of reflective writing are now commonly found in publications of collections of medical students' and clinicians' writings. One of these collections, *A Piece of My Mind*, is a compilation of essays from the Journal of the American Medical Association (JAMA). The following short essay is the reflection of a physician who recognizes the struggle to truly see the patient as a person:

> The beeper flashes "2580." Rare is the house officer who relishes a call from the ICU. As I look for a phone, questions tumble through my mind. Is it about Bed 3 with the GI bleed? Has Bed 2 dropped his pressure again? I could have sworn that the woman in Bed 11 would have a quiet night on the vent. Maybe it's just my intern. I told her to call when she

was hungry. I could use a snack too. How many pounds did I put on during this rotation? I pick up the phone across from Radiology as my beeper again flashes "2580." Someone's either really sick or really hungry.

"Hi. Did someone page me?"

"Bed 2 looks sick."

"I'm on my way."

It's amazing how a hospital evolves as it wades into the night. The aroma of microwaved popcorn and fried chicken hovers above the whirring floor-polishing machines. Dimmed hallways echo. The elevators move more quickly without the weight of roses and tiger lilies. Residents nod to each other as they pass.

Phone calls at 3 am are not like other calls. They are passages. Choices must be made. Even if the decision is to do nothing at all, it is rarely effortless. Frost wrote of the road not taken. There are many roads to choose from on this snowy eve, especially in the ICU.

The door opens and the rite begins: soap, lather, rinse, dry, repeat, go to the bedside. The nurse was right: Bed 2 looks sick. Panting. Sweating. Moaning. Approaching the bed, I scan the monitor not for vitals, but for his name. He has become Bed 2, the man with the stiff lungs and stiffer heart. Bed 2 is the Blue Man. Next to him is the Yellow Man. People of color tend to inhabit the ICU.

"Mr. West, what's wrong?"

"Call my wife." He grabs my hand and squeezes harder than his ventricle. "Call my wife." He's gurgling.

"Give him 100%. Where's the Lasix? Which one is the dobutamine? How high is the dopamine? He is DNR. What are the limits?

Mr. West rips off the face mask and wheezes, "Call my wife!"

Hopes rise as the wedge pressure drops. I leave to call his wife. How do you wake someone at 3am? Does every phone call panic Mrs. West? Surely she knows that Blue Men are not healthy. Does she take self-delusional solace that her husband is not the Yellow Man? I know what she is going to ask. I don't blame her. I would ask the same thing.

"Tell me, Doctor, should I come in?"

Suddenly Bed 2 is no longer the Blue Man, no longer Bed 2 with the dreadful ejection fraction and ghastly film. He is Mrs. West's Mr. West. Do I tell her to come in at 3am. How can I tell if this is his time? If he doesn't die tonight, will she believe me when I call her the next night? Am I being an alarmist? Choices have to be made.

"He's asking for you. You should come in."

She must dress, and then call her son to drive her to the hospital. The only traffic at 3am is delivery trucks and distraught families. How do you get dressed knowing your husband is dying and asking for you? Do you consciously choose which clothes to wear? What have I done to her?

> Mr. West is panting. He's motioning for me.
> "Did you call her?"
> Yes, she's on her way."
> "Good," and he closes his eyes as I open the drips wide. His breathing quickens and his numbers deteriorate. I check and recheck the jumble of lines. What else could I add? What should I subtract? Looking at Mr. West, I am ashamed of the hospital gown's voyeuristic rearlessness. I never knocked on his door. I referred to him as a case, a bed, a color. Looking at Mr. West, all I want to do is keep him alive. What am I forgetting?
> Mr. West knows. With his eyes closed and his mouth agape, he takes my hand. I am still. We hold hands. He doesn't improve but he doesn't worsen. Twenty minutes later, his wife and son arrive. They look at our interlocked fingers and understand. I give his hand to her and I leave the room. She knows. (Fleisher 44-45)

We can see in this reflection that both observation and self-assessment play a part in this story. Writing and sharing this story was an opportunity for this clinician to question himself and to enhance his connections to his work and the patients. Clinicians are often struggling against the hidden curriculum ever present in the medical setting in order to maintain their own humanity. Self-reflection in the form of reflective writing can be a means to staving off the influence of this hidden culture that relies on disconnection with patients rather than connection to survive. Reflective writing is slowly being embraced by medical educators in order to allow students to hone their self-reflection skills. In addition to writing about their own experiences with patients, as Dr. Fleisher writes above, exercises in writing a personal illness narrative can be utilized to help medical students begin to understand illness from the patient's point of view.

Similarly, telling complex stories and sharing these stories with others is an opportunity to for educators to teach students that the telling of any story shares a unique interpretation of events. Looking at the reflection of Dr. Fleisher, there is no doubt that another clinician in the ICU that night with Mr. West would have told a different story. In the sharing of stories, the student can learn about his/her role in the co-creation of the patient's story. In the telling itself, the teller (clinician or student) changes and influences how the story is heard by others. As discussed earlier, Kleinman describes empathic witnessing as the clinician's skill in the co-creation of the patient's story. Empathetic

witnessing promotes the therapeutic relationship between the clinician and the patient. Arthur Frank tells us that people who tell stories are witnesses (137). They are witnesses to suffering and to healing and recovery. This witnessing is the ability to truly see events from the patient's perspective; to connect with the patient. It promotes the empathy that the hidden culture of medicine all too often ignores and even discourages. Abraham Verghese talks about being attuned to character, through dialog with patients, allowing the clinician to remember the voice of the patient. He considers the clinician not just a storyteller but also a story-maker and player in the story of a patient's life (1016). As a player in someone's life, you are connected to that person. This connection is the goal of the therapeutic relationship.

Engel's fifth skill is reasoning with stories. Stories are part of our lives starting in childhood. Reasoning with stories starts as we learn from stories told and read to us. In our first books we not only learn colors and numbers, we learn from simple fables about right and wrong. Like the first stories we read or hear, the stories of patients' trigger emotions. Learning to notice that an emotion has been triggered is an opportunity to analyze the narrative in order to understand the feeling(s) they evoke. The feelings or emotions may come from a connection that is made with the patient or an ethical issue that the story reveals.

Ethical issues arise often in the practice of medicine. Engel's final narrative skill addresses medical ethics. One way that a clinician can prepare to deal with ethical dilemmas is to develop skills in narrative ethics. Narrative ethics relies on the patient's story as the source of moral education and discourse rather than relying on a set of moral principles. The benefit of engaging in narrative ethics is the ability to view the ethical problem as a story. The narrative often reveals not just the patient's voice but the voices of all those who are involved in the outcome of the ethical decision (Greenhalgh and Hurwitz 217-23). Rather than the application of ethical rules to a case history, engaging in narrative ethics is an opportunity to see the unique circumstances of a particular patient's story leading the clinician to the best ethical decision for all involved.

The skills outlined by Engel, when mastered, provide the clinician with ability to communicate with patients in a genuine and thoughtful manner. Narrative competence enhances the clinician's connection with the patient and development of a therapeutic relationship.

Skills of Mindfulness

In Engel's first narrative skill he talks about mindful listening. But mindfulness is a competency in its own right. "Mindfulness means paying attention in a particular way: on purpose, in the present moment and nonjudgmentally" (Kabat-Zinn *Wherever You Go, There You Are: Mindful Meditation in Everyday Life* 4). Jon Kabat-Zinn, known for his work in mindfulness meditation, warns that if we are not fully present we may miss critical moments. In communication with patients, missing those moments or that critical piece of information can lead to a less than optimal relationship with the patient and to a less accurate diagnosis and treatment As noted in Chapter Two, Epstein describes characteristics of mindfulness including curiosity and reflection (cognitive and emotional), insight, and being available and present in the encounter. Beyond being present, the road to mindful practice includes self-awareness and reflection. These skills are critical for providing empathetic, compassionate care to patients. They are essential so that the practitioner might be able to distinguish his/her point of view from the patient's ("Mindful Practice" 835). In her text, *From Detached Concern to Empathy*, Jodi Halpern discusses the role of curiosity in the therapeutic relationship. She talks about curiosity requiring the suspension of judgment and expectation in order to allow uncertainty. In that uncertainty, there are no expectations and therefore no judgments so the clinician is open to whatever occurs. Halpern refers to the skill of continual openness to others that must be learned in order to develop empathy (*From Detached Concern to Empathy: Humanizing Medical Practice* 130). All of these concepts are very similar to those discussed under narrative skills and they will appear again when skills of relationship-centered care are discussed. These redundancies are a reminder that there is a particular skill set that once mastered, will permit students to be competent in all three

areas discussed in this dissertation: narrative medicine, mindfulness and relationship-centered care.

Other skills of mindfulness have been discussed by a number of authors and researchers. In 2004, Baer, Smith and Allen developed the Kentucky Inventory of Mindfulness Skills. This inventory is based on four basic skills of mindfulness: Observing, Describing, Acting with Awareness, and Accepting (or Allowing) without Judgment. When carefully reviewed, these skills are actually sub-skills of the skills that have been discussed such as compassionate presence and attention.

Baer, et al. describe observing as noticing and attending to a range of stimuli particularly thoughts, sensations, and emotions. In attending to these observations clinicians are tuning-in to themselves and gaining self-awareness.

Describing asks the clinician to label or note observations and apply words such as "anxiety" or "frustration" or phrases such as "worrying about my family." When clinicians identifies patterns of thought or feeling, they are encouraged to just recognize those patterns without judgment or analysis and then to get back to attending to the present moment. This behavior allows them to acknowledge the thoughts or feelings which, with practice, can be moved aside to permit the return to the interaction with the patient. The clinician's acknowledgement is the critical part of this skill. If it were to be suppressed or ignored, it could lead to frustration and interfere with the patient relationship.

Acting with awareness refers to the clinician's ability to engage in an activity with focus and undivided attention. This is in contrast to things done on "automatic pilot" without awareness. Baer, et al describes skills associated with this awareness known as "participating" and "one-mindfully." They are defined as the clinician becoming one with an activity and completely focusing on one thing, respectively. In an age of multi-tasking, this may seem to some a step backward. In fact, it is a step forward; a step toward presence in the moment and true connection between the clinician and patient.

Accepting (or allowing) without judgment refers to the skill of accepting the present moment without evaluating it or attempting to change it. This is a particularly

useful skill when the clinician faces unpleasant circumstances. Many clinicians suffer from the need to fix things. They are care-takers and often want to make things better. In circumstances where it is not possible to cure or save, the clinician may feel frustrated and helpless. Accepting that inability without judging it as failure can be an invaluable skill (191-206).

The benefits of mindfulness have been recognized in a number of fields outside of medical education including psychotherapy, health promotion and social work. The methodologies to promote mindfulness vary across these disciplines. Ronald Epstein has outlined eight steps that are useful in fostering mindfulness in medical education. Again, there is redundancy between these "steps" and some of the skills outlined previously. These steps are included because they are useful in developing teaching modalities for students that promote mindfulness. These steps are:

1. Priming
2. Availability
3. Asking reflective questions
4. Active engagement
5. Modeling while "thinking out loud"
6. Practice
7. Praxis
8. Assessment and confirmation ("Mindful Practice in Action: Cultivating Habits of Mind" 12-16)

Epstein's first step, Priming, refers to the beginning of the process of becoming aware in general; that is to become aware of oneself and one's thoughts. Asking a question such as, "How do I prepare in the few moments before I walk into the room for the encounter with the patient?" helps the student become more self-aware. In time, noticing of these thoughts leads to acknowledgement of the thoughts and behaviors and the ability to set them aside in order to focus on the patient.

Being available is Epstein's next step and involves the student's ability to be present in the moment. This kind of intense attention often requires much preparation and practice in the form of self-reflection, journaling, and/or meditation. As noted in previous discussion, this step is the key to making the connection with the patient that leads to the possibility of a truly therapeutic relationship.

As the student moves along the path to availability and presence, Epstein's third step will require asking reflective questions. This activity encourages curiosity. The answer to the question is less important than the process of questioning itself. Reflective questions confront habitual behaviors by disrupting usual patterns. By letting go patterns of behavior and thought the student enters the situation without any preconceived notions of what will or should occur. In this way the student can be better prepared for the unexpected.

Epstein's step of active engagement refers to the connection between the student of mindfulness and the teacher. Assuring that this connection is strong requires that it be interactive. It means that the teacher and the student are both present physically and mentally. In many medical education settings this type of interaction does not occur regularly. Direct observation, supervision and feedback are labor intensive and only occasionally provided to students. This requirement makes more sense when we look ahead to the next step of modeling.

Modeling or what Epstein refers to as "thinking out loud" is practiced by the teacher and the student so that the student can learn how the teacher (expert) thinks and the teacher can correct the student when needed. With practice, this is incorporated into the student's habits, so that self-correction can occur.

Epstein's sixth step, Practice, is essential to mindful competence. Practice is the discipline of repetition with the goal of improving a skill. In the case of mindfulness, the purpose of practice is to strengthen the student's skills of attentiveness, presence, active engagement and listening. Even curiosity can be practiced with specific exercises. Most advocates of mindfulness suggest that practice include some time each day that is devoted to quiet reflection. This might be in the form of meditation or any other method that promotes an inner stillness.

Epstein's penultimate step, praxis, is the performance or application of a skill. When theory is put into practice it is praxis. The ability to react to a new situation with a learned skill such as attentiveness is how we might see praxis. Today, in most medical schools, students are observed in their interactions with standardized patients who are

trained “actors” who follow a script. In these observations of the student, the teacher can see if the skill practiced has led to the embodiment of the knowledge and therefore the appropriate application of the skill.

Finally, assessment and confirmation refers to the evaluation and feedback that are necessary to provide to students who are learning the skills of mindfulness. These are essential to the learning process and add to the ability of the student to reflect on his/her behavior and skills. To work most effectively, mindfulness training and the associated feedback need to be offered in an environment that supports curiosity, trial and error, the expression of ideas and feelings. These kind of safe environments are not readily found in medical schools today. However, they must be created and encouraged in order for students to master the skills of mindfulness. ("Mindful Practice in Action: Cultivating Habits of Mind" 13-17)

Skills of Relationship-Centered Care

As noted in the table in Chapter Two, Relationship-Centered Care (RCC) has several components each of which is associated with a particular set of skills, values, and areas of knowledge. In this chapter the focus is on the skills associated with RCC. These skills will be familiar as they are also skills needed for narrative competence and mindfulness. In developing a curriculum to teach these competencies the redundancies are helpful and offer an opportunity for students to practice skills that lead to all of these competencies. These skills are outlined here for the purpose of clarity in curriculum design.

The ability of the student to engage in self-reflection is the skill associated with the self-awareness component of RCC. The skills of writing reflectively, observing, and asking reflective questions allow the student to reach this goal of RCC. Curricular exercises that promote self-awareness, discussed in the next chapter, will move students toward competency in RCC and the other competencies.

The second component of RCC is the patient’s experience of health and illness. This component requires the skills of recognizing the patient’s life story and its meaning,

and viewing health and illness as part of the human condition. The narrative skills of reading and interpreting complex texts, writing reflectively, telling complex clinical stories, and reasoning with stories all lend themselves to the clinician's ability to understand the patient's story. Developing these narrative skills will help the student to develop the skills necessary to practice this component of relationship-centered care. As discussed in the previous section, in order to recognize the meaning of the patient's story, the student must learn to tune into the patient's "text" or story. Skills developed in close reading, writing and interpreting narratives can transform into the clinical skills of "reading" and interpreting the patient's story.

Skills of attention, engagement and acceptance go a long way toward helping to develop and maintain a caring relationship with a patient which is the third component of RCC. These skills have been discussed as skills of mindful practice but also play a substantial part in establishing a therapeutic relationship that is built on trust and understanding. The skills outlined by the Pew-Fetzer foundation for this component of RCC are attending fully to the patient, accepting and responding to distress in the patient and in oneself and facilitating hope, trust and faith. Beyond the skills of self-awareness that are required to successfully navigate this component of RCC is the understanding that there is value in offering the patient hope. Hope is central to the philosophy of medicine practiced by physician and author Jerome Groopman, who describes what he has learned in over thirty years of medical practice. "Now when I meet a new patient, listen to his history, perform his physical examination, review his laboratory tests and study his X rays, I am doing more than gathering and analyzing data. I am searching for hope. Hope, I have come to believe is as vital to our lives as the very oxygen that we breathe" (208). Groopman believes that within the uncertainty of every medical prognosis, there is room for hope. Although there may be very good reason for a patient to fear the outcome of an illness, there is also reason to hope. Helping students to understand the value of sharing their genuine hope with patients is a critical skill for RCC.

The last component of RCC is effective communication which relies on the skills of listening, imparting information, facilitating the learning of others, and promoting and accepting the patient's emotions (Tresolini and Force 28-30). These RCC skills relate to the narrative skills of practicing compassionate presence and mindful listening and telling complex stories, and the mindfulness skills of acting with awareness, and accepting (or allowing) without judgment. Effective communication is at the heart of the interaction loop that includes patient compliance and relationship satisfaction for both the patient and clinician. Patient compliance has a direct impact on outcomes and positive outcomes influence the clinician – patient relationship.

The substantial overlap between the skills of narrative, mindfulness and relationship-centered care reinforce the conviction that they are inseparable and should be presented to students together. The next chapter will focus on the methodology of teaching these skills to medical student

CHAPTER 4
METHODOLOGIES AND EXAMPLES FOR TEACHING MEDICAL INTERVIEWING SKILLS

Introduction

Medical interviewing/medical communication education has been slowly evolving over the last twenty years. In particular, in the last ten years there has been a movement from traditional single subject course work to a more inclusive modular approach which teaches several subjects (e.g. medical interviewing, physical diagnosis, and medical ethics) together in one offering. Unfortunately even with these advances, there is still no real innovation in the content of the medical interviewing portion of curricula. This chapter will provide methodologies and offer examples that can be utilized to teach a truly innovative medical interviewing curriculum that includes narrative medicine, mindfulness and skills in relationship-centered care. The model curriculum itself is offered in Chapter Five.

In an effort to better understand a truly innovative curriculum design, it is helpful to briefly review the development of medical interviewing curricula. A report on innovative programs in teaching medical communication skills was published by Haq et al in January 2004. Some of the programs reviewed addressed communication in very specific circumstances, such as communication in times of emotional distress, others were more broadly designed. The following table is adapted from that report and describes the more broadly designed programs.

Table 2.

Sample of Medical Interviewing Curricula

School	Content Areas	Learning Objectives	Methods	Evaluation
University of California San Francisco	• Patient education	• Explore patient education services available within a health care system • Interview a patient about the process of becoming educated about a disease or condition • Observe a nurse advising a patient • Follow up on a test result with a patient	• Observation during longitudinal ambulatory clerkship (year 3) •Patient interviews (year 3) • Small-group discussion(yea r 3)	• Pre and post student self-assessment of attitudes, knowledge, and skills • Student written program ratings
Dartmouth Medical School	• Advanced communication and building skills • Communica-ting and building relationships with families	• Describe patient-provider relationship-building skills • Understand how patient preferences influence medical decisions • Demonstrate efficient/effecti ve motivational strategies	• Longitudinal communicatio n curriculum in years 1–4 • Videotape of student interviews (year 3) • Balint sessions (year 3) • Home visit with chronically ill patient (year 3)	• Family-centered OSCE (including three stations) • Student written program ratings

Table 2 *continued*

School	Content Areas	Learning Objectives	Methods	Evaluation
Dartmouth Medical School		• Describe changes in provider-child-family relationships over time • Understand how patient-provider relationships affect outcomes • Understand legal aspects of patient-provider relationships		
University of Massachusetts	• Breaking bad news • Communica-ting with adolescents • Patient education	• Expand students' communication skills • Advance the appreciation of the physician-patient relationship • Enhance student skills in patient education and written communication	• Small-group sessions with standardized patients (year 3) • Small-group case-based sessions (year 3)	• Observation of student interviews with formative feedback • Student ratings of Program • Student self-assessment of confidence and competence
University of Nebraska	• Patient-centered interviewing • Patient education	• Elicit a complete history of the patient's presenting complaint	• Lecture (year 1–2) Small groups with standardized patients (year 1–2)	• Ten-station OSCE to assess basic interview and history skills (year 1)

Table 2 *continued*

School	Content Areas	Learning Objectives	Methods	Evaluation
University of Nebraska	• Behavior change • Domestic abuse • Substance use • Working with interpreters • Delivering bad news • Communica-tion with angry/ demanding patients	including social and psychological implications of illness • Communicate effectively regarding referrals, consultation, and coordination of care • Integrate risk factor assessment and prevention • Deliver effective patient education • Make appropriate behavioral change interventions	• Workshop including role-play and individual and group problem solving (year 3)	• Long OSCE to assess history, physical exam, prevention, and patient education (year 2) • Self-efficacy ratings for dealing with difficult patients (year 3)
University of Wisconsin	• Patient-centered interviewing skills • Behavior change End-of-life care • Addressing uncertainty	• Elicit patient perspectives • Provide effective patient education • Learn strategies to promote behavior change	• Lecture (year 1 and 2) • Small-group discussions, standardized patients (years 1–3) • Audiotapes of patient encounters (year 3)	• Student ratings of program (all years) • Student self-assessment of attitudes, knowledge, skills and behavior (year 3)

Table 2 *continued*

School	Content Areas	Learning Objectives	Methods	Evaluation
University of Wisconsin	• Interdisci-plinary team care • Participatory decision making with patients and families	• Involve patients in decision making • Interview patients for domestic violence and sexual assault • Present choices in a managed care environment • Demonstrate conflict negotiation skills	• Patient Care Management Project in community preceptorship (year 4)	• Audiotape self and group assessments • OSCEs (years 1–3)

Source: (238)

Although these programs were considered innovative in 2004, a careful review of the learning objectives and teaching methods reveals that none utilized concepts of mindfulness or narrative medicine. A few of the courses include some learning objectives related to relationship-centered care in their focus on patient-centered interviewing skills. As with many traditional medical interviewing courses offered in 2004, much of the curriculum is centered on patient education and motivational strategies for patient compliance.

Today medical interviewing is offered most often as part of a comprehensive course that includes a number of aspects of patient care in an effort to embrace a more holistic approach to the curriculum. This approach moves the curriculum from individual courses to modules or tracks that are more inclusive. Rather than individual courses in medical interviewing, physical diagnosis, medical ethics and/or human development, medical schools put forward broadly titled offerings that encompass all of these subjects.

Titles such as, “Introduction to the Patient” or “Patient Care” or “Doctoring” are now a staple of the first year and second year curricula of many medical schools. A review of the 2013 course offerings at the five medical schools examined in the 2004 study cited above reveals the following offerings:

The University of California San Francisco offers *Foundations of Patient Care*.

> A block that spans the entire Essential Core, covering clinical skills and reasoning, doctor-patient interaction, ethics, and professional development. Students are encouraged to undertake independent and self-directed learning and reflection. Clinical Interlude is a three-day immersion in the hospital setting that provides students their first in-patient experience just before winter break in the first year (The University of California San Francisco).

Dartmouth offers *On Doctoring*.

> On Doctoring is a two-year course that provides an understanding of the role of the physician in the clinical setting and in the community through longitudinal clinical and didactic experiences in the first two years of medical school. During the first year, the course will focus on patient interviewing, physical diagnosis, and physical exam, patient write-ups from student clinical encounters and developing the doctor-patient relationship. The second year builds on these skills with the addition of oral presentations (Geisel School of Medince at Dartmouth).

The University of Massachusetts offers *Doctoring and Clinical Skills (DCS)*.

> DCS utilizes learning communities as the primary mechanism for supporting student engagement in personal and professional development and lifelong learning through a skill-based curriculum with faculty mentors who foster long-term relationships with students throughout their medical school experience. Primary content offered in Doctoring and Clinical Skills during FOM 1 includes the medical interview, communication in medicine, physical examination, clinical reasoning, professionalism and medical ethics (University of Massachusetts Medical School).

The University of Nebraska offers *Integrated Clinical Experience*.

> The Integrated Clinical Experience (ICE) program is intended to help students recognize the clinical relevance of basic sciences and to gain an appreciation of the social, psychological, and ethical dimensions of the

> practice of medicine. Topics covered in this two year curriculum include: The history and physical examination, interviewing skills, behavioral sciences, ethics, preventive medicine, health care policy, and health care services research. In addition, students are given opportunities to participate in the practices of community and university based primary care physicians through the Longitudinal Clinic Experience and summer rural preceptorship (Primary Care Month) between the first and second years of medical school (University of Nebraska Medical Center).

The University of Wisconsin School of Medicine offers *Patient, Doctor and Society.*

> Patient, Doctor and Society is a four-semester course, focusing on biological, psychological and social aspects of patient centered care. The course teaches communication skills, physical examination, evidence-based medicine, professionalism and health care in society (School of Medicine and Public Health).

Similar to the courses introduced in 2004, these new integrative approaches also demonstrate the lack of the concepts that has been emphasized in this paper thus far. There is no mention in any of these descriptions of narrative medicine, mindfulness or relationship-centered care. These curricula are representative of the current state of medical interviewing education for the large majority of medical schools in the United States. They speak to what is missing from most medical education programs: that is, the true incorporation of medical humanism in the form of communication skills that offer the student an opportunity to understand themselves and their patients.

One school that has made some strides in a truly innovative approach to medical interviewing is Brown University's Alpert Medical School. Their course entitled "Doctoring" comes closest to providing aspects of narrative medicine, mindfulness, and relationship-centered care.

> Doctoring is a two-year required course intended to teach the knowledge, skills, attitudes, and behaviors of the competent, ethical, and humane physician. The course combines instruction in professional development, medical interviewing, and physical diagnosis with a weekly clinical experience in a community physician's office. Starting in their first semester of medical school and continuing for two years, students spend eight half-day sessions per semester at this community site with a physician-mentor . . . Self-reflection is an integral part of a physician's

> professional development. That is why students in the Doctoring course are required to keep "field notes" – integrative, reflective portfolio entries. Field notes provide a link between elements of the course that occur on campus and those that occur at the community site. These notes promote reflection and growth and support the development of "mindful" medical students. In addition to recording their own personal thoughts, the students respond to a focused assignment each week. These assignments link their learning with the campus-based section of the course and its objectives: communication, physical diagnosis, and professionalism. (Brown University Alpert Medical School)

Although this course is a first step towards the incorporation of narrative, mindfulness and relationship-centered care, there is room for further innovation and better methodologies that can truly provide students with the skills needed to practice medicine with empathy, compassion and diagnostic skill. This chapter will address the methodologies to teach these skills and provide examples of how they can be implemented in the curriculum as we examine narrative skills, mindfulness and relationship-centered care.

Teaching Narrative Skills

Chapter three discussed Engel's skills of narrative competence. These are:

> Practicing compassionate presence and mindful listening
> 1. Exercising moral imagination and expressing clinical empathy
> 2. Reading and interpreting complex texts
> 3. Writing reflectively and telling complex clinical stories
> 4. Reasoning with stories
> 5. Engaging in narrative ethics (208)

As we have discussed, the goal of teaching narrative skills is to develop narrative competence. Proponents of narrative medicine believe that the practitioner with narrative competence will be able to see patients in the context of their lives and understand their perspective, enhancing the relationship with the patient and promoting empathy. The clinician who practices with narrative competence also attains the added benefit of enhancing his/her professionalism through self-reflection.

There are many suitable methods for teaching narrative skills. Using a variety of techniques in one course helps to reach students with varying learning styles. Reading and interpreting texts is an important component of the curriculum. Given the nature of the medical interviewing curriculum, texts that involve medical issues are often most appropriate. Following Charon's description of a close reading drill developed for her graduate program in narrative medicine, the student examines a text for frame, form, time, plot, and desire (*Narrative Medicine Honoring the Stories of Illness* 114). These aspects of close reading have already been described in detail in chapter 3. Here they are discussed in the context of an educational exercise. In making use of this kind of exercise, parsing the text itself does not promote empathy, however, dissecting the text in this way requires very careful attention and will teach the student how to use that attention when listening to the patient's story, Utilizing the short story "Brute" by Richard Selzer (see appendix), this exercise is demonstrated. After reading the text students are asked to identify the following aspects of the text:

Plot – The short story begins with statements of haunting regret as Selzer recollects a traumatic event from his residency training that occurred 25 years in the past. He tells the story of a patient, brought in by the police, drunk and agitated: a huge black man with a gash in his forehead that needs suturing. The man tries to fight off the policemen bringing him but is finally restrained, tied to the emergency room stretcher. It is 2 am and Selzer is exhausted having been on call all day. As Selzer tries to examine the wound, the patient is uncooperative, tossing his head back and forth and cursing at him. Giving in to his anger and exhaustion, Selzer reaches for suture material and sews the man's earlobes to the stretcher mattress so that he cannot move his head. The patient gives up the struggle and Selzer cleans and sutures the wound. He snips the earlobe sutures and returns him to the police with his wound bandaged.

Form – Selzer's work is in the form of a short story or essay and takes place in the present and in his past (25 years before writing of the story). The narrator is the doctor, Selzer, who takes the reader back to this time in his past. This first person account allows the reader to identify with the narrator's situation.

Time – Although this is written from the present as a flashback, the timing of this story is both very brief, just a few hours, and very long, as Selzer describes an incident that occurred 25 years prior. The episode itself starts at 2 am when the patient is brought in to the emergency room and ends at 5 am when the patient is returned to the policemen who brought him in. The regret that Selzer writes about is much of a much longer duration and promises to remain with him for as long as he can remember the encounter.

Frame – Selzer writes this story to tell the reader of his regret; asking for forgiveness for his momentary weakness. Selzer carefully describes in detail, not only the events as they occurred but his thoughts as he responds to the events of that morning in the emergency room.

Desire – Since Selzer cannot ask the man in the story for forgiveness for his barbaric behavior, in writing and publishing the story, Selzer asks the reader to bear witness, understand his human frailty and forgive.

The aim in this type of exercise is have the student explore a text in a way that reveals feelings and emotions that might connect them to the story's characters in much the same way that they might connect with their patients. When this careful attention is moved to the clinical setting the student may recognize that the plot, frame, desire and timing of the patient's story can reveal not only the diagnosis but also what the patient needs from the encounter. The expectation is that this kind of exercise will strengthen the connection that the student might have for their patient in practice.

Although close reading exercises and reflection on a written text can be done with many types of narratives, illness narratives hold a very unique place in the development of a clinician's narrative skills. Illness narratives are most often the stories that patients tell of their illnesses and the effect illness has on their lives. Illness narratives can also include the stories of relatives and loved-ones who are affected by another's illness. These narratives articulate the life changing experiences of illness for those intimately involved.

Apart from providing an opportunity for close reading, illness narratives offer additional dimensions of the story that can be explored by the student. Arthur Frank

refers to these as the narrative types. He breaks illness narratives down in to three types; restitution narratives, chaos narratives and quest narratives. Each type provides a glimpse into the patient's illness journey. Each type can be identified by its plot. Restitution narratives follow the plotline: "Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank 77). The chaos narrative has, as it title implies, little order to the narrative. The plot is often a series of the patient's experiences and tend to be difficult for the reader to hear because they are unpleasant, sometimes graphic depictions of the experience of illness (Frank 97). They are often grief-stricken, sad and/or anxiety-ridden. The third type is the quest narrative. These offer the storyteller an opportunity to tell his/her story; to describe their illness journey and the lessons learned along the road (Frank 115). Illness narratives offer the student a sense of the pain and suffering created by the struggle of living with and dying from an illness. They offer an opportunity for identification with the fundamental emotions expressed in most illness narratives – isolation, loss, anger, grief, injustice, and sometimes triumph and joy.

The illness narrative by Kaethe Weingarten after her breast cancer treatment (see appendix) is a chaos narrative that can serve as a powerful tool for a close reading exercise. Exploring her experience with students provides the view of illness from the patient's perspective and a unique opportunity to share that experience with the patient through her writing. The student's understanding of the emotion described in this narrative can assist him/her in understanding their own patient's illness experience. Another method that can help the student to develop some of the skills of narrative, as outlined by Engel, is reflective writing.

The medical education literature has numerous examples of reflective writing exercises.[2] In 2009, Mann et al published a review of reflective practice studies in health

[2] (Sayantani DasGupta and Rita Charon, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy," Academic Medicine 79.4 (2004), T. et al Kind, "Learning to Connect," Patient Education and Counseling 75 (2009), K. et al Chretien, "The Reflective Writing Class Blog: Using Technology to Promote Reflection and Professional Development," Journal of General Internal Medicine 23.12 (2008), H. et al Wald, "'The Loss of My Elderly Patient:' Interactive Reflective Writing to Support Medical Students' Rites of Passage," Medical Teacher (2010), Hedy S. Wald, "Guiding Our Learners in Reflective Writing," Literature and Medicine 29.2 (2011), A. Howe, "How Medical Students Demonstrate Their Professionalism When Reflecting on Experience," Medical Education 43 (2009).

professions education. After examining 29 studies involving the use of reflection in medical education the authors conclude that reflection is most useful when it is used to assist students in integrating the affective domain (listening, discussing, explaining, etc.) into their understanding of medical practice. They also note that the learner may be helped by the provision of structure and specific guidance and as well as feedback on the content and process of their reflection (614-15). Shapiro et al suggest that reflective writing "builds skills in narrative competence, in part through its attention to voice, language, perspective, and emotion; and in part through the attitude of mindfulness created in listening/reading sessions" (238).

Implementing reflective writing exercises in the medical interviewing curriculum provides this opportunity for the student. The exercises proposed here consider the recommendations of Mann, Shapiro and others[3] who realize the importance of not only the writing but also the listening and reading in building empathy, professionalism and narrative competence.

One method is reflection on an assigned text such as a short story like Richard Selzer's "Brute," or a patient narrative like Weingarten's. After reading the text the students are assigned to write a reflection following a guideline that will require them to ask questions about the writer and narrative that will hopefully help them to not only understand the narrative but also their reaction to the narrative. The following guide is one I use with my students:

Use this reflection to contemplate your thoughts, feelings and reactions to what you read. The following are some suggestions to help you construct your thoughts. They

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[3] (J. et al Reichert, "Narrative Medicine and Emerging Clinical Practice," Literature and Medicine 27.Fall (2008), William Branch, et.al., "Becoming a Doctor - Critical-Incident Reports from Third-Year Medical Studentd," N Engl J Med 329.15 (1993), E. et al Driessen, "The Self Critical Doctor: Helping Students Become More Reflective," BMJ 336 (2008), Ronald M. Epstein, "Reflection, Perception and the Aquisition of Wisdom," Medical Education 42 (2008), Sayantani DasGupta, "Reading Bodies, Writing Bodies: Self-Reflection and Cultural Criticism in a Narrative Medicine Curriculum," Literature and Medicine 22.2 2003), C and Babelay Bryan, A., "Building Character: A Model for Reflective Practice," Academic Medicine 84.9 (2009), Karen V Mann, "Reflection: Understanding Its Influence on Practice," Medical Education 42 (2008), S. et al Mamede, "Effects of Reflective Practice on the Accuracy of Medical Diagnoses," Medical Education 42 (2008).

should serve as the starting point; once you gain comfort with this process you may develop your own line of questions that better fit your needs. Do not attempt to answer each question but use them as a guideline as you begin to record your reflections.

- Why do you think the author wrote this?
- What message did he/she want to send to the reader?
- Which particular passage (or two) particularly demonstrates this message?
- What would you change about this situation if you had the power?
- How does the piece make you feel? What does it bring up for you?
- Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
- What things in your own experience parallel the author's experience?
- What conclusions can you draw after reading this piece? (UMDNJ Physician Assistant Program "Guidelines for Your Reflection Journal")

After constructing their reflections, students can meet in small groups (usually no more than 10 students) to discuss the content of their writing. These small groups are usually facilitated by a faculty member.

Another method is to have the students reflect on an experience with a patient. As part of most medical interviewing curricula, students attend hospital or clinic sessions where they meet with patients to practice their skills of medical interviewing and physical diagnosis. The students are asked to reflect on these encounters and to briefly, in about 1 page, write down their thoughts. Pioneers of narrative medicine have called these non-medical notes made by students regarding their patient encounters, parallel charts or field notes. These notes are distinct from the medical record and are written after being given some kind of writing guide. The following are the guidelines that I use with my students:

> Reflection is a process that helps learners gain meaning from experience. This reflection will provide a chance to learn from your experiences and critically analyze their impact on you and your personal and professional development. Use this reflection to contemplate your thoughts, feelings and reactions to what you see, do, or hear during your encounters with patients.
>
> The following are some suggestions to help you construct your thoughts. They should serve as the starting point; once you gain comfort

with this process you may develop your own line of questions that better fit your needs. Do not attempt to answer each question but do try to include reflections on the encounter, yourself, and your future development. Use these questions as guidelines as you begin to record your reflections.

1. **Encounter:** Describe what happened: What did I do? Was this a new experience? How did I feel about my actions, thoughts, reactions during this experience? What have I learned about this patient and his/her community? Did my actions have any impact? What more can be done? What would I change about this situation if I had the power? How does this experience relate to what I am learning in school?
2. **Self:** Describe your thinking and emotional response: How was I feeling about participating in this experience before the encounter? What has this experience taught me about myself and my values? Has this experience affected my sense of self, my values, and my desire to help others? Has this experience affected my self-confidence? How has this experience changed the way I think? Has this experience increased my self-awareness, offered clarity and understanding of concepts or ideas, helped connect what I am learning in the program to the external world? Has this experience been an opportunity to develop empathy for others?
3. **Projection to the future:** Describe what you learned from this experience: How has this experience challenged me, my beliefs, assumptions or my perceptions? What effect will it have on my development as a professional? Do I want to change my attitudes or behaviors as a result of this experience? What more can I do to help myself become the best clinician I can be? How did the medical "system" color the experience? What additional experience should I seek to promote my clinical and professional development? (UMDNJ Physician Assistant Program "Guidelines for Reflection on a Patient Encounter")

Although these written reflections can also be brought to a small group for discussion, they should be turned in to a faculty member who reads the reflection and provides feedback to the student. One mechanism for providing feedback follows a methodology based on the BEGAN (Brown Educational Guide to Analysis of Narrative) feedback mechanism for reflective writing. Guidelines for faculty feedback are as follows:

1. First consider the context including: The setting, student's identity and background, stage of training and the type of encounter.

2. Read the narrative carefully from beginning to end without making any notes (overall impressions and reactions to the learner's written expression).
3. Record initial impressions triggered by the learner's written expression (overall impressions and reactions, as well as your clinical and/or personal experiences, views, and biases).
4. Reread and analyze the text – and note the following:
   a. key concepts, expressed emotions (e.g. verbs such as 'surprised', 'scared') and reflections
   b. key themes, categories, patterns
   c. lessons learned – consider both what the learner expresses and what you see as learning opportunities
5. Look for opportunities to provide positive feedback.
6. Use coaching rather than evaluative language.
7. Ask other reflection-inviting questions as appropriate for the reflection, such as:
   a. How were you informed by the patient's culture, belief, gender, family structure, personal and familial illness history, life experiences?
   b. How did your actions influence the outcome?
   c. What were you feeling?
   d. How did you feel about your interaction (Reflection on action)?
   e. What assumptions did you make about this situation? What else might be affecting this situation? Might there be alternative explanations? What could they be? (Fostering multiple perspectives)
   f. What skills did you learn? What new insights did you derive?
   g. How would you apply what you learned in your future work?
   h. How might you do things differently if you had a chance to repeat this situation? (Reis et al. 255-56)

In the last few years Reis, Wald and their colleagues at Brown University have focused their research on methods that go beyond how to provide feedback to students. Most recently their efforts have focused on evaluating reflective writing exercises. This year they published an evaluation rubric described as "a rigorously developed, theory-informed analytic rubric, demonstrating adequate interrater reliability, face validity, feasibility and acceptability" (H. Wald, et al 41).

Unfortunately, in this case, the educators at Brown University have taken the analysis of reflective writing exercises one step too far in their need to formalize and quantify the assessment. They have given in to the mandate to "measure" every outcome

in an unnecessarily quantitative way. Although the result of their assessment may add to the medical education literature by providing a better understanding of what happens in the process of reflective writing, it does not add to the student's experience. The practice of reflective writing is intended to be something different from the medical school tradition - something to make the process of medical education more thoughtful and contemplative and it should not fall prey to the medical school norms that it is intended to remedy.

Dozens of qualitative studies have examined the students' experience and validate the benefits of reflective writing.[4] I would argue against this call to assess reflective writing in this quantitative way. In fact, embracing this kind of rigorous assessment may be detrimental to maintaining reflective writing in medical school education. It adds an unnecessary burden for already overworked faculty who may have only tentative buy-in and it confuses the purpose of the educational exercise. Kuper et al. recently commented on the surge of qualitative research in medical education. They note that the strength of qualitative research is the ability to generate in-depth accounts of personal experiences and to explore the social and cultural framework within which students learn and clinicians practice (1-2). Using qualitative methods to assess reflective writing makes even more sense when we consider the strengths inherent in this methodology.

Teaching Mindfulness

Mindfulness is rarely considered an essential curricular element in medical education however, its focus on being present in the moment, is critical to the establishment of a therapeutic relationship between the clinician and the patient. As discussed previously, Epstein describes several steps that are useful in fostering

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[4] (Sayantani DasGupta and Rita Charon, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy," Academic Medicine 79.4 (2004), Branch, "Becoming a Doctor - Critical-Incident Reports from Third-Year Medical Studentd.", D. Hatem and E. Ferrara, "Becoming a Doctor: Fostering Humane Caregivers through Creative Writing," Patient Education & Counseling 45.1 (2001), MC. et al Nogueira-Martins, "Medical Students' Perceptions of Their Learning About the Doctor-Patient Relationship: A Qualitative Study," Medical Education 40 (2006), Kind, "Learning to Connect.", Howe, "How Medical Students Demonstrate Their Professionalism When Reflecting on Experience.".

mindfulness ("Mindful Practice in Action: Cultivating Habits of Mind" 12-16). The model curriculum offered in this dissertation focuses on teaching skills of priming, availability, asking reflective questions and practice. Assessment and confirmation are part of the evaluation process.

Priming is the first step in becoming aware of oneself and one's thoughts. A series of exercises that progress from a one to two minute breathing exercise to a 45 minute body-scan exercise help students to focus on being present. Starting with a simple exercise helps prepare students for making this a regular practice. In the simplest exercises the student is asked to begin class by stopping all activity, sitting, and becoming aware of his/her breathing. They note how they are feeling and what they perceive is happening. They are instructed to just breathe and notice how they feel without judging or changing anything. This one to two minute exercise can be repeated several times during the day (Kabat-Zinn *Wherever You Go, There You Are: Mindful Meditation in Everyday Life* 12-13) and students should be encouraged to practice these whenever they can. The exercises offered to students should progress in complexity and length over the weeks that the curriculum is delivered. The following are examples that could be included in a mindfulness curriculum:

Sitting with breath includes the above but also asks the students to bring awareness back to the breath when they find their minds wandering.

This might be followed by *sitting with thoughts and feelings* which is an exercise that includes the above and introduces noticing the process of thinking and watching thoughts as they come and go through your field of attention without being drawn into the thought itself. Similarly the student would note feelings as they pass through his/her awareness. The discipline is in noting the feelings but not entering into them and allowing them to pass (Kabat-Zinn *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness* 72-74).[5]

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[5] Exercises can be found in a many meditation and mindfulness texts including the following: Jon Kabat-Zinn, Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness (New York: Dell Publishing, 1990), Jon Kabot-Zinn, Mindfulness for Beginners: Reclaiming the Present Moment - and Your Life (Boulder: Sounds True, 2012), Jon Kabat-Zinn, Wherever You Go, There You

Much of this is practiced as "homework" and students are asked to write about/reflect on their experiences by keeping a diary. Diary entries are shared in total or in part with their classmates and the instructor in small group sessions. The *body-scan* exercise asks the student to lie down, eyes closed, and to move their attention from one region of the body to another, breathing into and out of each region as they move systematically through their bodies. In each region, the student ends the scan by breathing out the stress in that area of the body. This exercise provides an opportunity for the students to practice very focused concentration and attention (Kabat-Zinn *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness* 75-93).

Being available involves the ability to be present in the moment. The exercises outlined above help the students to develop the ability to focus and maintain their attention on one specific activity. In patient care, this skill can be transferred to the focus on the patient, allowing the provider to remain present throughout the medical interview.

As noted in the previous chapter, the path to availability and presence involves curiosity. Asking reflective questions will encourage curiosity. Reflective questions confront habitual behaviors by disrupting usual patterns. By letting go of patterns of behavior and thought, the student enters the situation without any preconceived notions of what will or should occur. In this way the student can be better prepared for the unexpected, which is often confronted in medicine. These questions are particularly helpful when they are posed after a clinical encounter. The design of the model curriculum offered in this dissertation includes a number of visits to a hospital site to practice interviewing and examining patients. After each clinical encounter the students are asked to record the medical history and to answer several reflective questions. The answers to those questions are the impetus for small group discussion in the days following the clinical encounter. Questions posed might include:

Are: Mindful Meditation in Everyday Life (New York: Hyperion, 1994), D. McCown, Reibel, D., Micozzi, M., Teaching Mindfulness: A Practical Guide for Clinicians and Educators (NY, NY: Springer, 2011).

1. Did any of your expectations change once you met and talked with the patient?
2. Were you pushed outside of your comfort zone? If so, what was the hardest part about it?
3. Was there anything discouraging about the experience?
4. What was most surprising?
5. Where did you feel challenged?
6. Has this experience challenged any stereotypes you have?
7. What have you learned by observing and/or listening?
8. How will this experience change the way you act in the future?
9. What lesson would you like to take with you into your future?
10. What has been the best aspect of this experience?
11. How has the experience with this patient impacted you?
12. How do you think you affected this patient? (Butler University)

Practice is the discipline of repetition with the goal of strengthening the skills of attentiveness, presence, active engagement and listening. As noted previously, students are assigned daily "homework" in the form of quiet reflection or meditation. These assignments provide the daily practice that students need in order to hone their skills.

Finally, assessment and confirmation is the evaluation and feedback that are necessary to provide to students who are learning the skills of mindfulness. In order to provide the appropriate feedback, faculty who are involved in teaching the course need to be trained in how to convey feedback in an environment that supports curiosity, trial and error, and the expression of ideas and feelings. In order to become proficient in creating this kind of safe environment and to assure competence in mindfulness, faculty should be provided with in-service education about mindfulness or be required to attend a mindfulness-based meditation workshop.[6] Additionally, on site education regarding the role of narrative medicine and relationship-centered care should be offered to faculty. It is essential that the faculty involved in running the small groups are genuine in their interest in students' attaining these skills and that they are skilled themselves.

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[6] Mindfulness Meditation Workshops based on stress reduction are available widely. Although they are stress-reduction workshops and not specifically aimed at training practitioners, they teach all the skills necessary for the purposes of faculty involved in this course. For an example of a program see: <http://www.umassmed.edu/cfm/7day/index.aspx>.

Teaching Skills of Relationship-Centered Care

This Chapter and Chapter 3 have discussed most of the skills of relationship – centered care including narrative skills and skills of mindfulness and empathy. Relationship-centered care also includes the skills of exercising moral imagination, clinical empathy and narrative ethics. In this section, the methodologies to promote skills in these areas are discussed.

Exercising moral imagination is the ability of clinicians to understand their own biases and values with the expectation that this knowledge will help them to establish non-judgmental therapeutic relationships with their patients. Exercises in identifying biases and values clarification help the student to begin this process. Values clarification was described by Raths in 1966. He created a process of valuing composed of three basic elements. These are:

> Prizing – prizing one's beliefs and behaviors and publically affirming these.
> Choosing – choosing one's beliefs and behaviors freely from alternatives after consideration of the consequences.
> Acting – acting on ones beliefs with consistency and repetition. (Raths)

Exercises that assist students in discovering their values and beliefs are a starting point on the road to self-reflection. Exercises in the model curriculum include "forced choices" which asks students to complete surveys in class that lists 6 -12 statements. For each statement, the students fill-in one choice: agree, disagree or are unsure. The surveys are completed anonymously. These surveys can focus on one healthcare issue such as HIV where values and bias can affect the relationship between the provider and the patient or it can cover a mix of issues in healthcare delivery. In an HIV survey, for example, statements may include the following:

1. I have anxiety about treating HIV+ patients.
2. HIV is a punishment for immoral behaviors.
3. I believe that people who are accused of rape should be mandated to have HIV testing.
4. If I test positive for HIV, I would tell my family and friends very soon.
5. Sterilization should be encouraged for women who are HIV+.
6. Hospitalized HIV+ persons should be clearly identified so that all staff are aware.

7. I would eat at a restaurant where I know HIV+ people frequently dine.
8. I would eat at a restaurant that I know hired an HIV+ chef. (UMDNJ PA Program "Values Clarification Exercise - Forces Choices - Hiv/Aids")

A more mixed survey may include statements such as:

1. The "morning after" pill promotes irresponsible sexual behavior and should not be prescribed if requested.
2. I would be incapable of providing healthcare to a child molester wounded during apprehension after he/she had committed such a perverted act on an innocent child.
3. Prescribing oral contraceptives to minors encourages early sexual experimentation and therefore should be given to minors only with full parental knowledge and permission.
4. Homosexuals choose their sexual lifestyle and should not expect open acceptance from "straight" heterosexuals.
5. People suffering from depression could pull themselves out of it if they just tried harder and stopped feeling sorry for themselves.
6. The cost of caring for the uninsured in emergency rooms and inpatient is driving our hospitals into bankruptcy. Hospitals should at least be allowed to narrow their losses by only accepting patients who are legal residents of this country. (UMDNJ PA Program "Values Clarification Exercise - Forces Choices - Health Care").

After completing the survey anonymously, they are turned in to the instructor who shuffles them and passes them back out to the students. The students are then asked to look at the answer they have in front of them for the first statement and if it is "agree" they move to one side of the room, "disagree" to the center of the room and "unsure" to the other side of the room. This allows students to see how the class as a whole responded. Then the instructor asks someone in the agree section to defend that point of view. This methodology provides the student with an opportunity to discuss the various points of view without revealing their own personal point of view to the class. This exercise is valuable for a number of reasons. It allows for self-reflection, it provides an opportunity for students to see how their colleagues feel about the issues as a group, and it provides a safe environment to discuss the various points of view.

Developing skills of empathy is the other half of this skill set. In a 2009 review article, Hojat describes a number of exercises to enhance empathy in health care

professionals[7]. Of those he describes, a particularly useful approach is to Audio- or Video-Tape student encounters with simulated patients. In this exercise, video-taped conversations between simulated patients and students can be analyzed to identify opportunities for empathetic responses, as well as demonstrate missed opportunities. The taped interview, reviewed in a one on one session with an instructor, can be very valuable to students as it is an opportunity for them to actually see themselves interact with a patient. Studies have shown that this type of activity helps to enhance empathy.[8]

Hojat's review includes many activities to enhance empathy in health care students that have been discussed in other sections of this paper. These include the study of literature and improving narrative skills.[9]

The methodologies and examples outlined in this chapter are designed to teach the skills of narrative, mindfulness and relationship-centered care to students who are

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[7] For other approaches refer to: (Mohammadreza Hojat, "Ten Approaches for Enhancing Empathy in Health and Human Services Cultures," Journal of Health & Human Services Administration 31.4 (2009).

[8] Enhancing empathy is discussed in: (R. Kalish, M. Dawiskiba, Y. C. Sung and M. Blanco, "Raising Medical Student Awareness of Compassionate Care through Reflection of Annotated Videotapes of Clinical Encounters," Education for Health 24.3, R. W. Sanson-Fisher and A. D. Poole, "Training Medical Students to Empathize: An Experimental Study," Med J Aust 1.9 (1978).

[9] For other discussion in this area see: Victoria Bonebakker, "Literature & Medicine: Humanities at the Heart of Health Care: A Hospital-Based Reading and Discussion Program Developed by the Maine Humanities Council," Academic Medicine 78.10 (2003), Rita Charon, "Reading, Writing, and Doctoring: Literature and Medicine," American Journal of the Medical Sciences 319.5 (2000), Rita Charon, "Literature and Medicine: Origins and Destinies," Academic Medicine 75.1 (2000), Rita Charon, "Medicine, the Novel, and the Passage of Time," Annals of Internal Medicine 132.1 (2000), Rita Charon, "The Narrative Road to Empathy," Empathy and the Practice of Medicine, ed. et.al. Spiro (New Haven: Yale Univerisity Press, 1993), Rita et al Charon, "Literature and Medicine: Contributions to Clinical Practice," Annals of Internal Medicine 122.8 (1995), DasGupta and Charon, "Personal Illness Narratives: Using Reflective Writing to Teach Empathy.", J. Herman, "Reading for Empathy," Medical Hypotheses 54.2 (2000), A. H. Jones, "Literature and Medicine: An Evolving Canon," Lancet 348.9038 (1996), Tim Lancaster, Ruth Hart and Selena Gardner, "Literature and Medicine: Evaluating a Special Study Module Using the Nominal Group Technique," Medical Education 36.11 (2002), Glenn Nordehn, Joshua Froman and Frederic Hafferty, "Literature-Based Education in Medical School. Duluth Medical School Faculty and a Student Reflect on a Lesson in Which Literature Led the Student to Better Understand the Physician-Patient Relationship," Minnesota Medicine 87.7 (2004), R. Selzer and R. Charon, "Stories for a Humanistic Medicine," Academic Medicine 74.1 (1999), Johanna Shapiro, Elizabeth Morrison and John Boker, "Teaching Empathy to First Year Medical Students: Evaluation of an Elective Literature and Medicine Course," Education for Health 17.1 (2004), J. R. Skelton, J. A. Macleod and C. P. Thomas, "Teaching Literature and Medicine to Medical Students, Part Ii: Why Literature and Medicine?[See Comment]," Lancet 356.9246 (2000).

entering the medical profession. They allow for both the development and reinforcement of skills in these three critical areas. They promote critical communication skills and encourage students to practice medicine with empathy and compassion for their patients. Utilizing skilled instructors who act as role models and create a safe environment to discuss the practice of compassionate care, students can be afforded an opportunity to develop skills that will provide them with the competencies to be caring and effective practitioners.

In the following pages, I will demonstrate the application of the methods discussed earlier to teach the essential skills of narrative, mindfulness and relationship-centered care by proposing a fifteen-week, self-contained and flexible course of instruction for medical interviewing. The course encompasses medical narrative, the medical interview, cultural competence, and the covenant between the clinician and the patient.

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CHAPTER 5
INTRODUCTION TO MEDICAL INTERVIEWING: AN INNOVATIVE CURRICULUM FOR MEDICAL STUDENTS

Introduction to the Instructor's Guide

This dissertation has argued that mindfulness, narrative medicine, and relationship-centered care are critical competencies for today's clinicians. This course is the first step in providing students with a curriculum that teaches the skills that are necessary to realize these competencies. As described in the syllabus, this course introduces the student to the skills required to conduct a thorough medical interview while maintaining a therapeutic relationship-centered interaction with the patient. In order to accomplish this, the course starts off with basic interviewing skills and builds on these by offering opportunities to practice needed skills and receive feedback from the instructor. At the same time, concepts including mindfulness, narrative medicine, relationship-centered care and cultural competence are introduced so that the student can incorporate these into the patient encounter.

Each unit has specific objectives. The units follow each other in a logical fashion so that concepts are introduced and practiced as the students move toward clinical clerkships where they will be expected to have some mastery of these skills.

This course design is unique. It goes beyond the typical medical interviewing curriculum to include the skills necessary for mindfulness, narrative medicine and relationship-centered care. It also includes time for the student to have actual patient encounters in a hospital setting. These encounters are critical to meeting the goals of the course. They provide the student with a "real life" opportunity to practice the skills learned and to receive feedback from in-hospital preceptors and the faculty/ instructor. Details for setting up hospital visits are included in the appropriate units.

Each unit includes the content that can be placed on PowerPoint slides. The slides are presented in sections; each section covers a key concept of the unit. In addition,

readings and exercises that reinforce the objectives for the unit and give students an opportunity to practice new skills are included either as in-class activities or homework. There is flexibility in using these exercises and readings. For in-class activities, each unit includes notes to the instructor at selected points in the lecture where the exercises or readings might best be introduced. Although the curriculum can be implemented exactly as offered in the units, the instructor is encouraged to adjust the units by adding their own stories and experiences to the content. Instructors should feel free to add or substitute readings and/or exercises that they feel will meet the unit objectives. In addition to the exercises provided, guidelines for providing feedback and grading rubrics are included as appropriate. These can also be adjusted as needed by the instructor.

Student evaluation is accomplished in a number of ways. There are a variety of written assignments and graded observed simulated clinical examinations (OSCEs.) OSCE scripts and checklists in addition to information on how to conduct OSCEs are included in the course materials.

There is a works cited page at the end of each unit. The instructor will note that some of the PowerPoint slides include a parenthetical reference, each of these can be found in the works cited. The listed texts and articles should be reviewed thoroughly by the instructor before teaching the unit. These should also be provided to the students who may want to do additional reading. If materials are added or changed, the work cited section should be adjusted so that students have access to all the relevant materials.

Introduction to Medical Interviewing
Course Syllabus

Course Description:

Offered to students in preparation for their clinical clerkships, this course is designed to help students develop interpersonal skills including verbal communication, empathy, mindfulness and narrative competence. The course focuses on a relationship-centered approach to patient care. It includes specific interviewing skills, particularly as they relate to taking a complete medical history, as well as skills of mindfulness and narrative competence.

Throughout the course students will be encouraged to reflect upon assigned readings and their hospital experiences in order enhance their understanding of the patient experience.

Course Goal:

The goal of this course is to help the student acquire and improve skills in medical interviewing in the context of practicing companionate patient care. The student is taught how to gather information while developing/maintaining a therapeutic relationship with the patient.

Sessions:

Three hours per week for fifteen weeks

Evaluation:

Students receive a Pass or Fail grade.

The grade is based on attendance and completion of all assigned coursework.

Teaching Strategy:

Lectures; class discussion; role-playing; practice sessions with model patients; small group discussions; assigned readings; medical narrative, and oral presentations of case histories of varying length.

Overall Course Goals:

Upon completion of this course the student will be able to:

1. Develop the skills needed to practice companionate patient care
2. Conduct a complete medical history by obtaining necessary biological,

psychological, social, and cultural information from a patient within the context of relationship-centered care

3. Identify the principles of relationship-centered care
4. Describe the importance of trust and confidence in developing an effective clinician- patient relationship
5. Define and explain the importance of using specific interviewing techniques including open-ended questioning, silence, empathy, and confrontation
6. Develop skills in mindfulness that will assist in being present and attentive to others; particularly patients
7. Discuss common psychological responses to physical illness in both the patient and interviewer
8. Discuss appropriate techniques for delivering results of findings with patients, patient education, and involving the patient in treatment planning
9. Describe appropriate methods of interviewing families and children
10. Discuss how personal values may be different between individuals of varying cultures and how to treat those individuals without judgment
11. Use the medical narrative as a means of self-reflection, to promote empathy for patients, and to develop competence in the human dimensions of healthcare
12. Understand how to work effectively with an interpreter

Table 3.

Units of Study

Unit	Topic	In-class Activity	Homework Assignments
1	Introduction to Key Concepts; Getting started with Basic Techniques	Mindfulness Exercise: Breath Counting Reflection on a patient narrative exercise	Reflection on a clinician narrative

Table 3 *continued*

Unit	Topic	In-class Activity	Homework Assignments
2	Relationship-Centered Care	Mindfulness Exercise: Breath Counting Values Clarification Exercise In-class reflection of exercise and discussion Small group discussion of HW reading	Reflection on a clinician narrative
3	Techniques and the Medical History - the HPI and ROS	Mindfulness Exercise: Breath Counting Instructor Role Play for the HPI Write up HPI	Reflection on patient narrative
4	Mindfulness	Guided Eating Meditation Small group discussion of Unit 2 and 3 homework	Choose any meditations on CD to practice several times per week Write a reflection of your weekly meditation practice
5	The medical History – Past and Social History	Small Group Instructor Role Play for the full History Take notes during role play	Write up full history Continue meditation
6	OSCE #1	Gather information for HPI from simulated Patient	Continue meditation and reflection
7	The Problem List and Assessment and the Parallel Chart	Develop List of pertinent positives Develop problem list Develop Assessment	Continue meditation Prepare for hospital visit

Table 3 *continued*

Unit	Topic	In-class Activity	Homework Assignments
	Hospital visit #1	Gather information for HPI, Pertinent Positives, problem list and Assessment based on history only Create a parallel chart for this visit	History write-up And Parallel chart
8	Narrative medicine and close reading	Small group close reading exercise Small group review of H&P #1	Continue meditation Close Reading Exercise (Mistakes)
9	Case Presentations	Instructor Role Play Write HPI	Continue meditation Develop List of pertinent positives Develop problem list Develop Assessment Prepare for hospital visit
	Hospital visit #2	Gather information for HPI, PE, Pertinent Positives, problem list and Assessment Create a parallel chart for this visit	Continue meditation History and Physical write-up And Parallel chart
10	The Plan	Small group review of H&P #2	Continue meditation

Table 3 *continued*

Unit	Topic	In-class Activity	Homework Assignments
11	Orders	Develop plan and orders for role play patient	Continue meditation View film and write reflection on "The Doctor" Prepare for hospital visit
	Hospital visit #3	Gather information for HPI, PE, Pertinent Positives, problem list, Assessment, plan And orders Create a parallel chart for this visit	Continue meditation History and Physical write-up And Parallel chart
12	Understanding and Managing Difficult Clinical Encounters	Discussion of film "The Doctor" Small group review of H&P #3	Continue meditation Read "SPIKES Protocol for Delivering Bad news" article
13	Breaking Bad News "Wit"	View movie "Wit" Small group focused discussion	Continue meditation Prepare for hospital visit
	Hospital visit #4	Gather information for HPI, PE, Pertinent Positives, problem list, Assessment, Plan and orders Create a parallel chart for this visit	History and Physical write-up And Parallel chart

Table 3 *continued*

Unit	Topic	In-class Activity	Homework Assignments
14	Culturally competent clinical practice and working with an interpreter	View video: Communicating effectively through an Interpreter Small group review of H&P #4	Continue meditation Close Reading Exercise (Birth)
15	OSCE	Focused History and Physical Exam on simulated patient	

Unit 1

Introduction to Key Concepts;
Getting started with Basic Techniques

This unit provides an overview of the entire course and introduces the medical interview. It presents some of the basic techniques used in conducting a medical interview in addition to introducing the key course concepts of relationship-centered care, mindfulness and narrative medicine. Each of these key concepts will appear later in course in greater depth. A review of the unit objectives which are presented in slide one will provide the instructor with a guide to the unit.

At the end of unit there are four appendices. The first two include a reading exercise and a breathing/simple mediation exercise for the in-class activities. Appendix three is a reading homework assignment. The fourth appendix is a guide to providing feedback to students on written reflections.

The following is an outline of the material that can be converted to PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Recognize that research supports the need for formal training in the area of interviewing techniques.
2. Identify listening as the key skill in any interviewing situation.
3. Define relationship-centered care and recognize the benefits of this model.
4. Describe the four habits for getting the most out of the clinical encounter.
5. Explain the techniques of confrontation, facilitation, silence and open-ended questioning and discuss when it is appropriate to use each technique.
6. Describe cultural competence and recognize that the skills required are needed in every patient encounter.
7. Define narrative competence

8. Identify the Medical Narrative as an opportunity to better understand the patient experience.
9. Recognize that mindfulness can assist in self-refection and being present for the patient.

SLIDE 2: Key Concepts/Sections

- Introduction and the Helping Relationship
- Relationship – Centered Care
- The Medical Interview and Basic Techniques
- Cultural Competence
- Narrative Competence
- Mindfulness

Section 1 – Introduction and the Helping Relationship

SLIDE 3: Why is a Formal Course in Interviewing Techniques Important?

- Research supports the hypothesis that the interview is integral to the process and outcomes of medical care.
- Patients are more concerned with how much you care rather than how much you know.
- Patient and practitioner satisfaction is based on perceptions of the patient-practitioner relationship.

SLIDE 4: The Helping Relationship - Carl Rogers (Greenberg)

In 1958 Rogers defined the Three Basic Elements of the Helping Relationship

1. Unconditional Positive Regard
2. Genuineness and Congruence
3. Empathy

Implicit in all this is respect for the patient

SLIDE 5: How can we become good practitioners?

- Self-awareness - be aware of your feelings, your ability to serve as a role model and ability to relate to patients
- Interest - show genuine interest in the welfare of others and the influence of culture on all people
- Knowledge and Skills - be competent in your area of practice and maintain your skills through life-long learning
- Mindfulness/listening – being present in the moment without judgment and listening to your patients

Section 2 – Relationship-Centered Care

SLIDE 6: Principles of Relationship-Centered Care (Beach)

1. Relationships in Health Care Ought to Include Dimensions of Personhood as Well as Roles: Recognizes that the patient and the clinician are unique individuals with their own experiences and values
2. Affect and Emotion Are Important Components of Relationships in Health Care: Empathy is encouraged - the patient is supported through the emotional presence of the clinician. Empathy can help patients experience and express their emotions
3. All Health Care Relationships Occur in the Context of Reciprocal Influence: Clinicians benefit and grow from knowing their patients
4. Relationship-Centered Care Has a Moral Foundation: Authentic relationship fostered is morally desirable - clinicians become invested in the patient's experience and outcome; necessary if one is to serve others genuinely and be renewed from that serving

Section 3 – The Medical Interview and Basic Techniques

SLIDE 7: Getting the Most out of the Clinical Encounter: The Four Habits (Frankel)

1. Invest in the Beginning
2. Elicit the Patient's Perspective
3. Demonstrate Empathy
4. Invest in the End

SLIDE 8: 1. Invest in the Beginning

- Create Rapport Rapidly: Introduce self to everyone in the room
- Acknowledge wait and attend to patients comfort and privacy
- Put the patient at ease
- Adapt your language, pace and posture to the patient

SLIDE 9: Elicit the patient's concern(s)

- Start with open-ended questions such as "What brings you here today?" or "What can I do for you today?"
- Let the patient tell his/her story
- Speak directly to the patient even when using an interpreter

SLIDE 10: Use Facilitation

- Verbal or nonverbal communication that encourages the patient to say more
- Verbally use "uh huh" or "I see" or "Go on" or "tell me more"
- Nonverbal message sent through use of head nodding, or attentive posture

SLIDE 11: Use Silence

- Encourages communication - gives patient an opportunity to collect thoughts

- Use with nonverbal facilitation - be attentive, convey interest in what they have to say and how they feel
- Always use if patient is expressing strong emotion - can be very therapeutic
- Do not use if the patient shows obvious discomfort with the process
- May not work well with teens

SLIDE 12: Use Confrontation

- Allows practitioner to direct the patient to something he/she may not have been aware of, e.g., "you look sad", or "you seem tense"
- Identification of feelings may open communication
- Often used when verbal and non-verbal behavior are inconsistent
- Always use confrontation in a way that conveys caring not irritation or frustration

SLIDE 13: Plan the visit with the patient

- Summarize and repeat concerns back to check accuracy with the patient
- Let the patient know what to expect during the visit
- Prioritize when necessary and let the patient know that a follow-up visit will be scheduled to address additional concerns

SLIDE 14: 2. Elicit the Patient's Perspective

- Ask for the patient's ideas - Find out what these symptoms mean to the patient.
- "What do you think might be causing the problem?"
- "What worries you about this problem?"
- Listen with sympathy and understanding to the patient's perception of the problem

SLIDE 15: Elicit Specific Requests

- Determine what the patient expects from you during that visit.
- Can be done in a number of ways: **Before** the treatment plan is determined, e.g. "How were you hoping I could help you today?"
- or **After** treatment plan is discussed, e.g."Is there anything else that you were hoping for with this visit?"

SLIDE 16: Explore the Impact

- How has the illness affected daily life/work/school/ family
- Provides information on patient's functional status
- Helps formulate the treatment plan

SLIDE 17: 3. Demonstrate Empathy

- The goal is to have the patient leave the encounter feeling "known and understood"
- Be open to the patient's emotions
- Recognize that each patient is a unique person with his/her unique story
- Convey empathy verbally and nonverbally

SLIDE 18: Five Types of Empathic Responses (Cohen-Cole)

- Reflection - "I can see that you are…"
- Legitimization - " I can understand why you feel…"
- Support - " I would like to help."
- Partnership - "Let's work together…"
- Respect and Support - "You're doing great."

SLIDE 19: Demonstrating Empathy includes:

- Explaining your perceptions of the problem

- Acknowledging and discussing the differences and similarities between your perspective and the patient's

SLIDE 20: 4. Invest in the End

- Deliver diagnostic information
- Provide education
- Recommend treatment
- Involve the patient in the decision - making process by discussing treatment goals
- Negotiate agreement
- Complete the visit - ask for questions, ask if patient's expectations have been met, reassure patient of ongoing care

Section 4 – Cultural Competence

SLIDE 21: Cultural Competence (Betancourt et al. 297)

- "Understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system…
- and devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations."

SLIDE 22: Framework for Cross-Cultural Health Care (Berlin and Fowkes)

L E A R N

- ***Listen*** with sympathy and understanding to the patient's perception of the problem
- ***Explain*** your perceptions of the problem
- ***Acknowledge*** and discuss the differences and similarities
- ***Recommend*** treatment

- ***Negotiate*** agreement

SLIDE 23: The Patient's Perspective (Shapiro, Hollingshead and Morrison)

From a 2002 study looking at attitudes and beliefs about cultural competence

- Don't make assumptions based on skin color or surname
- Listen carefully
- Take patient seriously, acknowledge his/her expertise about own body
- Give clear, complete, explanations
- Incorporate folk remedies
- Have empathy, be caring and concerned, treat patient with dignity and respect
- Apologize if you kept patient waiting or if you make a mistake

Section 5 – Narrative Medicine

SLIDE 24: Narrative – The Patient's Story (Sacks)

"If we wish to know a man, we ask 'what is his story, his real, inmost story?', for each of us *is* a biography, a story. Each of us *is* a singular narrative, which is constructed continually and unconsciously by, through and in us – through our perceptions, feelings, our thoughts, our actions… through our spoken narrations… we are each of us unique"

SLIDE 25: Narrative Competence (R. Charon "What Narrative Competence Is For")

- The ability to acknowledge, absorb, interpret and act on stories and plights of others
- Can be accomplished by reading of literature and/or reflective writing

SLIDE 26: Sources of Narrative (R. Charon "Narrative Medicine: Form, Function, and Ethics")

Medical fiction

Written by physicians and other health care providers, - fictionalized accounts that express their experiences in medicine.

Lay exposition

Appears in magazines like The New Yorker and newspapers such as the New York Times - regularly publish essays written by physicians intended for a lay audience.

Medical autobiography

Books like the House of God or A Taste of my own Medicine - movie The Doctor - allow the writer to describe experiences in medical training and/or practice.

SLIDE 27: Sources continued

Stories from practice

Tells of experiences in practice or training - intended audience is others in the health care system. Annals of Internal Medicine and Journal of the American Medical Association

Writing exercises in medical training

May take the form of prose, poetry, critical incident reports or parallel charts - These encourage reflection on the experience of caring for patients.

***Note to instructor:** this is an ideal time to distribute the reading assignment in

Appendix 1 can be read aloud in class by the instructor or a student. This should be followed by a discussion of the reading using the prompts included in the appendix.

Section 6 – Mindfulness

SLIDE 28: Mindfulness

"Mindfulness means paying attention in a particular way: on purpose, in the present moment and nonjudgmentally" (Kabat-Zinn *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness*)

SLIDE 29: Mindfulness includes: (Baer)

Observing

Involves noticing and attending to a range of stimuli particularly thoughts, sensations, and emotions - tuning-in to yourself and gaining self-awareness.

Describing

Labeling observations and applying words such as "anxiety" or "frustration" or phrases such as "worrying about my family." Recognize patterns without judgment or analysis and then to get back to attending to the present moment.

SLIDE 30: Mindfulness cont.

- Acting with awareness
- Refers to engaging in an activity with focus and undivided attention - In contrast to "automatic pilot" without awareness; a step toward presence in the moment and true connection between the clinician and patient
- Accepting (or allowing) without judgment
- Refers to the skill of accepting the present moment without evaluating it or attempting to change it

***Note to instructor:** this is an ideal time to practice mindfulness by doing the mindfulness exercise offered in Appendix 2. This should be directed by the instructor as described in the appendix.

Before ending class, hand out homework reading in appendix 3 or have it available to students on-line. Ask them to read the essay and write a reflection of the reading following the prompts provided. Appendix 4 provides an instructor's guide to giving feedback on student reflections.

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Appendix 1

The Absolute Worst Thing

by Seth Carey, *Nonfiction*

Ever since kindergarten, I'd wait at the school bus stop with my best friend Chris Kelly. To kill the time we'd invent games. 'The absolute worst thing' was a real favorite. We'd dream up the worst situations we could think of and progressively build upon them until they were as dreadful as possible.

No matter how we tried to outdo it, the absolute worst we could come up with was always trumped by one particular scenario:

"What if you could still think and feel but you weren't able to move?"

We agreed—this was The Absolute Worst Thing.

That was about thirty years ago, and I still think it's the absolute worst thing.

I was diagnosed with Lou Gehrig's Disease (ALS) December 14, 2001—no problem remembering that date. The doctors who diagnosed me were careful to explain that this meant a death sentence. I was thirty-nine years old.

When they suggested one more blood test, since "maybe you're lucky and you just have AIDS," I knew that the absolute worst thing was for real, and it was happening to me. I knew things were going to get ugly, so I told my good friend (and recent girlfriend), Shannon, that she should run from me. Luckily for me she ignored sound advice and asked to get married instead.

We got married that March.

In the last two years, seven months, and eight days, this disease I'd never heard of has been busy kicking my ass. I've gathered way too much info on ALS (all of it depressing) and can rattle on about it. It boils down to this: ALS kills motor neurons, the signal pathways to voluntary muscles. Those are what you use for things you want to do, like petting the cat, rolling over in bed, holding your head up...you get the idea.

Those muscles are also used in breathing, something I do regularly, and very much hope to keep on doing.

I have bulbar onset ALS, whose symptoms include uncontrollable outbursts of laughter and weeping, sometimes both at once. Fortunately for me, most of my outbursts have been in the more socially acceptable form of laughter. The slightest humorous thought, or the dreaded heart-tug of a Spielberg moment, so popular in phone commercials, and I wave goodbye to self-composure. It makes it tough to act macho. It's not as bad as it was initially but I still cry in my oatmeal most mornings.

I miss being able to do everything I used to do. I thought I understood what I'd miss and could sort of stockpile experiences to keep from missing them too much. It worked better with some things than with others.

I knew that I'd miss fishing, so I did a butt-load of it. But how can you stock up on hugging your wife?

We have three cats I can no longer pet. Shannon, my wife, sometimes takes my hand and runs it over the fur of one that's nearby. The cats start purring and, usually, I end up sobbing.

Mosquito season has now become its own special form of torture. I watch the mosquitoes land on me. They walk about a bit searching for just the right spot to drill. I try to explain to whomever is around, what's happening. My voice is hard to understand in the best circumstances, but when you add frustration and impending doom, I'm reduced to undecipherable yowls. They only know I'm upset, but not why.

I know all too well there's nothing funny about ALS. It's stripped me of the use of my body and voice. It has been an endless source of frustration and humiliation.

But there's already enough depressing crap written about ALS. Laughter and denial are the tools that make living with this nightmare possible.

I credit my approach to dealing with ALS to the many hours I've spent stuck in highway traffic. When you find yourself in a traffic jam, you are faced with a choice. You can get all mad, flipping the finger to everyone, banging on the dashboard. Or you put on your favorite CD, rummage around for a roach, and sing along with the guitar solo.

Either way you're going to end up at the same place.

Reflection on Patient Narrative Exercise

Reading and discussion of "The Absolute Worst Thing" (Carey)

Reflect as a group and discuss. Instructor will use the following prompts as needed to stimulate discussion:

- Why do you think the author wrote this?
- What message did he/she want to send to the reader?
- Which particular passage (or two) particularly demonstrates this message?
- How does the piece make you feel? What does it bring up for you?
- Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
- What things in your own experience parallel the author's experience?
- What conclusions can you draw after reading this piece?

The focus for the discussion should be about the opportunity this reading provides for the students to understand what it is like to be a patient with ALS. The author is able to describe his losses, regret, and sadness. Allow the students to discuss this using the questions above as prompts if necessary. The objective of this exercise is to demonstrate that narrative can help students to understand the patient in the context of their lives and illness and in that way, develop empathy.

Appendix 2

Mindfulness Exercise:

Breath Counting (5 mins) (Weil)

The instructor will ask the class to sit in a comfortable position with the spine straight and head inclined slightly forward. Gently close your eyes and take a few deep breaths. Then let the breath come naturally without trying to influence it. Ideally it will be quiet and slow, but depth and rhythm may vary.

- To begin the exercise, count "one" to yourself as you exhale.
- The next time you exhale, count "two," and so on up to "five."
- Then begin a new cycle, counting "one" on the next exhalation.

Never count higher than "five," and count only when you exhale. You will know your attention has wandered when you find yourself up to "eight," "12," even "19."

This is an easy and quick way to introduce breathing and mindfulness to students. It may be best to dim the lights if possible and slowly read the exercise to the students in a soothing voice. You can periodically repeat the last two sentences during the five minutes. Alternatively, you can play soothing music. At the end of the 5 minutes, ask the students to refocus on their presence in the room and slowly, when ready open their eyes. Take a minute or two to ask how they felt during the exercise and how they feel now. You might ask some specific questions such as "Was this difficult to do?" or "Could they see themselves stopping for a moment before entering a patient's room to breathe and center themselves so they could be present for the encounter?"

Appendix 3

Homework

Opportunity for Reflection on Clinician Narrative

Read: "The Beauty of Reflex Hammering" (Freedman)

Instructions for students: Write a reflection on the reading and contemplate your thoughts, feelings and reactions to what you read. There is no set length required. These reflections will be collected by the instructor who will return your work with feedback. The following are some suggestions to help you construct your thoughts. They should serve as the starting point; once you gain comfort with this process you may develop your own line of questions that better fit your needs. Do not attempt to answer each question but them as a guideline as you begin to record your reflections.

- Why do you think the author wrote this?
- What message did he/she want to send to the reader?
- Which particular passage (or two) particularly demonstrates this message?
- What would you change about this situation if you had the power?
- How does the piece make you feel? What does it bring up for you?
- Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
- What things in your own experience parallel the author's experience?
- What conclusions can you draw after reading this piece?

Make two copies of this reflection, one to hand in to the instructor, one to keep for class discussion.

The Beauty of Reflex Hammering

Jacob L. Freedman

To the untrained eye, Neurology can appear to be a sadistic profession. Many of our patients are comatose and our daily exams consist of pinching their fingers and toes as hard as we can and documenting that for the ninth straight day there is no reaction to painful stimuli. As I lament this to Duncan, my fellow psychiatric resident who has also been rented out to the Neurology Consult Service, he completes a physical by hollering into a patient's left ear. It is obvious that our patient is unresponsive to verbal commands and when I tell Duncan to keep it down, he tells me that his wife screams at him every night and why can't he have a turn to yell at some people. Especially since they aren't able to hear him.

As we walk to see our next patient, I tell Duncan that I am discouraged with my experience on the Neurology service. We always seem to be called to evaluate horrendous cases after it's too late for any curative interventions. We then poke and prod our patients repetitively and pour cold water into their ears to see if their eyes spin around. We stick Q-Tips into their noses and observe whether their grimaces are symmetrical. We have them memorize nonsensical lists of words like "Physicist-Prism-Amphibian" and then we call the Psychiatry Team when they kick us out of the room because we need someone to make a professional comment on our patients' "affective dysregulation as evidenced by opposition to thorough medical evaluation."

Somewhere in between the physical torture of crushing people's toenails with a reflex hammer and the psychological stressors of making them count backwards from two hundred sixty two in increments of thirteen, I wonder if we'll get more information out of our patients by waterboarding them. Duncan suggests that we might use therapeutic lashings to help our patients who suffer from tremors. He suggests that maybe this will condition them to stop shaking when we tell them to touch their index fingers to their noses and when I give him a quizzical look, he reminds me that it worked for Pavlov's dogs.

Our next patient is Mr. Stevens, a seventy-eight-year-old veteran admitted to the hospital for a heart attack which required bypass surgery which subsequently caused a stroke. This in turn landed him on our list this morning. We were consulted for "pathological crying" and when Duncan reads this, he suggests that they probably should have consulted the patient's mother instead. I remind him that the patient is in his seventies and that the patient's mother is probably deceased. Duncan notes that the patient's mother probably died from embarrassment that her son was still crying like a baby even in his old age. I concur that the patient is likely yellow-bellied and we knock on the door and enter.

Mr. Stevens smiles at us and then barks, "Who the hell are you?" I smile back and show him my ID badge, forgetting that it rats me out as a psychiatrist and he tells me, "I don't need any damn psychiatrists, I'm not crazy, the other doctors already told me that." I apologize and explain to him that Duncan and I have been exiled to the Neurology Consult Service as part of our training and that while we are in fact psychiatrists most of the time, today we're wearing our Neurology hats even if we forgot to take off our Psychiatrist ID cards. Mr. Stevens remarks that I also forgot to take off my psychiatrist beard and reemphasizes, "I don't need any psychiatrists, I'm *not* crazy, I *told* you already." He immediately begins sobbing hysterically and I hand him a tissue from the box on the table next to him. He takes it and dabs at his cheeks and tells me a third time that he's not crazy, "It's just that something in my brain is broken and I cry like a girl scout for no damn reason!"

Duncan and I sit down and Mr. Stevens proceeds to tell us the story of how he was diagnosed with a small stroke after his bypass surgery a few days ago and has since experienced at least six episodes of bizarre crying every day. The only other neurological symptom he's experienced is numbness in his right leg but otherwise the stroke left him in pretty good shape. When Duncan and I pull out our reflex hammers he shakes his head and starts crying. "This is exactly what I mean, I just start crying for no damn reason. I'm not sad, I just start crying. It's ridiculous."

I reach to hand him another tissue but he waves it away as he's already stopped his tears and seems back to his cantankerous self. I ask him if we can examine him and he starts crying again. "I don't need to be examined anyways. You idiots poked me just about everywhere last time I was here after my first stroke and you didn't find anything then and you ain't gonna find anything now! Why don't you go poke each other instead, you perverts!" Duncan and I nod to Mr. Stevens and bid him good day. We tell him that we'll discuss the case with our Boss and that we'll make the appropriate recommendations to his primary medical team. Mr. Stevens smiles and waves us goodbye.

Duncan and I page our Boss who happens to be the world's expert on epilepsy in pregnant women. This means she has about twenty-three seconds to discuss any case that is unrelated to either pregnancy or epilepsy. She calls us back in exactly nine seconds and explains that we'll have to present the case quickly because she has four patients waiting in clinic, a lecture to give at the medical school later this afternoon, and is consulting with a pharmacology corporation on the other line to make some extra pocket money to pay for her step-daughter's Suzuki violin lessons.

She then explains that she really doesn't need to hear anything more about the case because she already reviewed the chart online and that the patient clearly has Pseudobulbar Affect. She tells us we can treat it with a standard antidepressant like Zoloft or whatever else we want to do but just to make the recommendations and move on because she also needs to edit a review article on post-partum seizure evaluation for the *American Journal of Neurology* before it hits the press tomorrow.

Duncan wonders out loud if our Boss might have put some extra thought into Mr. Stevens if we had told her that he was thirty-six weeks pregnant with an epileptic fetus. He asks me what I know about Pseudobulbar Affect because all he knows is that it's abbreviated PBA. I know even less so we decide to look it up online and figure out what the heck we'll recommend as a treatment.

As we sit down and log onto a computer to search for "Pseudobulbar Affect," I ask Duncan if he thinks that the *New York Times* would run a front page article if they

knew that the Neurology Consultants at the most prestigious teaching hospital in Boston were getting all of their moves from Google. Duncan remarks that they'd only care if we were Tea Party-ers protesting our socialist government's takeover of health care.

Wikipedia says Pseudobulbar Affect is characterized by "pathological crying." Duncan says maybe we should try getting Mr. Stevens some medical marijuana to induce "pathological laughing-and-nacho-eating," which might even things out. I remind him that we aren't practicing medicine in California, and we continue our search online. After stops at eHow.com, Twitter Health, then finally WebMD, I find the first-line medication for management of Pseudobulbar Affect and send a page to Mr. Stevens' primary medical team telling them to start the drug. I ask Duncan if he finds Neurology to be too reductionist. He hands me a tissue and asks if I am going to pathologically cry.

Duncan tells me that he misses psychiatry's taboo on touching patients, but that he finds it fascinating to pore over MRI scans and correlate anatomy with sensory, motor, and mood-related symptoms. Duncan is excited by the possibility of mapping the brain and finding the exact location where he can have an electrode planted to fire every time his wife yells at him. He is confident that, set properly, the electrode can convert "You haven't taken the trash out for two weeks" into "How about a margarita and a back rub." He is convinced that this technology will work even better than cocaine and without the risks of addiction and losing your medical license.

I ask him if, as a psychiatrist, he is concerned by the prospect of breaking human emotions down to electrical currents, and of reducing paranoia, love, and creativity to ions that drift through protein channels. Duncan tells me that he is more concerned by the unchecked proliferation of nuclear technology in unstable Middle Eastern regimes, the subsequent risk of dirty bombs coming onto American soil through Canada, and the recent unavailability of organic buffalo milk yogurt at Trader Joe's. I agree. He asks me if it's really any worse than psychiatric medications that would take away Mr. Stevens' tears but neuter his personality. Duncan asks me why I shouldn't be more frustrated that Psychiatry can't ever fix our patients' unemployment, traumatic childhoods, catastrophic

love-interests, and architecturally-uninspired government housing, and that instead we just dole out pills that castrate their mood.

I ask Duncan why he used "neutering" and "castrate" in the same paragraph and he responds that he watched a *Price is Right* re-run yesterday on his day off and Bob Barker had reminded him "to have your pets spayed or neutered." Duncan adds that "neutering" is a technically appropriate term because most pills we prescribe in Psychiatry double as libido-killers, orgasm-inhibitors, and erection-impairers.

I momentarily consider these grave problems within the field of Psychiatry and then smile because I don't have to think up any solutions until I finish my eight-week contract with the Neurology Consult Service. Duncan says we should try to appreciate these last precious weeks of caring for unconscious patients before we resume our careers as psychiatrists. I agree and we walk down the hall to see our next comatose patient. Neurology can be a reductionist and somewhat sadistic profession but at least we get a chance to whack people with reflex hammers.

Appendix 4

Providing feedback to Students

The mechanism for providing feedback suggested follows a methodology based on the BEGAN (Brown Educational Guide to Analysis of Narrative) feedback mechanism for reflective writing. (Reis et al.)

Guidelines for faculty feedback are as follows:

1. First consider the context including: The setting, student's identity and background, stage of training and the type of encounter.
2. Read the narrative carefully from beginning to end without making any notes (overall impressions and reactions to the learner's written expression).
3. Record initial impressions triggered by the learner's written expression (overall impressions and reactions, as well as your clinical and/or personal experiences, views, and biases).
4. Reread and analyze the text – and note the following:
    a. key concepts, expressed emotions (e.g. verbs such as 'surprised', 'scared') and reflections
    b. key themes, categories, patterns
    c. lessons learned – consider both what the learner expresses and what you see as learning opportunities
5. Look for opportunities to provide positive feedback.
6. Use coaching rather than evaluative language.
7. Ask other reflection-inviting questions as appropriate for the reflection, such as:
    a. How were you informed by the patient's culture, belief, gender, family structure, personal and familial illness history, life experiences?
    b. How did your actions influence the outcome?
    c. What were you feeling?
    d. How did you feel about your interaction (Reflection on action)?

e. What assumptions did you make about this situation? What else might be affecting this situation? Might there be alternative explanations? What could they be? (Fostering multiple perspectives)
f. What skills did you learn? What new insights did you derive?
g. How would you apply what you learned in your future work?
h. How might you do things differently if you had a chance to repeat this situation?

Unit 2

Relationship-Centered Care (RCC)

This unit is moves beyond the introduction to relationship-centered care (RCC) presented in Unit 1. It focuses on values clarification which is a key component of RCC. In this unit the students complete a Values Clarification Survey and have an opportunity to discuss their reactions. The concept of the hidden curriculum is introduced and explored through a discussion of the prior homework reading assignment. It is suggested that this discussion be conducted in small groups of 8-10 students per group. Facilitators who are familiar with the reading and the objectives of the assignment will be needed to implement the groups. If additional facilitators are not available, this discussion can be done in a large group setting. The unit begins with an opportunity for students to practice the breathing exercise introduced in Unit 1. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

At the end of unit there are two appendices which include the in-class values exercise and the homework reading assignment. Please refer to Appendix 4 in Unit 1 for guidelines to providing feedback to students on reflective writing.

The following is an outline of the material that can be converted to PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Practice mindfulness breathing exercise
2. Discuss the value of the therapeutic relationship
3. Recognize the unique aspects of the relationship-centered care model
4. Practice the skills needed for relationship-centered care including recognition of values and self-reflection
5. Define the hidden curriculum

6. Discuss strategies to maintain a humanistic approach to patient care despite pressures that may arise in clinical training and practice.

SLIDE 2: Key Concepts/Sections

- Mindfulness Breathing
- Relationship-centered care
- Self-Reflection
- Values Clarification
- Hidden Curriculum

Section 1: Mindfulness Breathing

SLIDE 3: Focusing and Centering

- Let's start with the breathing exercise we did last week
- It is helpful to get used to purposeful breathing/relaxation/centering before beginning a task or starting an encounter with a patient

SLIDE 4: Mindfulness Exercise: Breath Counting (5 mins) (Weil)

- Sit in a comfortable position with the spine straight and head inclined slightly forward. Gently close your eyes and take a few deep breaths. Then let the breath come naturally without trying to influence it. Ideally it will be quiet and slow, but depth and rhythm may vary.
- To begin the exercise, count "one" to yourself as you exhale.
- The next time you exhale, count "two," and so on up to "five."
- Then begin a new cycle, counting "one" on the next exhalation.
- Never count higher than "five," and count only when you exhale. You will know your attention has wandered when you find yourself up to "eight," "12," even "19."

***Note to the instructor: Follow the guidelines provided in Unit 1, appendix 2.**

Section 2 – Relationship-Centered Care

SLIDE 5: Relationship-Centered Care (RCC) (Beach)

- One of the Goals of the encounter is to develop a therapeutic relationship with the patient
- For this we rely on our ability to listen, be empathetic and truly understand the patient
- Relationship-centered care helps us to accomplish this

SLIDE 6: The unique aspect of relationship-centered care is the focus on the relationship

- It is not patient-centered
- It is not clinician – centered
- It recognizes that the benefit of the encounter is directly connected to the nature of the **relationship** between the clinician and the patient

SLIDE 7: Why is the relationship the focus?

- Emphasizes clinician – patient communication
- Emphasizes shared values
- Emphasizes mutual respect
- Recognizes "two-way" nature of the encounter
- Promotes empathy

Section 3 – Self-Reflection

SLIDE 8: What skills are necessary to engage in RCC?

- Self-reflection is key

- The goal of self-reflection is learn about your own values and biases
- You may or may not want to work on changing your values and/or biases
- In either case, awareness is critical to the clinician – patient relationship

SLIDE 9: How do I engage in Self-Reflection?

- Written reflection based on readings (may be written by patients, practitioners or others involved with patient care) – helps to clarify feelings and values
- Recognition of unconscious bias – offers opportunity to explore your own bias and learn about your own value system

SLIDE 10: Unconscious Bias (Teal et al.)

- We all have some unconscious bias
- Practitioners need to be aware of these because they can impact clinical decision making
- Requires a process of moving from recognition of the bias/value to acceptance, modification and finally integration

Section 4 – Values Clarification

SLIDE 11: Values Clarification

- Exercises that help us to identify our personal values
- Opportunity to reflect on these
- Consider how we feel about this new awareness
- Decision to modify these? Or not?

***Note to instructor:** At this point you can distribute the values clarification exercise provided in Appendix 1. Ask the students to take a few minutes to complete the survey. Let them know that their answers will not be shared unless they want to share them. Slide 12 below describes the in-class written reflection to the students. Let the students

know that the surveys and reflections will not be collected but there will be an opportunity for discussion in class.

SLIDE 12: In-Class Reflection

Think about your responses to the values exercise

Take 15 minutes to reflect consider the following:

1. In reviewing my responses, I am (or am not) surprised by some of my values.
2. If I could change one or two responses – which would they be and why?
3. If you want to change something: What strategies might I use to change?
4. If not: Defend your decisions on one or two of your choices.

***Note to instructor:** When students have completed the written reflection you can begin the discussion of Values Exercise/Reflection. In this large group discussion ask students to volunteer to share their reactions to their own discoveries made in the values exercise. The instructor should guide the discussion to maintain a positive outlook on one's ability to discover values and if desired, modify values.

The focus should be on the student's ability to maintain and/or develop values that are consistent with building therapeutic relationships with patients. After several students have shared their experience the instructor can turn back to the last PowerPoint slide.

SLIDE 13: The Hidden Curriculum (Hafferty and Franks)

1. The homework essay by Jacob Freedman is a good introduction to what is called "the hidden curriculum"
2. These are the informal messages students get about professionalism, empathy and genuine compassion
3. How can students protect themselves from these negative influences?

***Note to instructor:** Discussion of Prior Homework Reading in Small Groups:

(Freedman, Jacob. “The Beauty of Reflex Hammering”. The Bellevue Literary Review, 2011. NYU Langone Medical Center. January 31 2013.)

- Break students up into groups of 8 - 10 students to share responses and discuss the homework reading. Faculty facilitators will meet with students in small groups to guide the discussion of the essay.
- Students will be asked to share their thoughts and facilitators will try to keep the focus on how they might react in the same situation and how they might behave in order to maintain their humanity in the face of the hidden curriculum.
- Facilitators can use assigned prompts to stimulate discussion in addition to added prompts below:
- Why do you think the author wrote this?
- What message did he/she want to send to the reader?
- Which particular passage (or two) particularly demonstrates this message?
- What would you change about this situation if you had the power?
- How does the piece make you feel? What does it bring up for you?
- Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
- What things in your own experience parallel the author’s experience?
- What conclusions can you draw after reading this piece?
- Before ending class, hand out homework reading in appendix 2 or have it available to students on-line. Ask them to read the essay and write a reflection of the reading following the prompts provided. Refer to Unit 1, Appendix 4 for an instructor’s guide to giving feedback on student reflections.

Works Cited

Beach, et. al. "Relationship-Centered Care: A Constructive Reframing." *JGIM* 21 (2006): S3-8. Print.

Geisler, Sheryl. "Values Clarification Exercise." University of Medicine and Denistry of NJ (UMDNJ) Physician Assistant Program, n.d. Print.

Hafferty, Frederic and Ronald Franks. "The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Eduation." *Academic Medicine* 69.11 (1994): 861-71. Print.

Teal, C. R., et al. "Helping Medical Learners Recognise and Manage Unconscious Bias Toward Certain Patient Groups." *Med Educ* 46.1 (2012): 80-8. Print.

Weil, Andrew. "Weil". 2013. Jan 31 2013. <www.drweil.com/drw/u/.../three-breathing-exercises.html>.

Appendix 1

Values Clarification Exercise

(Circle the choice that represents your immediate reaction to the statement)

1. The "morning after" pill promotes irresponsible sexual behavior and should not be prescribed if requested.
   AGREE DISAGREE

2. I would be incapable of providing healthcare to a child molester who is wounded during apprehension after committing a perverted act on a child.
   AGREE DISAGREE

3. All education and government services in the United States should be provided in English. If immigrants want to live in the U.S. they should learn to speak English.
   AGREE DISAGREE

4. Homosexuality is a choice. Therefore homosexuals should not expect open acceptance from society.
   AGREE DISAGREE

5. People suffering from depression should just buck-up and pull themselves out of it. They could do this if they tried hard enough and stopped relying on drugs and therapists.
   AGREE DISAGREE

(adapted from the UMDNJ PA Program Values Clarification Questionnaire 3/6/13) (Geisler)

Appendix 2

Homework Reading

Instructions for students: Write a reflection on the reading and contemplate your thoughts, feelings and reactions to what you read. There is no set length required. These reflections will be collected by the instructor who will return your work with feedback. The following are some suggestions to help you construct your thoughts. They should serve as the starting point; once you gain comfort with this process you may develop your own line of questions that better fit your needs. Do not attempt to answer each question but them as a guideline as you begin to record your reflections.

- Why do you think the author wrote this?
- What message did he/she want to send to the reader?
- Which particular passage (or two) particularly demonstrates this message?
- What would you change about this situation if you had the power?
- How does the piece make you feel? What does it bring up for you?
- Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
- What things in your own experience parallel the author's experience?
- What conclusions can you draw after reading this piece?

  Make two copies of this reflection, one to hand in to the instructor, one to keep for class discussion.

INVASIONS

by Perry Klass

Morning rounds in the hospital. We charge along, the resident leading the way, the interns following, the two medical students last, pushing the cart that holds the patients' charts. The resident pulls up in front of a patient's door, the interns stop as well, and we almost run them over with the chart cart. It's time to present the patient, a man who came into the hospital late last night. I did the workup-interviewed him, got his medical history, examined him, wrote a six-page note in his chart, and (at least in theory) spent a little while in the hospital library, reading up on his problems.

"You have sixty seconds, go!" says the resident, looking at his watch. I am of course thinking rebelliously that the interns take as long as they like with their presentations, that the resident himself is long winded and full of pointless anecdotes - but at the same time I am swinging into my presentation, talking as fast as I can to remind my listeners that no time is being wasted, using the standard hospital turns of phrase. "Mr. Z. is a seventy-eight-year-old white male who presents with dysuria and intermittent hematuria of one week's duration." In other words, for the past week Mr. Z. has experienced pain with urination, and has occasionally passed blood. I rocket on, thinking only about getting through the presentation without being told off for taking too long, without being reprimanded for including nonessential items or for leaving out crucial bits of data. Of course, fair is fair, my judgment about what is critical and what is not is very faulty. Should I include in this very short presentation (known as a "bullet") that Mr. Z. had gonorrhea five years ago? Well, yes, I decide, and include it in my sentence, beginning, "Pertinent past medical history includes…" I don't even have a second to remember how Mr. Z. told me about his gonorrhea, how he made me repeat the question three times last night, my supposedly casual question dropped in between "Have you ever been exposed to tuberculosis?" and "Have you traveled out of the country recently?"

"Five years ago?" The resident interrupts me. "When he was seventy-three? Well, good for him!"

Feeling almost guilty, I think of last night, of how Mr. Z. s voice dropped to a whisper when he told me about the gonorrhea, how he then went on, as if he felt he had no choice, to explain that he had gone to a convention and "been with a hooker – excuse me, miss, no offense'' and how he had then infected his wife, and so on. I am fairly used to this by now, the impulse people sometimes have to confide everything to the person examining them as they enter the hospital. I don't know whether they are frightened by suggestions of disease and mortality, or just accepting me as a medical professional and using me as a comfortable repository for secrets. I have had people tell me about their childhoods and the deaths of their relatives, about their jobs, about things I have needed to ask about and things that have no conceivable bearing on anything that concerns me.

In we charge to examine Mr. Z. The resident introduces himself and the other members of the team, and then he and the interns listen to Mr. Z.'s chest, feel his stomach. As they pull up Mr. Z.'s gown to examine his genitals; the resident says heartily. Well now, I understand you had a little trouble with VD not so long ago. And immediately I feel like a traitor; I am sure that Mr. Z. is looking at me reproachfully. I have betrayed the secret he was so hesitant to trust me with.

I am aware that my scruples are ridiculous. It is possibly relevant that Mr. Z. had gonorrhea; it is certainly relevant to know how he was treated, whether he might have been reinfected. And in fact, when I make myself meet his eyes, he does not look nearly as distressed at being examined by three people and asked this question in a loud booming voice as he seemed last night with my would-be-tactful inquires.

In fact, Mr. Z. is getting used to being in the hospital. And in the hospital, as a patient, you have no privacy. The privacy of your body is of necessity violated constantly by doctors and nurses (and the occasional medical student), and details about your physical condition are discussed by the people taking care of you. And your body is made to give up its secrets with a variety of sophisticated techniques, from blood

tests to X-rays to biopsies - the whole point is to deny your body the privacy that pathological processes need in order to do their damage. Everything must be brought to light, exposed, analyzed, and noted m the chart. And all this is essential for medical care, and even the most modest patients are usually able to come to terms with it, exempting medical personnel from all the most basic rules of privacy and distance.

So much for the details of the patient's physical condition. But the same thing can happen to details of the patient's life. For the remainder of Mr. Z.'s hospital stay, my resident was fond of saying to other doctors, "Got a guy on our service, seventy-eight, got gonorrhea when he was seventy-three, from a showgirl. Pretty good, huh?" He wouldn't ever have said such a thing to Mr. Z.'s relatives, of course, or to any nondoctor. But when it came to his fellow doctors, he saw nothing wrong with it.

I remember another night, 4:00 A.M. in the hospital and I had finally gone to sleep after working-up a young woman with a bad case of stomach cramps and diarrhea. Gratefully, I climbed into the top bunk in the on-call room, leaving the bottom bunk for the intern, who might never get to bed, and who, if she did, would have to be ready to leap up at a moment s notice if there was an emergency. Me, I hoped that, emergency or not, I would be overlooked in the top bunk and allowed to sleep out the next two hours and fifty-five minutes in peace (I reserved five minutes to pull myself together before rounds). I lay down and closed my eyes, and something occurred to me. With typical medical student compulsiveness, I had done what is called a "mega-workup" on this patient? I had asked her every possible question about her history and conscientiously written down all her answers. And suddenly I realized that I had written in her chart careful details of all her drug use, cocaine, amphetamines, hallucinogens, all the things she had said she had once used but didn't anymore. She was about my age and had talked to me easily, cheerfully, once her pain was relatively under control, telling me she used to be really into this and that but now she didn't even drink. And I had written all the details in her chart. I couldn't go to sleep, thinking about those sentences. There was no reason for them. There was no

reason everyone had to know all this. There was no reason it had to be written in her official chart, available for legal subpoena. It was four in the morning and I was weary and by no means clear-headed; I began to fantasize one scenario after another in which my careless remarks in this woman's record cost her a job, got her thrown into Jail, discredited her forever. And as I dragged myself out of the top bunk and out to the nurses' station to find her chart and cross out the offending sentences with such heavy black lines that they could never be read, I was conscious of an agreeable sense of self-sacrifice - here I was, smudging my immaculate mega-write up to protect my patient. On rounds, I would say, "Some past drug use," if it seemed relevant.

Medical records are tricky items legally. Medical students are always being reminded to be discreet about what they write—the patient can demand to see the record, the records can be subpoenaed in a trial. Do not make jokes. If you think a serious mistake has been made, do not write that in the record-that is not for you to judge, and you will be providing ammunition for anyone trying to use the record against the hospital. And gradually, in fact, you learn a set of evasions and euphemisms with which doctors comment in charts on differences of opinion, misdiagnoses, and even errors. "Unfortunate complication of usually benign procedure." That kind of thing. The chart is a potential source of damage; damage to the patient, as I was afraid of doing, or damage to the hospital and the doctor.

Medical students and doctors have a reputation for crude humor; some is merely off-color, which comes naturally to people who deal all day with sick bodies. Other jokes can be more disturbing; I remember a patient whose cancer had destroyed her vocal cords so she could no longer talk. In taking her history from her daughter we happened to find out that she had once been a professional musician, singing and playing the piano in supper clubs. For the rest of her stay in the hospital, the resident always introduced her case, when discussing it with other doctors, by saying, "Do you know Mrs. Q.? She used to sing and play the piano-now she just plays the piano." As you learn to become a doctor, there is a frequent sense of surprise, a feeling that

you are not entitled to the kind of intrusion you are allowed into patients' lives. Without arguing, they permit you to examine them; it is impossible to imagine, when you do your very first physical exam, that someday you will walk in calmly and tell a man your grandfather's age to undress, and then examine him without thinking about it twice. You get used to it all, but every so often you find yourself marveling at the access you are allowed, at the way you are learning from the bodies, the stories, the lives and deaths of perfect strangers. They give up their privacy in exchange for some hope—sometimes strong, sometimes faint—of the alleviation of pain, the curing of disease. And gradually, with medical training, that feeling of amazement, that feeling that you are not entitled, scars over. You begin to identify more thoroughly with the medical profession-of course you are entitled to see everything and know everything; you're a doctor, aren't you? And as you accept this as your right, you move further from your patients, even as you penetrate more meticulously and more confidently into their lives.

Unit 3

More Techniques and Recording the Medical History
The HPI and ROS

This unit is designed to provide a brief review of techniques introduced in Unit 1 and to introduce how to record the medical interview. It will also present some new techniques used in conducting a medical interview. In this Unit the students will receive a handout that includes the outline of the entire medical history. This handout will be utilized in several units as the students learn each section. In this unit the HPI and ROS will be taught. The students will have an opportunity to practice writing an HPI via an instructor role play. A review of the unit objectives which are presented in slide one will provide the instructor with a guide to the unit.

At the end of unit there are three appendices which include the student handout, the instructor role-play and the homework assignment. Please refer to Appendix 4 in Unit 1 for guidelines to providing feedback to students on reflective writing.

The following is an outline of the material that can be converted to PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Practice mindfulness breathing exercise
2. Demonstrate how to avoid bias in gathering data for the medical history
3. Assess the medical situation in order offer appropriate reassurance
4. Assess the patient's language skills to assure comprehension
5. Efficiently gather the medical history in order to record the History of Present Illness (HPI)
6. Appropriately ask the questions in the Review of systems (ROS)
7. Utilize the "analysis of a symptom" in order to best describe the patients symptomology

SLIDE 2: Key Concepts/Sections

- Mindfulness Breathing
- Interviewing Techniques:
- Avoiding Bias
- Appropriate Reassurance
- Appropriate Vocabulary
- Attentiveness
- Gathering the Medical History

Section 1 Mindfulness Breathing

SLIDE 3: Focusing and Centering

- Let's start with the breathing exercise we did last week
- It is helpful to get used to purposeful breathing/relaxation/centering before beginning a task or starting an encounter with a patient

SLIDE 4: Mindfulness Exercise: Breath Counting (5 mins) (Weil)

- Sit in a comfortable position with the spine straight and head inclined slightly forward. Gently close your eyes and take a few deep breaths. Then let the breath come naturally without trying to influence it. Ideally it will be quiet and slow, but depth and rhythm may vary.
- To begin the exercise, count "one" to yourself as you exhale.
- The next time you exhale, count "two," and so on up to "five."
- Then begin a new cycle, counting "one" on the next exhalation.
- Never count higher than "five," and count only when you exhale. You will know your attention has wandered when you find yourself up to "eight," "12," even "19."

Section 2 – Interviewing Techniques

SLIDE 5: Review of Medical Interviewing Techniques

- Facilitation
- Silence
- Confrontation

SLIDE 6: Avoiding Bias

- Our goal is to get accurate and non-biased information
- Use open-ended questions to avoid suggestion: "When does the pain begin?"
- If absolutely needed, give the patients choices: "Does the pain begin right after meals or do you notice it at other times?"

SLIDE 7: Appropriate Reassurance

- We want to create an atmosphere of support and reassurance
- Support can be conveyed in many ways including responding empathetically
- Reassurance must be used appropriately and truthfully or it will lead to distrust
- Support and reassurance must be conveyed in a genuine manner

SLIDE 8: Appropriate Vocabulary

- Language should be simple, concise and non-technical
- Take into account the patient's educational level, language skills, social and cultural background
- Use interpreters when needed (if your patients have limited ability in the language(s) you speak fluently)

SLIDE 9: Attentiveness

- LISTEN CAREFULLY
- Be aware of your posture, tone, facial expression and gestures - they all send messages
- PAY ATTENTION
- MINDFULNESS – be there in the moment - don't worry about what you have to do or say next - that will come.

SLIDE 10: Review of the Approach to the Clinical Encounter (Frankel)

Invest In the Beginning - Introduce yourself, establish rapport and the patient's expectations

Elicit the Patient's Concerns - give the patient time to tell his/her story and find out what the symptoms mean to the patient

Demonstrate Empathy - let the patient feel "known and understood"

Invest in the End - provide diagnostic information, education in a way that the patient understands and include the patient in the development of the treatment plan

SLIDE 11: Shifting the Interview

Once you have let the patient tell their story you need to shift to more direct questioning that will help you to gather specific information about the patient's medical problem.

Section 3 –Gathering the Medical History

***Note to the instructor**: Hand out "Complete Outline for Recording the Medical History" document, including "Analysis of a Symptom" (Appendix 1)

SLIDE 12: The Complete Medical History (UMDNJ "Complete Outline for Recording the Medical History")

I. Chief Complaint (CC)
II. History of Present Illness (HPI)
III. Medications
IV. Allergies
V. Past History (PH)
VI. Family History (FH)
VII. Social History (SH)
VIII. Review of Systems (ROS)

Today we will discuss the CC, HPI, Medications, Allergies and ROS

SLIDE 13: The Medical History

- (always start with the date)

I. The Chief Complaint (Abbreviated: "C.C.")

- Briefly state the chief complaint (one or two symptoms) in the patient's own words, if possible and appropriate, and indicate the duration.

SLIDE 14: II. The History of Present Illness (HPI)

Organize the present illness in a logical sequence.

1. Identify patient as male/female, age, race, and any chronic illness or major medical history with duration or dates
    i. Example: This is a 55-year old white female with a history of angina pectoris x 10 years and coronary artery bypass surgery 2 years ago, who is now complaining of...
2. Record onset of the symptoms and the timing from when the patient last felt well
    ii. Record time by using days prior to admission rather than the actual date

iii. Example:. ... who felt well until 3 days prior to admission when she started to experience....

SLIDE 15:

3. Develop the present illness in a chronological order of each symptom, group of symptoms, or event
   iv. Use specific time lines if possible (number of days, weeks, months, or years) or the age of the patient when the symptoms began
   v. Describe each chronologic period of the present illness
   vi. **Uniformity in listing the temporal relationships is a necessity**
4. Describe each symptom completely with respect to onset, characteristics, and course (see *analysis of a symptom* attached)
   vii. Include all positive and negative information regarding the pertinent review of systems.

SLIDE 16

5. Note any and all therapy used in the present illness, including medication, herbal, self- or home-remedies, or anything else used to relieve the symptoms.
   viii. Note amount, route, duration of therapy and results (especially toxic effects)
   ix. List any practitioner or institution visited for present illness

6. Also include ***when pertinent to the present illness:***
   x. Hospitalizations, including a brief description of the illness, course, treatment and final diagnosis
   xi. Related past medical history including course and treatment
   xii. Family history, e.g. for hypertensive patient, record family history of hypertension, heart disease, renal disease, etc
   xiii. Related social history, e.g. for hypertensive patient, record history of smoking, diet, stress

SLIDE 17

7. Indicate the effect of the illness upon the general well-being of the patient or a change in personal habits, ie., eating, sleeping, social activities, work

   xiv. Record any psychological reaction to his/her illness , i.e. understanding of his/her illness and attitude toward his/her illness - anxiety, depression, fear, irritability

SLIDE 18: III. MEDICATIONS:

List of all current medications including prescription, over-the-counter, home remedies, vitamins, minerals, herbals, and supplements

- Include dosage, route, frequency
- Can be sentence or table form

SLIDE 19: IV. ALLERGIES/INTOLERANCES:

Include any drug allergies or intolerance. Describe the patient's reaction

SLIDE 20: Analysis of a Symptom

1. Total Duration/Onset
   a. Onset (number of days, months, years, ***not*** actual date or day). Onset determines duration
   b. Manner of onset (gradual or sudden)
   c. Precipitating and predisposing factors related to onset (emotional disturbance, physical exertion, fatigue, bodily function, pregnancy, environment, injury, infection, toxins and allergies, therapeutic agents)

SLIDE 21:

2. Characteristics at onset (or any other time)
   a. Character (quality)

b. Location and radiation (for pain)
c. Intensity or severity
d. Temporal character (continuous, intermittent, rhythmic); include the frequency and/or duration
e. Aggravating and relieving factors
f. Associated symptoms

SLIDE 22

3. Course since onset
    a. Incidence
        - Single acute attack
        - Recurrent acute attack
        - Daily occurrence
        - Periodic occurrences
        - Continuous chronic episode
    b. Progress (better, worse, unchanged)
    c. Therapies used and effect
    d. Seen health care provider in past for similar symptoms

***Note to the instructor:** Suggested approach to this section: After explaining the ROS and its use. Go around the classroom asking each student to take a system or part of a system and pronounce the symptom and then "translate" the medical term to the word or words they would use to ask about this symptom when talking with a patient. For example, epistaxis could be "translated" to nose bleeds.

SLIDE 23: VIII. REVIEW OF SYSTEMS

- Arrange the review of systems in the order indicated on handout
- Underline each region or physiologic system for clarity and emphasis

- Within each system, ***group all positive symptoms together at the beginning, followed by the negative symptoms***
- The symptoms and events associated with the present illness are recorded in the HPI and should not be repeated in the review of systems (simply write "see HPI")
- *In general,* the review of systems concerns itself with symptoms which have been present in the *last **6 months***
- Generally, each positive should include the duration, whether medical treatment was sought, any medications or home remedies taken, and their results

SLIDE 24

- ***General:*** Present height and weight (loss or gain, period of time, contributing factors), weakness, fatigue, malaise, fever, chills, or night sweats
- ***Skin:*** Pruritus, rashes, color changes, tendency to bruising, lesions (include location), excessive dryness; change in hair, nails or moles; location of all tattoos and body piercings (other than ears)
- ***Head:*** Dizziness, headaches

SLIDE 25

- ***Eyes:*** Glasses or contact lens use and recent change, last eye examination date and result; any visual loss (diplopia, field cut, blurriness), injury, infection, scotomata, photophobia, excessive lacrimation, injection, glaucoma, or cataracts
- ***Ears***: Any hearing loss/use of a hearing aid, tinnitus, vertigo, discharge
- ***Nose and Sinuses***: Loss of smell, sinus pain, epistaxis, congestion, discharge, postnasal drip, frequent head colds

SLIDE 26

- ***Oral Cavity:*** Last dental examination date and result; toothache or recent extractions; soreness of throat, bleeding (lips, gums, mouth, tongue), disturbance of taste, hoarseness, change in voice
- ***Neck:*** Pain, stiffness, masses
- ***Nodes:*** Tenderness or enlargement of cervical, axillary, epitrochlear, or inguinal nodes

SLIDE 27

- ***Breasts:*** **Everyone**: Pain, masses, discharge
- ***For women:*** Self-examination and frequency, date of last health care provider exam; last mammogram and result (as appropriate)
- ***Respiratory:*** Dyspnea, chest pain, cough, sputum, hemoptysis, wheezing, exposure to tuberculosis; dates and results of most recent chest x-ray and PPD

SLIDE 28

- ***Cardiovascular:*** Chest pain/discomfort, palpitation, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cyanosis, syncope; date of last EKG and result
- ***Gastrointestinal***: Appetite, dysphagia, heartburn, postprandial or other abdominal pain, jaundice, nausea, vomiting, hematemesis; excessive flatulence or bloating, obstipation; character and/or color of stools (bleeding, melena, clay colored), diarrhea, constipation, tenesmus, rectal conditions (pruritus, hemorrhoids, fissures, fistula), or hernia

SLIDE 29

- ***Genitourinary: Urinary:*** Dysuria, frequency, nocturia, hematuria, pyuria, oliguria, problems with micturition (retention, hesitancy, urgency, narrowing

of stream, dribbling), incontinence, renal colic, history of recurrent urinary tract infections or urinary tract calculi

MALE:

- Testicular pain, change in size of scrotum, scrotal masses, self-examination and frequency; penile pain, lesions or discharge; erectile dysfunction; disorders of the prostate; date and result of last PSA screening

SLIDE 30

FEMALE:

- ***Menstrual history;*** last period, menarche, cycle and duration, amount of flow, premenstrual symptoms, dysmenorrhea, intermenstrual bleeding
- ***Obstetrical history***: grav./para. As necessary, specify elective or spontaneous abortions
- ***Gynecologic history:*** vaginal discharge, dyspareunia, coital bleeding, endometriosis, uterine fibroids, ovarian cysts. Date of last pap smear and result, any history of abnormal pap; menopause and associated symptoms; post-menopausal bleeding

SLIDE 31

- ***Extremities:*** Vascular: Intermittent claudication, ulceration, coldness of extremities, hair loss, thrombophlebitis, edema, varicose veins
- ***Joints:*** Pain, swelling, limitation of motion, morning stiffness (note location and migratory nature)
- ***Muscles:*** Pain, cramps
- ***Back:*** Pain (location and radiation, especially to the extremities), stiffness, limitation of motion, injury

SLIDE 32

- ***Central Nervous System:***

- **General:** History of any loss of consciousness, convulsions
- **Mentative:** Speech disorders, memory disorders
- **Motor:** Tremor, weakness, paralysis, clumsiness of movement
- **Sensory:** Anesthesia, paresthesia, pain

SLIDE 33

- ***Hematopoietic***: Bleeding tendencies, anemia, transfusion(s) and reaction, exposure to toxic chemicals or radiation; blood type
- ***Endocrine***: Intolerance to heat or cold, change in skin, inappropriate relationship between appetite and weight, nervousness, tremors, polyuria, polydipsia, polyphagia, hirsutism, past or present use of hormone therapy

SLIDE 34

- ***Psychological:*** Mood changes, nervousness, anxiety, excessive crying, euphoria, depression, change in sleep pattern or concentrating ability, anhedonia, or hallucinations

***Note to instructor:** Instructor Role Play (see Appendix 2).

- Two instructors sit in the front of the classroom and act out the very brief patient/practitioner role play.
- The students are asked to take notes so that they can construct an HPI from the information gathered. The case is written for a male patient but can easily be changes to a female patient. At the end of the formal role play, the students are invited to ask questions of the patient or clarify information.
- The students are then given 15-20 minutes to construct the HPI. Once completed the instructor hands out the HPI expected (provided in the

appendix) and reviews it with the students. This affords the students an opportunity to see how they did in comparison to what the instructor expected.

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Appendix 1

COMPLETE OUTLINE FOR RECORDING THE MEDICAL HISTORY

All documents should include the date and time the patient was interviewed.

I. CHIEF COMPLAINT (Abbreviated: "C.C.")

- Briefly state the chief complaint concisely in the patient's own words, if possible and appropriate, and indicate the duration.

II. PRESENT ILLNESS

- Organize the present illness in a logical sequence.
  1. Identify patient as male/female, age, race, and any chronic illness or major medical history with durations or dates
     - Example: This is a 55-year old white female with a history of angina pectoris x 10 years and coronary artery bypass surgery 2 years ago, who is now complaining of...
  2. Record onset of the symptoms and the timing from when the patient last felt well
     - Record time by using days prior to admission rather than the actual date
     - Example: ... who felt well until 3 days prior to admission when she started to experience....
  3. Develop the present illness in a chronological order of each symptom, group of symptoms, or event
     - Use specific time lines if possible (number of days, weeks, months, or years) or the age of the patient when the symptoms began
     - Describe each chronologic period of the present illness
     - **Uniformity in listing the temporal relationships is a necessity**

4. Describe each symptom completely with respect to onset, characteristics, and course (see *analysis of a symptom* attached)
    - Include all positive and negative information regarding the pertinent review of systems
5. Note any and all therapy used in the present illness, including medication, herbal, self- or home-remedies, or anything else used to relieve the symptoms.
    - Note amount, route, duration of therapy and results (especially toxic effects)
    - List any practitioner or institution visited for present illness
6. Also include ***when pertinent to the present illness:***
    - Hospitalizations, including a brief description of the illness, course, treatment and final diagnosis
    - Related past medical history including course and treatment
    - Family history, e.g. for hypertensive patient, record family history of hypertension, heart disease, renal disease, etc
    - Related social history, e.g. for hypertensive patient, record history of smoking, diet, stress, ETOH use
7. Indicate the effect of the illness upon the general well being of the patient or a change in personal habits, ie., eating, sleeping, social activities, work
    - Record any psychological reaction to his/her illness , i.e. understanding of his/her illness and attitude toward his/her illness - anxiety, depression, fear, irritability

III. MEDICATIONS

List of all current medications including prescription, over-the-counter, home remedies, vitamins, minerals, herbals, and supplements

- Include dosage, route, frequency
- Can be sentence or table form

IV. ALLERGIES/INTOLERANCES:

Include drug, food, seasonal, environmental, and animal allergies or intolerance; describe the patient's reaction

V. PAST HISTORY

A. Medical:

- Child: General health as a child. List any major childhood illnesses or conditions (as appropriate ask about measles, mumps, rubella, chicken pox, rheumatic fever, or asthma)
- **Adult:** Any medical condition not developed in HPI should be discussed in detail here. Any conditions fully developed in the HPI should not be repeated here; instead refer reader back to HPI
- **In reverse chronological order** list all past illnesses including course of disease and current status (include time of occurrence and diagnostic label, therapies used, current impact on function, etc)
- Specifically inquire about common conditions: cardiovascular disease, hypertension, heart murmurs, stroke/TIA, respiratory diseases (as appropriate COPD, TB, asthma), kidney disease, endocrine disorders including diabetes and thyroid disorders, autoimmune diseases, cancer, liver disease/hepatitis, HIV, and mental health conditions
- General: Name of regular health care provider or note that patient does not have a regular health care provider;
- estimate frequency of visits for acute or routine care and the date and reason for the most recent visit

B. Surgery: Date of each operation (reverse chronological order), type of operation (and as appropriate reason for surgical procedure), name of hospital and course of treatment (including transfusions), complications or sequelae from surgery or course of treatment, type of anesthesia (general, local, etc.) and any complications associated with the anesthesia

C. **Hospitalization:** Date of each hospitalization (reverse chronological order), diagnosis, name of hospital and course of treatment (including as appropriate studies carried out, treatment and results of treatment) and complications or sequelae

D. **Injuries:** Include head trauma, fractures, major lacerations, major burns, blunt trauma, etc; include date of occurrence, cause, complications and outcome

E. **Immunizations:** Include for everyone: tetanus, measles, rubella, mumps, poliomyelitis, hepatitis B. As appropriate ask about: influenza, pneumococcal pneumonia, hepatitis A, meningococcal, varicella, zoster, Gardisil

VI. FAMILY HISTORY

Indicate if living or deceased. If living (↑) record age and state of health, if deceased (↓) record age and cause of death

- PGM
- PGF
- MGM
- MGF
- Mother
- Father
- Siblings
- Children
- Spouse

Specifically inquire about family history of (other than listed above): cardiovascular disease, hypertension, stroke/TIA, respiratory diseases (ex. TB exposure and asthma), kidney disease, endocrine disorders including diabetes and thyroid disorders, autoimmune diseases, cancer, HIV, mental health conditions, migraines, bleeding disorders/anemia, allergies, or any other disease suggested by the patient's history

When identifying family illnesses, state who in the family has illness if not included above, e.g. maternal aunt with a history of breast cancer

VII. SOCIAL HISTORY

A. Date and place of birth

Residence and duration

Recent travel

B. **Habits:**

- Sleep - quality of sleep, duration
- Alcohol intake (CAGE when appropriate)
- Tobacco
- Illicit drugs: type and route of administration
- (specifically ask about current ***and*** past use)
- Diet: General quality and frequency
- Caffeine intake: Coffee/Tea/Cola-amount and frequency
- Exercise: Type and frequency
- Safety screening (as appropriate):

  Seat belt use

  Amount of sun exposure and sunscreen use

  Smoke detectors in home

  Helmet use

  Firearm safety

C. Education: Level of education

D. Occupational history:

- Past and present work and exposure to known physical hazards in each position
- Work environment including number of hours at work and attitude (satisfaction, security) toward work and employer
- If retired include former work history
- If unemployed, source of income?

E. Relationship Status: Current status, quality of relationships, hx of any abuse (SAFE questions when appropriate)

F. Sexual History: (Tailor to the individual patient) Age at first experience, gender of partner(s), total # of lifetime partners, currently sexually active, activity (oral, vaginal and/or anal), frequency, libido (drive and satisfaction); contraception (past and present); history of STIs including HIV risk assessment, prevention of STI transmission (condoms, etc); last HIV test date and result

G. Living Environment: Community, living conditions (examples: flight of stairs, number in household, household responsibilities, pets, exposure to violence, etc.)

H. Support System: Examples may include: friends, community involvement, quality of relationships, religious affiliation (FICA as appropriate), etc.

I. Military Hx.: Branch of service, dates, where stationed, assignment and duties, +/- combat, discharge status

VIII. REVIEW OF SYSTEMS

- Arrange the review of systems in the order indicated below
- Underline each region or physiologic system for clarity and emphasis
- Within each system, **group all positive symptoms together at the beginning, followed by the negative symptoms**
- The symptoms and events associated with the present illness are recorded in the HPI and should not be repeated in the review of systems (simply write “see HPI”)
- *In general*, the review of systems concerns itself with symptoms which have been present in the last **6 months**
- **Generally, each positive should include the duration, whether medical treatment was sought, any medications or home remedies taken, and their results**

GENERAL: Present height and weight (loss or gain, period of time, contributing factors), weakness, fatigue, malaise, fever, chills, or night sweats

SKIN:_ Pruritus, rashes, color changes, tendency to bruising, lesions (include location), excessive dryness; change in hair, nails or moles; location of all tattoos and body piercings (other than ears)

HEAD: Dizziness, headaches

EYES: Glasses or contact lens use and recent change, last eye examination date and result; any visual loss (diplopia, field cut, blurriness), injury, infection, scotomata, photophobia, excessive lacrimation, injection, glaucoma, or cataracts

EARS: Any hearing loss/use of a hearing aid, tinnitus, vertigo, discharge

NOSE AND SINUSES: Loss of smell, sinus pain, epistaxis, congestion, discharge, postnasal drip, frequent head colds

ORAL CAVITY: Last dental examination date and result; toothache or recent extractions; soreness of throat, bleeding (lips, gums, mouth, tongue), disturbance of taste, hoarseness, change in voice

NECK: Pain, stiffness, masses

NODES: Tenderness or enlargement of cervical, axillary, epitrochlear, or inguinal nodes

BREASTS:

Everyone: Pain, masses, discharge

For women: Self-examination and frequency, date of last health care provider exam; last mammogram and result (as appropriate)

RESPIRATORY: Dyspnea, chest pain, cough, sputum, hemoptysis, wheezing, exposure to tuberculosis; dates and results of most recent chest x-ray and PPD

CARDIOVASCULAR: Chest pain/discomfort, palpitation, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cyanosis, syncope; date of last EKG and result

GASTROINTESTINAL: Appetite, dysphagia, heartburn, postprandial or other abdominal pain, jaundice, nausea, vomiting, hematemesis; excessive flatulence or bloating, obstipation; character and/or color of stools (bleeding, melena, clay colored), diarrhea, constipation, tenesmus, rectal conditions (pruritus, hemorrhoids, fissures, fistula), or hernia

GENITOURINARY:

URINARY: Dysuria, frequency, nocturia, hematuria, pyuria, oliguria, problems with micturition (retention,hesitancy, urgency, narrowing of stream, dribbling), incontinence, renal colic, history of recurrent urinary tract infections or urinary tract calculi

MALE: Testicular pain, change in size of scrotum, scrotal masses, self-examination and frequency; penile pain, lesions or discharge; erectile dysfunction; disorders of the prostate; date and result of last PSA screening

FEMALE:

Menstrual history: last period, menarche, cycle and duration, amount of flow, premenstrual symptoms, dysmenorrhea, intermenstrual bleeding; menopause and associated symptoms; post-menopausal bleeding

Obstetrical history: grav./para. As necessary, specify elective or spontaneous abortions

Gynecologic history: vaginal discharge, dyspareunia, coital bleeding, endometriosis, uterine fibroids, ovarian cysts. Date of last pap smear and result, any history of abnormal pap

EXTREMITIES:

Vascular: Intermittent claudication, ulceration, coldness of extremities, hair loss, thrombophlebitis, edema, varicose veins

Joints: Pain, swelling, limitation of motion, morning stiffness (note location and migratory nature)

Muscles: Pain, cramps

BACK: Pain (location and radiation, especially to the extremities), stiffness, limitation of motion, injury

CENTRAL NERVOUS SYSTEM:

General: History of any loss of consciousness, convulsions

Mentative: Speech disorders, memory disorders

Motor: Tremor, weakness, paralysis, clumsiness of movement

Sensory: Anesthesia, paresthesia, pain

HEMATOPOIETIC: Bleeding tendencies, anemia, transfusion(s) and reaction, exposure to toxic chemicals or radiation; blood type

ENDOCRINE: Intolerance to heat or cold, change in skin, inappropriate relationship between appetite and weight, nervousness, tremors, polyuria, polydipsia, polyphagia, hirsutism, past or present use of hormone therapy

PSYCHOLOGICAL: Mood changes, nervousness, anxiety, excessive crying, euphoria, depression, change in sleep pattern or concentrating ability, anhedonia, or hallucinations

ANALYSIS OF A SYMPTOM

1. Total Duration/ Onset
    a. Onset (number of days, months, years, ***not*** actual date or day). Onset determines duration
    b. Manner of onset (gradual or sudden)
    c. Precipitating and predisposing factors related to onset (emotional disturbance, physical exertion, fatigue, bodily function, pregnancy, environment, injury, infection, toxins and allergies, therapeutic agents)
2. Characteristics at onset (or any other time)
    a. Character (quality)
    b. Location and radiation (for pain)
    c. Intensity or severity
    d. Temporal character (continuous, intermittent, rhythmic); include the frequency and/or duration
    e. Aggravating and relieving factors
    f. Associated symptoms

    The following mnemonic may be helpful:

    O Onset

    P palliation/provocation

    Q quality

    R region/radiation

    S severity

    T timing
3. Course since onset
    A. Incidence
        1. Single acute attack
        2. Recurrent acute attacks
        3. Daily occurrences
        4. Periodic occurrences

5. Continuous chronic episode

B. Progress (better, worse, unchanged)

C. Therapies used and effect

D. Seen health care provider in past for similar symptoms

Appendix 2

Date

Time

Name: Don Jones

CC: Chest pain and cough x 12 hours

HPI:

This is a 33 year old white male who presents complaining of constant severe left sided chest pain and productive cough which began abruptly at 10pm last night.

The patient felt well until one week ago when he developed a mild "head cold" with nasal congestion and rhinorrhea. He denies fever during this time and took no medications to relieve these symptoms. Last night he suddenly developed shaking chills and a temperature of 103.5^{o}F oral. Later in the evening he developed a productive cough of thick yellow sputum (2-3 tsps./hour) which was occasionally pink stained and rusty. In addition, he began having sharp chest pain (8/10 on pain scale) which is worse on inspiration and exacerbated by coughing. He denies any radiation of the chest pain and states that nothing relieves the pain. He was unable to sleep due to the above symptoms. The patient has been taking 2 ibuprofen every 4-6 hours since last night which has lowered his temperature to lOl^{o}F oral. He denies dyspnea, wheezing, or exposure to tuberculosis. He had a chest x-ray at age 18 when he entered college; he was told the x-ray was normal. He denies ever having a PPD, any recent travel and states that no one else at home has similar symptoms.

The patient has smoked 1 ppd X 12 years. In addition, he has a five year history of a cough productive of small amounts of whitish sputum. The cough is worse in the morning and in the winter. He denies any past history of previously diagnosed respiratory disease and states that he has not seen a health care provider in eight years.

He is leaving on a vacation to San Diego tomorrow and hopes that this illness will not affect his plans.

Medications: Ibuprofen (see HPI), denies taking any on regular basis

Allergies: No known drug, food, seasonal, environmental, or animal allergies/intolerances

Past Medical History: To be continued....

***Note to instructor:** Based on this HPI for Don Jones, the instructor acting as the patient should be completely familiar with the case and able to provide the history that has been recorded. The instructor playing the clinician should treat the role play as a clinical encounter, introducing him/herself and asking open-ended "why are you here today" type questions to start the encounter. The instructor should be modeling good techniques at all times, remaining attentive, and slowly moving from open-ended to specific questioning for the ROS and other pertinent parts of the medical history.

Appendix 3

Homework Reading

Instructions for students: Write a reflection on the reading and contemplate your thoughts, feelings and reactions to what you read. There is no set length required. These reflections will be collected by the instructor who will return your work with feedback. The following are some suggestions to help you construct your thoughts. They should serve as the starting point; once you gain comfort with this process you may develop your own line of questions that better fit your needs. Do not attempt to answer each question but them as a guideline as you begin to record your reflections.

- Why do you think the author wrote this?
- What message did he/she want to send to the reader?
- Which particular passage (or two) particularly demonstrates this message?
- What would you change about this situation if you had the power?
- How does the piece make you feel? What does it bring up for you?
- Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
- What things in your own experience parallel the author's experience?
- What conclusions can you draw after reading this piece?

Make two copies of this reflection, one to hand in to the instructor, one to keep for class discussion.

When You Come Into My Room

[A Piece of My Mind]

Schmidt, Stephen A. EdD

When you come into my hospital room, you need to know the facts of my life

that there is information not contained in my hospital chart

that I am 40 years married, with 4 children and 4 grandchildren

that I am "genetically Lutheran" . . . with gut disease, like Luther himself

that I am a professor

that I teach teachers, priests, sisters how to nurture faith in the next generation

that I love earthy sensuous life, beauty, travel, eating, drinking J&B scotch, the theater, opera, the Chicago Symphony, movies, all kinds, water skiing, tennis, running, walking, camping

that I love loving, the wonder and awe of sexual intimacy

that I enjoy gardening, smell of soil in misty rain and scorching sun

that I have led a chronic illness group for 12 years

When you come into my room, you need to know the losses of my life

that I have Crohn's disease and 3 small-bowel resections

that I have been hospitalized more than a dozen times for partial bowel obstruction

that I am chronically ill, and am seeking healing, not cure

that my disease has narrowed my life, constricted it

that I once fantasized but no longer dream about being president of Concordia or Mundelein College

that I can no longer eat fresh salads or drink a glass of wine

that I love teaching but sometimes have no energy left at the end of the day

that my Crohn's disease is active in the fall and spring, cyclically in tune with my work

that when I was to give my presidential address to the Association of Professors

and Researchers in Religious Education, I was in the hospital for surgery

that when a colleague read my speech, I felt professionally diminished

that I can travel only where there is modern technology . . . I need fiberoptic intubation

When you come into my room, you need to know my body

that I am afraid of medical procedures done at night . . . I awake fearfully to 10 feet of air in an IV tube . . . I kink the tube and call . . . nurses come quickly. . . but I will not forget . . . and my body remains sleepless in any hospital

that I know the loss of 25 pounds, not recorded in my chart . . . I had to beg for a subclavian catheter for additional nutrition before I received one

that I am afraid of fifth-year residents . . . they tell me if my intestine does not open in 4 more days, I will have to have another surgery . . . information not helpful or useful

that I am on Pentasa, prednisone, Bentyl, Questran, vitamin B_{12}, Relafen . . . more than 20 pills each day . . . if I remember

that I hate rounds held outside my room, rounds that do not include nurses, my wife, my children, my pastor, or even me . . . rounds done over me, around me, but not with me

that this body seems battered, old, vulnerable, tired . . . but still me

that I live by medication

that I live by technology

that I live by waiting, in the eternal "advent season" of doctors' offices

When you come into my room, you need to know my heart

that I am emotional . . . a fully functioning feeling person

that I am afraid of the NG tube, sometimes wrapped in my mouth, clogged

that I fear surgery, each time

that I once felt I could not breathe in recovery

that I fear awakening from surgery with an ostomy

that with each partial obstruction I am anxious about another surgery

that I have lost confidence in my body

that I experience sadness and depression more often now than before the disease

that many persons chronically ill consider suicide, I am one of them

that the advent of symptoms is scary and debilitating

that I am angry at life's unfairness: my brother, older, eats too much drinks too much plays too much and is healthy, always healthy

so too my wife and it seems also my colleagues . . . like I once was but am no longer, ever

that I worry about the future . . . insurance

that I am anxious about aging and how I will cope

that I long for one perfect day, only one symptom-free 24 hours

that I lust for remission

that being sick is narcissistic, boring, dull, painful

that there are times I want to give up

When you come into my room, you need to know my mind and my spirit

that I seek meaning in suffering

that suffering is the nudge to the religious question

that I have faith and lose it

that I cling to my faith in spite of all evidence opposite

that I am trapped by the struggle for meaning yet engaged by it

that I am slowly coming to believe that meaning is what we bring to suffering, not what we gain from it

that God, faith, meaning, ultimate concern, love, salvation are the being of my being

that I struggle with God

that Job was more just than God

that in my religious quest words are important, music is a mirror to my soul, and Eucharist, the stuff of mystery

that I believe deeply that I need to engage suffering

that disease forces the God question and nurtures the Godless response

that illness focuses the issue of death

When you come into my room, you need to sustain my hope

You need to know that I believe love wins over hate, hope over despair, life over death

that I hope against hope

that I pray and believe prayer heals

that some days I am able to make meaning of suffering

that I am more gentle, more compassionate, better with dying, more loving, more sensitive, deeper in grief and in joy

Sit at my "mourning bench" if you are my physician

listen to me, talk truthfully to me

you need to know all this if you want to heal me

And bear my rage about my disease

that I will never be cured

that my daughter has Crohn's disease and is only 33 years old

that she too has had her first surgery and lives with many of my feelings

and I am angry and sad

And support my hope

that tomorrow there may be new medicines

that today you care deeply

that you will do your best

When you come into my hospital room, promise me presence

promise me a healing partnership

keep hope alive

it is all I have.

Stephen A. Schmidt, EdD

Chicago, Ill

Unit 4

Mindfulness

This unit is designed to move beyond the introduction to mindfulness presented in Unit 1. After a brief review of the Unit 1 concepts, the instructor should move on to a fuller discussion of mindfulness by moving through the PowerPoint presentation. This discussion will focus on the skills needed for mindfulness, the benefits and challenges to being mindful and suggestions for ongoing practice. The student will engage in and reflect on a more extensive mindfulness exercise (as compared with the breathing exercises that they have done in class thus far.) They will be asked to reflect on this in a large group setting after the exercise is concluded. The small group exercise for this class is a discussion of the last two homework readings. It is suggested that this discussion be conducted in small groups of 8-10 students per group. Facilitators should be familiar with the reading and the objectives of the assignment. If additional faculty are not available, this can be done in a large group setting. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

At the end of unit there is one appendix that includes the transcript of the in-class meditation exercise. The homework for this unit is a reflection on meditation practice. All instructions for class are in Slide 19. The instructor should refer to unit 1, appendix 4 for instructions on providing feedback to students.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Define mindfulness
2. Discuss the 4 basic skills associated with mindful practice
3. Describe and discuss the 7 attitudinal foundations of mindfulness
4. Practice mindful meditation

5. Discuss what it means to have a true authentic voice

SLIDE 2: Key Concepts/Sections

- The meaning and benefit of Mindfulness
- Attitudinal Foundation of Mindfulness
- Mindfulness and you – challenges to Mindfulness

Section 1 - The meaning and benefits/challenges of Mindfulness

SLIDE 3: Mindfulness

As we discussed in the first lecture:

"Mindfulness means paying attention in a particular way: on purpose, in the present moment and nonjudgmentally" (Kabat-Zinn *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness*).

SLIDE 4

We also discussed: (Baer)

- Observing
- Describing
- Acting with awareness
- Accepting (or allowing) without judgment

SLIDE 5: Benefits of Mindfulness (S. e. a. Shapiro)

- Shown to reduce anxiety and overall psychological distress in medical students
- Shown to increase empathy levels

SLIDE 6: How do we become mindful clinicians?

- Start with daily practice

- Mindfulness exercises such as the one we have done in the last two classes is the beginning of mindfulness practice
- Being present in the moment for yourself so that you can be present with your patients

SLIDE 7: Regular Practice

- Throughout the semester we will practice mindfulness using a variety of exercises
- We will start each class with a mindfulness exercise
- We will repeat some of the exercises several times to help us to become more familiar with them
- Some of you may find it useful to practice these exercises outside of class

SLIDE 8: More about mindfulness (Kabot-Zinn)

- Mindfulness is a way of being so it requires practice
- Moment-to-moment awareness through careful, systematic and disciplined attending
- Cultivate compassion for ourselves and eventually extend that to others

Section 2 - Attitudinal Foundation of Mindfulness

SLIDE 9: Attitudinal Foundation of Mindfulness

Non-judging

Recognize that almost everything we think is a judgment. What would it be like to just notice that and not judge?

Patience

"No place to go, nothing to do"

Beginner's mind

Being open to all there is to learn, humility, appreciation of the excitement of "not knowing"

SLIDE 10: Attitudinal Foundation of Mindfulness

Trust

Can you trust yourself? Your thoughts? Your senses? Your awareness?

Non-Striving

Recognize the here and now and appreciate this moment as opposed to thinking about the next moment when things might be better? (Such as…when I graduate I will be able to…)

SLIDE 11: Attitudinal Foundation of Mindfulness

Acceptance

Accept the current reality and act on it. Make the most of the situation

Letting go

Or letting things be as they are, embracing the current situation for what it is without judgment

SLIDE 12: Recommendations for Practice

Posture: For our purposes, sitting in a chair, sit with your feet uncrossed and flat on the ground. Sit forward in the chair so that you are supporting your back (not leaning against the back of the chair)

Eyes: You can try eyes open or closed. If open, let your gaze fall unfocused on the ground a few feet from you

SLIDE 13: Recommendations for Practice

Sleepiness: Important to stay awake. Can splash cold water on your face before beginning

Finding the time: In class, I will find the time for you but outside of class it would good to make a commitment to practice - shutting off all devises, finding a time of privacy and no interruptions

Guided Practice in-class exercise

***Note to instructor:** At this point the instructor can dim the lights and allow the students to practice a longer meditation exercise. The instructor can play the CD ROM from Kabot- Zinn's book or read the text in Appendix A slowly and in a soothing manner.
Eating a raisin - Each class member takes one raisin
Jon Kabat-Zinn's eating meditation (See Appendix A)
After going through the exercise, ask the students to reflect on the experience (Slide 14)

SLIDE 14: Reflecting on the Experience

- What was easy?
- What was hard?
- What was surprising?

Section 3 - Mindfulness and you – challenges to Mindfulness

SLIDE 15: Mindfulness and You

- Beyond reducing anxiety and helping me to become more empathetic mindfulness can help you focus on why you are here
- Help you to remain connected to your true authentic self.
- Just as we must learn to listen to our patients, we must also learn to listen to ourselves

SLIDE 16: Important Questions to Ask Yourself (Speigel)

1. Do I recognize myself?

Is what I am doing (thinking and saying) consistent with I have always been?

2. Whose voice am I using?

   Listen to yourself in conversation. Are you speaking with your true authentic voice or are you speaking like (or behaving like others you have encountered)? If the latter, is this a good thing? Is it true to who you are?

3. Am I disavowing something important to me?

   Are you paying attention (or ignoring) signals that are telling you that doing or saying something is not being true to yourself?

SLIDE 17: Factors in medical education that make it difficult to be mindful

- Delayed gratification – basic sciences, before clinical sciences, before patient care
- Conflicts of opinion with authority figures –
- Lack of time
- Stress
- Second-guessing yourself
- Burnout

SLIDE 18: What can you do?

- Bond with classmates: Leave the competition behind, study in groups, make time for social activities with classmates
- Reflect regularly on staying true to yourself, your goals, your ideals
- Stay in touch with your emotions through reflection, reading and writing

SLIDE 19: Homework Assignment:

Continue practicing mindfulness by choosing mindfulness meditation exercises from the Kabot-Zinn CD ROM or others if you prefer. Practice at least 3 times per week on your own. Write a weekly reflection on your practice. Try to reflect

on the challenges you are facing in maintaining your practice, benefits of practice, and anything else you'd like to share related to your practice.

***Note to instructor:** Discussion of Prior Homework Readings in Small Groups:

Small Group Discussion: "Invasions" by Perri Klass, and "When You Come Into My Room" by Stephen Schmidt

- Break students up into groups of 8 - 10 students to share responses and discuss the homework reading. Faculty facilitators will meet with students in small groups to guide the discussion of the essay.
- For "Invasions": Students will be asked to share their thoughts and facilitators will try to keep the focus on how this medical student is struggling with finding her true authentic voice.
- For "When you come into my room": Students will be asked to share their thoughts and facilitators will try to keep the focus on the patient's illness narrative can give insight in to the patient's experience of illness and medical care. How the student, as a future clinician, might consider what they learn for the poem in approaching future patients. Can they see how being mindful might impact the relationship with this patient?
- Facilitators can use assigned prompts to stimulate discussion in addition to added prompts below:
    - Why do you think the author wrote this?
    - What message did he/she want to send to the reader?
    - Which particular passage (or two) particularly demonstrates this message?
    - What would you change about this situation if you had the power?
    - How does the piece make you feel? What does it bring up for you?

  - Has reading this text increased your self-awareness, offered clarity and understanding of concepts or ideas, or helped you to connect what you are learning in school to the external world?
  - What things in your own experience parallel the author's experience?
  - What conclusions can you draw after reading this piece?
- After discussion written reflections should be returned to students with instructor feedback.

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Appendix 1

Mindfulness for Beginners

Transcript from CD-Rom:(Kabot-Zinn)

Eating meditation (18 minutes)

Take one raisin; "bring it up towards the face for closer inspection, and just drinking it in through your eyes, as if you have never seen one of these things before, and maybe even forgetting that it's called a raisin. And seeing it in its fullness, you've certainly never seen this particular one before. So noticing its surface features, color, shape, as you turn it in your hands, just sort of seeing whether there are any unique features to it. As I'm doing it I notice a kind of little circular scarring at one end, which of course you'll know is the equivalent of our belly button. Sort of evidence that this shriveled up little something was once connected to a much larger whole. But just drinking it in through the eyes and then maybe closing your eyes when you feel like it and feeling it through your fingers, really getting in touch with this object. Noticing the ridges and the valleys and maybe even putting it in the palm of your hand and feeling the heft of it; it has a certain weight to it, and maybe even bringing it up to the nose at a certain point and again drinking in the fragrance, anything at all in the domain off smell coming off of this object. And again perhaps with the eyes closed if it helps you to be more in touch with your experience from moment to moment, just sensing what's here to be smelled. Allowing the in-breath to bring in the aroma, the fragrance, if there is any, off of this object and when you are ready allowing your eyes to open, and continuing to hold it in your fingers and feeling it and seeing it and be aware of the quality of the attention you are bringing to this hugely familiar object and staying as best you can present with the seeing, with the touching, as best you can from moment to moment. When you're ready, if you want to, you can even bring it up to one of your ears and see if you can hear anything coming from it as you turn it around real close to the ear. We don't often listen to our food, but it's not out of the question that you could use the hearing sense and some foods actually do fizzle or flame or make crackling noises. You may find that this little

object will surprise you if you turn it around in your ears. But then bringing it back to where you can see it. And then gradually bringing it up towards the lips and noticing as you do that, that the arm and the hand really know how to do this, to position it right in the center of your mouth. When you where 6 months old your body didn't quite do it this way and whatever you were eating wound up all your face, all over the floor, all over your body. But just honoring how well the gross motor functioning of the arm and hand can bring this object right up to your lips. And as you do that, before you touch it to the lips or let it come inside, noticing if anything is going on in your mouth. As I do it, I'm finding that there's a strong secreting of saliva in my mouth. And it's clear that there's a certain kind of anticipation that feeding is going to start happening fairly soon. But noticing that this object hasn't come into the mouth yet so it's all around anticipation, the mind is anticipating eating and the body is actually secreting, not only secreting, but actually synthesizing and generating enzymes and fluid to prepare the mouth for this initial step in the process of digestion. It's a real mind-body phenomenon. You'd probably have the same thing happen if you didn't even have the raisin in your hand. And you can certainly feel that for yourself if you were to imagine biting down at this moment on a nice juicy fresh cut wedge of lemon, mind-body phenomenon. So now with great sensitivity slowly bringing the raisin to the lips and noticing how it comes into the mouth. Noticing how this whole thing works, feeling what goes on to bring this object into the mouth. And then noticing how it gets positioned between the teeth. The role of the tongue in receiving it and positioning it, just holding all of this in awareness, moment by moment by moment. Without biting down, yet, just feeling the intelligence in the tongue, in the cheeks, in the teeth and in the mind, that is so well suited for this activity we call eating, and we do so many times a day with very, very little awareness. And then slowly when the raisin is positioned where the mouth wants it to be positioned, slowly start biting down on it, and taking maybe 3, 4 or 5 very deliberate, intentional, mindful chews while you remain open to whatever is going on in the mouth in any of sensory domains, including hearing, including tasting, including feeling the texture, and then slowly continuing to chew and experiencing chewing and tasting, moment by moment, by

moment, just the direct experiencing of chewing and tasting to the degree that it's possible even underneath any thoughts that might be going on about this experience, he direct sensory experience of the teeth coming down on this object and taste in the mouth. And as you continue to do this make sure that you don't swallow it yet. But noticing the changes in texture and in taste that go on with continued chewing and before we do swallow it, seeing if you can be in touch with the first impulse that arises to actually swallow this stuff and be aware of the intension to swallow and how that whole thing gets arranged. How whatever's left gets positioned for swallowing then being in touch with the swallowing, and then the aftermath of the swallowing resting in awareness, of how it feels in this moment, as you sit here. And if you like, even in your mind's eye, or sensing in any way that you can, following what you swallowed down into the belly where it will come to rest in the stomach. And allowing your awareness to expand to include a sense of the body as a whole, sitting here, having just eaten one raisin with this kind of present moment, open-hearted, spacious attention. And just resting here in this being, in this awareness, feeling how things are, right now, in this moment, in the aftermath of all that's come before. Whether your eyes are open, whether your eyes are closed, seeing if you can feel how it is in the body, how it is in the mouth, how it is in the heart, and how it is in the mind. And just resting here, you can say outside of time, in the present moment. Without having to have anything has to happen next. Of course if you want to eat another raisin mindfully on your own at some point, certainly feeling free to do that. But ultimately the challenge here, the practice here, is to simply be with each moment as it is. For the seeing, the smelling, for the moving, for the receiving of the raisin, for the chewing and tasting, the swallowing and the aftermath, and to be the knowing, to be that which knows the experience in its unfolding, as its unfolding, and resting here moment by moment by moment, until you hear the sound of the bells which will mark the end of this first guided introductory mindfulness meditation. [bell struck]

Appendix 2

Illness Narrative

by Kaethe Weingarten

These days I can feel the interior of my brain. The neurons alternate between chaos and silence. Eerie. I have been shot from a cannon far from where I previously stood. That person's life was ordered and bound by a lattice of ritual. Vomit, vomit, vomit. Sleep, sleep, sleep. Shabbat dinner prepared by my dear friend Lois, while I lie on her forest-green couch listening to the amiable conversation of our two families. Sleep, walk, sleep, walk. Blood counts checked. Work. Work. Work.

It was a life. A fabric. I had medicines to taper. Sores to anoint with salves. Clients to see. Children to tend. Food prepared by others to eat.

End of chemo. End of being held in community. I am on my own. September. A new year. Fifth grade for Miranda. Eighth grade for Ben. Back to my life. Able. To take care of them.

Maybe I've been beaten up, raped, robbed, tied up, thrown into a back alley, found by the police, and just brought home. Maybe I was lost in the desert for twelve days and I am still seeing mirages, still thirsty, still crawling on my hands and knees with skin peeling from my knuckles and legs. Or maybe my head is really a pumpkin and the insides are full of seeds. Shake me and you can hear the shlooshing sound I make.

I am lost. Awash. I have no words. The only images are those received ones for chaos and dissolution. I have sounds, but they are primitive, animal sounds and there is no place to make them except with Hilary. We meet twice a week and exercise. We walk along the Charles River. Hilary knows I am a ghost. My purpose and my meaning have been surreptitiously removed. I know I look like a person, but I am not.

I am no longer good. I no longer think thoughts that good people think nor do I act like I did when I was a good person. I have no idea how what I am now can become what others are. I lack coherence.

I try. I train for a mini-triathlon (swim, bike, run), so that I can attribute any aches and pains to my exercise. In the pool, swimming the crawl, I feel supported by the water. It is the one place where my life is not effortful.

After I swim, I stand in the shower as long as I can. The heat is comforting. I feel almost calm. Later, I read that showers deliver carcinogens through the skin because the water is not filtered. I have decided, post-treatment, to be careful, not crazed, about my cancer vigilance. Is a quick shower careful and a long one not? What about the chlorine in the pool? I decide to swim and take short showers.

I learn about supplements: retinoids, beta-carotene, the B, C, and E vitamins. I buy them. I learn about zinc and selenium and I am in over my head. I cannot figure out whether they retard or enhance tumor growth, are antagonists to the cancer cells, each other or me. I give them up.

The magazine cover says "breast cancer." Like the Woody Allen character in the movie "Annie Hall" who hears the word "Jew" everywhere he goes, as in "Did Jew..?", I hear "breast cancer." It's as if newspapers, magazines, and tabloids have suddenly gotten a memo from their publishers: "Do breast cancer." Statistics abound. One in nine. Then, one in eight. Breast cancer research is drastically underfunded. Momentarily, I think I have the energy to get politicised, but the burst of adrenaline is fear and I am reduced to unspeakable terror not galvanised into action.

I do not approve of my thoughts. I think, I want this or I don't want that or I want to do this or I don't want to do that. Outloud, I say, "What do you want?" and "I'm not sure."

I am in a bind. Fighting cancer is a full-time job. I have to buy tofu and cook it without oil. I have to learn to juice. I must swallow vitamins and minerals at prescribed times of day. I have to meditate and do yoga. I have to be in group therapy, have individual therapy and talk to my friends to have "social support." I must express my emotions, particularly my anger, and above all, I must avoid stress. Stress is now my enemy. But it's my life, no?

I have a household to run, clients to see, classes to teach, presentations to write, supervision to offer, children to nurture, and a husband to love. I have a body to monitor and at the first sign of waywardness or lumpiness or acheyness I am to report it. I am not to notice what a doctor may tell me later is not there.

I am beyond exhaustion into loopiness which I conceal from everyone but Hilary. To the outside world, I am now doing all that I did, plus cancer care which, I tell people, is a part-time job. I make nine trips to the hospital in September for various doctor's appointments and scans. I park, wait, see doctors, take tests, have pre-visit anxiety and post-visit de-briefing. I gag when I visit the oncology floor, so it's disgusting too.

It is also lonely.

Unit 5

The Medical History: Past, Family and Social History

This unit is designed to present the past medical history, family history and the social history as it pertains to the medical interview. Students often struggle with the social history because it requires asking about the more sensitive areas of the patient's life. Asking questions about alcohol use, drug use, sexual habits, and personal safety present challenges for students that make the discussions presented in this unit very relevant. The in-class exercise is an instructor role play that gives the students an opportunity to practice gathering these parts of the medical history. It is suggested that this role play be conducted in small groups of 8-10 students per group. Facilitators should be familiar with the case and the objectives of the assignment. If additional faculty are not available, this can be done in a large group setting. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

At the end of unit there are two appendices. The first appendix is a complete history and physical sample for the students to use as a guide. The second appendix is the full history for the instructor role play which is the in-class small group exercise for this class.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives:

Upon completion of this unit the student will be able to:

1. Record the past history, family history and the social history effectively
2. Become comfortable in asking the sexual history
3. Utilize special interviewing techniques such as CAGE, FICA or SAFE questions when appropriate

SLIDE 2: Key Concepts/Sections

- Past medical history
- Family History
- Social History
- CAGE questions
- FICA questions
- SAFE questions

SECTION 1 - Past medical history

SLIDE 3: Past History (UMDNJ "Complete Outline for Recording the Medical History")

- Record of all the patient's past experiences with illnesses and medical treatments
- Often, systematic inquiry into past medical history and other areas of the history will uncover additional information that actually applies to the understanding of the present illness

SLIDE 4: Order of Past History

Medical:

- Childhood
- Adult
- General
- Surgeries
- Hospitalizations
- Injuries
- Allergies
- Immunizations

SLIDE 5: Childhood

- General health as a child
- List any major childhood illnesses or conditions
- As appropriate ask about measles, mumps, rubella, chicken pox, rheumatic fever or asthma

SLIDE 6: EXAMPLE:

⊕ rubella, age 6; no complications or sequelae; general health was good

- Adult
- In reverse chronological order list all chronic illnesses or pertinent past illnesses
- Include diagnosis, date/year of occurrence, course of disease and current status, therapies used, and complications or sequelae

SLIDE 7

Complication

Event occurring *during* a disease which is not an essential part of the disease

- Ex. Post operative infection

Sequelae

A morbid condition following as a *consequence* of a disease

- Ex. Heart valve defect following rheumatic fever

SLIDE 8: Adult

Specifically inquire about common diseases:

- cardiovascular disease
- hypertension
- heart murmurs

- stroke (TIAs)
- respiratory disease (as appropriate COPD, TB, asthma)
- kidney disease
- endocrine disorders including diabetes and thyroid
- autoimmune diseases
- cancer
- liver disease/hepatitis
- HIV
- mental health conditions

SLIDE 9: Adult Examples

- ⊕ hypertension, dx 1995; controlled with nifedipine, diet and exercise, checked every 3 months since dx, no recent change in tx.
- ⊕ depression, dx 1993; controlled since diagnosis, weekly psychotherapy; fluoxitine

SLIDE 10: You do not need to re-explain any conditions that are explained in the HPI

- Instead note the condition as follows:

  ⊕ Type 2 DM (see HPI)

Don't forget to list the negatives

- It is important to document that you asked questions regarding health history. For this reason it is very important to list negative responses as well as positive ones:
- Example: Denies cardiovascular disease, heart murmur, stroke/TIA, respiratory disease, kidney disease, endocrine disorders including diabetes and thyroid, cancer, or liver disease/hepatitis, or HIV

SLIDE 11: General

- Name of regular health care provider or note that the patient does not have a regular provider
- Estimate the frequency of visits for acute or routine care
- date and reason for the most recent visit

SLIDE 12: General examples

- (see adult MedHx)
- Dr. John Amigo -family physician
- Dr. Elana Sol - psychotherapist
- Last visit to Dr. Amigo was 2 weeks ago for routine exam

SLIDE 13: Surgery

- date of each operation , listed in reverse chronological order
- type of operation (and reason, if necessary)
- name of hospital and course of treatment
- complications or sequelae from the surgery
- type of anesthesia and any complications

SLIDE 14: Also include:

- Same day surgery
- Ophthalmic surgery
- Cosmetic surgery
- Cesarean sections
- Elective abortions
- D&Cs

SLIDE 15: Surgery Examples

- 1995- elective bilateral tubal ligation, Morristown Memorial Hospital, no complications, epidural anesthesia without complications
- 1994- Laparoscopic cholecystectomy; Morristown Memorial Hospital, no complications; general anesthesia without complications

SLIDE 16: Hospitalizations

- date of admissions in reverse chronological order
- diagnosis
- name of hospital
- course of treatment (as appropriate)
- complications or sequelae

SLIDE 17: Hospitalization examples

- (see surgery)*
- 1987- NSVD, Somerset Medical Center, epidural anesthesia, no complications
- 1966- Pneumonia, St. Barnabas Medical Center x 1 week, treatment unknown, no complications or sequelae

***Reminder to reader:** there were other hospitalizations for surgical procedures

SLIDE 18: Injuries

- date
- cause
- complications
- outcome
- Include head trauma, fractures, major lacerations, major burns, blunt trauma, etc.

SLIDE 19: Injury examples

- 1993- Fractured left radius secondary to fall; casted X 4 weeks; no complications or sequelae
- 1990 - laceration to right hand from cut glass, received 32 sutures; no complications or sequelae

SLIDE 20: Immunizations

Include for all adults:

- Tetanus/ Pertussis (Tdap vs. Td)
- measles
- mumps
- rubella
- poliomyelitis
- Hepatitis B

SLIDE 21: Current Guidelines (update as necessary)

As appropriate for adults:

- Influenza (not to be confused with Hib)
  > 50 yrs. old or risk factors
- Pneumococcal pneumonia
  > 65 yrs. old or risk factors
- Hepatitis A
  Based on Risk factors
- Meningicoccal
  College freshman or risk factors
- Varicella
  No hx of illness
- Zoster
  > 50 yrs. Old

- Gardisil (HPV)
  Females and males 9-26 yrs. old

SLIDE 22: Immunization examples

- Received all "childhood" vaccines, specifics unknown; MMR booster 2004, tetanus booster 1990 (see injuries); hepatitis B series 1994
- denies ever receiving influenza or hepatitis A

SECTION 2 - Family history

SLIDE 23: Family History

- Focuses on the health problems of the patient's closest relatives
- Important when investigating the possibility of genetically transmitted diseases and also helps with life stresses
- First ask about specific relatives, then ask about specific diseases
- Indicate if living or deceased
- If living record age and state of health
- If deceased, record age at death and cause and other chronic diseases

SLIDE 24: Family History Examples

- PGM: ↑ age 66, Type 2 DM
- PGF: ↓ age 62, liver failure secondary to alcoholism
- MGM: ↑ age 89, HTN
- MGF: ↓ age 84, bladder CA
- Mother: ↑ age 56, osteoporosis, depression
- Father: ↑ age 58, good health
- Sister: ↑ age 38, depression, migraine headaches
- Husband: ↑ age 36 in good health

***Note:** Up and down arrows are used to indicate living or deceased

No family hx of stroke/TIA, respiratory disease, kidney disease, other endocrine disorders, autoimmune diseases, HIV, bleeding disorders/anemia or allergies

SECTION 3 - Social history

SLIDE 25: Social History

Attempt to learn something about the patient as a person and how lifestyle influences his/her health

- Helps you to see the patient in the context of his/her life
- Offers a way to enrich the overall patient- practitioner experience

SLIDE 26

When structuring the social history, attempt to answer the following:

- How does the patient's lifestyle support the illness (or wellness)?
- How does the patient's lifestyle contribute to the development or progression of the illness?
- How will the lifestyle choice interfere or assist with getting well?

SLIDE 27: How social history might come into play:

Discharging a patient after stroke

- How many stairs will the patient have to climb?
- Who will prepare the food?
- How will she juggle the complicated medication schedule?
- How will she get to the office for subsequent visits?

SLIDE 28: Examples

- date and place of birth
- residence

- recent travel
- Example:

  Birth- May 20, 1960, Puerto Rico

  Residence- NYC since age 7

  Travel- Argentina 1 month ago

SLIDE 29: Habits

- sleep- quality, duration
- Example: 7-8 hours a night; restful
- Alcohol Use
- alcohol intake- amount and freq. hx of abuse or withdrawal symptoms
  - Example: 2 bottles of beer with dinner daily
  - CAGE questions when appropriate:

SLIDE 30: CAGE Questions (Buchsbaum DG)

Validated screening questionnaire for alcohol use disorders that includes four questions about alcohol-related experiences. Each of the CAGE questions is scored 0 or 1 and summed for a total possible score ranging from 0 to 4 points.

- "Have you ever thought about ***cutting*** down?"
- "Have you ever gotten ***annoyed*** when people talk to you about drinking?"
- "Have you ever felt ***guilty*** about your drinking?"
- "Do you ever have a drink first thing in the morning?" ***(eye opener***)

2 or more "yes" answers indicate alcohol dependence

SLIDE 31

tobacco-amount and duration

- Example: quit 2 yrs ago; previously 2 ppd x 10yrs (or 20 pack years)

illicit drugs- type, frequency, route of administration

- Example: marijuana use, approx. 2 times per month. Patient reports it does not affect ability for perform activities of daily living

Always ask about current and past use of alcohol, tobacco and illicit drugs

SLIDE 32: Avoid vague terms

Always clarify words such as:

- social
- frequent
- casual
- rarely
- "not much, you know just when I'm with friends…."
- "Only on the holidays or at weddings…."

SLIDE 33

diet- frequency and quality of meals, or any special diets

- Example: 2 well balanced meals daily

caffeine- intake and sensitivity to it

- Example: 2 - 20 oz. cups coffee, 2 cans soda daily

exercise

- Example: 45 minutes cardio at gym 3x/wk

SLIDE 34: Safety Screening

As appropriate for the setting:

- Seatbelt use
- Amount of sun exposure and sunscreen use
- Smoke detectors in home
- Helmet use
- Firearm safety

SLIDE 35: Safety Screen Examples

- Seat belt: only on long car rides
- Sun exposure: less than 15 minutes/day, no sunscreen
- Smoke detectors: yes, does not test
- Helmet use: does not ride bike/Ski
- Firearms: none in home

SLIDE 36: Education

- Level of Education
- Example:
- MS – Microbiology

SLIDE 37: Occupational history

- Past and present work and exposure to known physical hazards in each position
- Work environment including number of hours at work and attitude toward work and employer
- If unemployed, source of income
- If retired, use prior work history

SLIDE 38: Occupational Example

- Lab project manager x 5 yrs; reports “stressful” but “satisfying” environment, works approx.50hrs/ wk; denies any exposure to physical hazards
- If retired:
- Retired 1995; previously insulation installer in office buildings x 35 years; exposed to asbestos on a daily basis, no safety gear used

SLIDE 39: Relationship Status

Current status, quality of relationships, hx of abuse

- Example:

  Married x 2 years, says relationship is "strained" because both pt and husband work long hours, no hx of abuse

SLIDE 40: A Word on Abuse (Koss, Woodruff and Koss) (McFarlane et al.)

- Abused individuals are more likely to tell primary care provider about history of abuse than psychiatrists, police or lawyers
- Direct questioning works better than self-reporting questionnaires

SLIDE 41: Asking about Abuse

- A warm up sentence if often helpful
  - "Many women have experienced violence in their lives"
  - "While violence is common, woman who experience it often feel alone"
  - "Have you ever been hit, slapped, kicked or otherwise hurt by someone?"
- SAFE questions when appropriate

SLIDE 42: SAFE questions (Ashur)

Stress/Safety

- "Do you feel safe in your relationship?"
- " Should I be concerned about your safety?"

Afraid/Abused

- "Are their times in your relationship when you have felt abused?"
- "Are you in that situation now?"

SLIDE 43: SAFE questions (Ashur)

Friends/Family

- "Are your family/friends aware you have been hurt?"
- "If you told them, would they be able to give you support?"

Emergency Plan

- "Do you have a safe place to go in an emergency?"
- "If you feel you are in danger now, would you like help in locating a shelter or developing an emergency plan?"

SLIDE 44: Sexual History

- Sexual problems are common in the general population
- Many patients find it difficult to begin a conversation regarding sexual concerns
- many coexisting medical problems and medications affect sexual function/ dysfunction
- Patients are often grateful when they are interviewed about sexual function

SLIDE 45: Questioning Guidelines

- Justify reason for asking the questions
- Indicate your concern is for health and lifestyle satisfaction reasons
- Questions will often vary with patients age and overall lifestyle

SLIDE 46: Sexual Orientation

- never assume sexual preference of any patient
- refer to all partners as partners and not by gender (or husband, wife, etc.)
- treat the patient with respect, regardless of your own sexual preferences or personal beliefs

SLIDE 47: Sexual history format

- Age at first experience
- gender of partners
- total number of lifetime partner(s)
- currently sexually active
- Activity (oral, vaginal and/or anal)
- frequency, libido
- Sexual History Format (cont)
- Use of contraception (past and present)
- history of STIs, current prevention
- HIV risk assessment, past testing and results

These may be adjusted based on the patient's age and lifestyle

SLIDE 48: Sexual History Example

Example for a 25 year old female:

- First intercourse 17y.o.; 6 total lifetime partners, all male, currently monogamous relationship X 1 year; satisfied with frequency and activity; on OCPs; no history of STIs; both patient and partner HIV tested 6 months ago; results negative

SLIDE 49: Sexual History Example

Example for a 32 year old man:

- First sexual experience age 20, over 10 male and female partners, currently involved with 2 partners, practices oral, vaginal, and anal penetration, no contraception or STD prevention. No history of STIs or HIV testing.

SLIDE 50: Sexually History Example

Example for an 80 year old woman

- First experience age 21, 1 male partner; no activity since her husband's death 10 years ago.

SLIDE 51: Sexual History- ways to ask the difficult questions

- Currently involved in a sexual or intimate relationship?
- Are you sexually involved with one person or more than one person?
- Do you have sexual relations with males, females, or both?
- Are you satisfied with the kind of sex you are having?
- Do you participate in oral, vaginal/penile, and/ or penile/anal sex?
- Do you have a need for contraceptive info. or a contraceptive method?

SLIDE 52: Sexual History- ways to ask the difficult questions

- How do you protect yourself from sexually transmitted diseases?
- Have you ever been hurt or frightened while engaged in sexual activities?
- Have you ever participated in sexual activities which you didn't want?
- Do you have any questions or concerns about sex?
- Is there anything we haven't discussed that you think is important for me to know?

Note to Interviewer: As the patient responds to your questions, pay attention you his/ or tone of voice, which can provide clues to a particular problem and whether you should proceed with further questioning

SLIDE 53: Living Environment

- Community
- living conditions- Examples may include:
  - flights of stairs
  - number in household
  - household responsibilities
  - pets

- exposure to violence

SLIDE 54: Living Environment Example

- 3 bedroom apt with 2 cats and 2 other people, two flights up, no elevator, no AC, safe neighborhood

SLIDE 55: Support System

Examples may include:

- friends
- community involvement
- quality of relationships
- religious affiliation

SLIDE 56: Spirituality and Religious Beliefs (Borneman, Ferrell and Puchalski)

FICA

Faith and belief:

- "Do you consider yourself a spiritual or religious person?"

Importance and influence:

- "What importance does faith have in your life?"
- "What role do your beliefs play in coping with illness?"

Community:

- "Are you part of a spiritual or religious community?"

Address of care:

- "Would you like me to address these issues in your healthcare?"

SLIDE 57: Military History

- branch of service
- dates
- where stationed

- assignment and duties
- combat
- discharge status

SLIDE 58:

Example: Navy SEALS from 1964-1966, Vietnam War, active in combat, honorable discharge, no major physical injuries

***Note to instructor:** Small Group Role Play with Instructor: Sarah Flemm (appendix 2).

Instructor should review case prior to role-play.

Inform group that they are asking a FULL HISTORY. This means HPI through all the ROS. Students will write up the full history and send it to group instructor within 72 hours. Faculty need to review the case for feedback (no grade) and hand back by the next meeting.

1. Hand out the John/Jane Doe normal history and physical (appendix 1). Let them know that they can use it as a guide for their write-ups.
2. For HPI—ask the group for a volunteer to do the questioning alone. If you don't get any volunteers, pick one of your strong students. Once they begin to struggle, ask the group to help him/her out.
3. After the HPI, go around the group and have each student ask you a section of the History…medical, then family, split the social, then split the ROS. They will need to take notes of the positives so they can be prepared to write it up at home.
4. If the students have completed the entire history early, they can begin to write-up their cases or they are free to go.
5. When you hand back each student's case, make sure you attach Sarah Flemm version (appendix 2) so they can see how their case should be written.

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Appendix 1

John/Jane Doe

Date:

Time:

CC: Routine Full History and Physical

HPI: This is a 26-year old Hispanic male/female with no significant past medical history who presents for a complete history and physical after obtaining new health insurance. His/her last complete physical was 7 years ago when (s)he entered college. There are no complaints at this time.

Medications: None

Allergies: Denies drug, food, seasonal, environmental or animal allergies or intolerances

PH: Medical

Child: chicken pox at approximately 5 years old; no complications; general health as child was good

Adult: No cardiovascular disease, hypertension, heart murmurs, stroke/TIA, respiratory diseases, kidney disease, endocrine disorders, autoimmune diseases, cancer, liver disease/hepatitis, HIV, or mental health conditions

General: no regular health care provider (see HPI)
Surgeries: none
Hospitalizations: none
Injuries: none

Immunizations: MMR, tetanus, and polio as child; last MMR and Td booster 4 years ago; denies influenza, hepatitis A or B, or meningococcal vaccine

FH:

PGM:	↑ 78; hypertension
PGF	↑79; benign prostatic hyperplasia
MGM:	↑68; hypertension
MGF	↑72; hypertension
Mother:	↑50; good health
Father:	↑49; good health
Brother:	↑27; good health
Sister:	↑22; good health

There is no family history of cardiovascular disease, stroke/TIA, respiratory disease, kidney disease, endocrine disorders, autoimmune diseases, cancer, HIV, mental health conditions, migraines, bleeding disorders/anemia, or allergies

SH:

born:	April 29, XXXX – Montville, NJ
residence:	Hoboken x 4 months
recent travel:	none
sleep:	8 hours per night, restful
alcohol:	2 cans beer, approximately 1 time per week
tobacco:	denies
illicit drugs:	denies
diet:	3 meals per day- healthy, well-balanced low fat, high protein
caffeine:	2 cans coke daily
exercise:	none

Safety screen:

seatbelt:	always
sun exposure:	on weekends; wears sunscreen if outside more than 1 hour

smoke detectors: thinks it works; not aware they should be checked on regular basis

helmet use: rides bike often; does not wear helmet

firearms: no guns in home

Education: MBA - Marketing

Occupation: product marketing manager at pharmaceutical company x 4 months; previously a student
works 40-50 hours/week; high job satisfaction
no known exposure to physical hazards

Relationship Status: girl (boy) friend x two years; high satisfaction; denies history of abuse

Sexual History: sexually active with girl (boy) friend only, satisfied with frequency and libido. First experience at age 16; four partners all female (male); uses condoms for contraception; denies history of STIs; no known HIV exposure; never HIV tested

Environment: lives with roommate in 2 bedroom apartment; satisfied with environment

Support System: many close family and friends

Military: none

ROS: General: Ht. 5'9", Wt. 160 lbs; no recent weight change, no weakness, fatigue, malaise, fever, chills, night sweats

Skin: no pruritus, rashes, color changes, tendency to bruise, lesions, excessive dryness; no change in hair, nails or moles; denies tattoos and body piercings

Head: no dizziness or headaches

Eyes: no use of glasses or contact lenses; last eye exam more than 10 years ago; no known visual loss, injury, infection,

scotomata, photophobia, excessive lacrimation, injection, glaucoma, or cataracts

Ears: no known hearing loss, tinnitus, vertigo, or discharge

Nose and Sinuses: no loss of smell, sinus pain, epistaxis, congestion, discharge, post nasal drip, frequent head colds

Oral: last dental exam 7 years ago; no problems at the time; no recent toothaches, throat soreness, bleeding, taste disturbance, hoarseness or change in voice

Neck: no pain, stiffness, masses

Nodes: no tenderness or enlargement of cervical, axillary, epitrochlear or inguinal nodes

Breasts: (if male) no pain, masses or discharge

(if female) denies pain, masses, discharge, monthly self-exam, last breast exam by a health care provider 7 years ago; never had a mammogram

Respiratory: no dyspnea, chest pain, cough, sputum, hemoptysis, wheezing, exposure to TB; never had a CXR or PPD

Cardiac: no chest pain/discomfort, palpitation, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cyanosis or syncope; never had an EKG

GI: appetite good, no dysphagia, heartburn, postprandial or abdominal pain, jaundice, nausea, vomiting, or hematemesis; no excessive flatulence or bloating, obstipation; BM daily, stools brown and firm, no change in stools, diarrhea, or constipation; no tenesmus, rectal conditions, or hernias

GU: (If male) no dysuria, frequency, nocturia, hematuria, pyuria, oliguria, problems with micturition, incontinence, renal colic, history of recurrent urinary tract infections or urinary tract calculi; no testicular pain, change in size of scrotum, scrotal masses; no self exam; no penile pain,

lesions or discharge; no erectile dysfunction; no prostate disorders; never had a PSA screening

(If female) no dysuria, frequency, nocturia, hematuria, pyuria, oliguria, problems with micturition, incontinence, renal colic, history of recurrent urinary tract infections or urinary tract calculi

Menstrual: Menarche- age 12, cycles are 28 days, moderate flow for 5 days, no premenstrual pain. dysmenorrhea, or intermenstrual bleeding

OB: G_oP_o

GYN: Last PAP April of this year; No vaginal discharge, dyspareunia, coital bleeding, endometriosis, uterine fibroids, ovarian cysts; no history of abnormal PAPs, never had a mammogram

Extremities:

Vascular: no intermittent claudication, ulceration, coldness of extremities, hair loss, thrombophlebitis, edema or varicose veins

Joints: no pain, swelling, limitation of motion or morning stiffness

Muscles: no pain or cramps

Back: no pain, stiffness, limitation of motion or injury

CNS:

General: no hx of loss of consciousness or convulsions

Mentative: no speech or memory disorders.

Motor: no tremors, weakness, paralysis or clumsiness of movement

Sensory: no anesthesia, paresthesia or pain

Hematopoietic: no bleeding tendencies, anemia, transfusions, exposure to toxic agents or radiation; blood type unknown

Endocrine: no intolerance to heat or cold, change in skin, inappropriate relationship between appetite and weight, nervousness, tremors, polyuria, polydipsia,

polyphagia, hirsutism, or past or present use of hormone therapy

Psych: no mood changes, nervousness, anxiety, excessive crying, euphoria, depression, change in sleep pattern or ability to concentrate; no anhedonia or hallucinations

Physical Exam This is a well developed, Hispanic male (female) sitting comfortably in a chair, in no acute distress. He (she) appears stated age of 26.

Vital signs: T 98.6 F (oral); P 80; R 16; HT. 5'9"; Wt. 160; BMI: 24; BP: R-sitting 120/80; L-sitting 120/80

Skin: Good turgor, warm, dry; no rashes, scars, bruises, lesions, cyanosis, or clubbing of the nails

Head: atraumatic, scalp without rashes or lesions; no alopecia

Eyes: acuity 20/20 OD, 20/30 OS with handheld chart at 14 inches; eyebrows evenly distributed, conjunctiva pink, sclera nonicteric, no ptosis or lid lag; no swelling of the lacrimal apparatus; PERRL, EOM's intact, no nystagmus; visual fields without defect; fundus - discs well delineated, no A-V nicking, hemorrhages, or exudates

Ears: acuity good to whispered voice at one foot; auricles without pain on movement; canals patent; TM's gray with good light reflex, landmarks visualized

Nose: nasal mucosa pink, septum midline, no sinus tenderness

Mouth: lips pink, buccal mucosa and gums pink and moist, no lesions; teeth in good repair, tongue protrudes in midline, palate rises symmetrically,

uvula remains in midline, gag reflex present; pharynx pink, no exudates, tonsils present, not enlarged

Neck: supple, trachea midline, no lymphadenopathy, no thyromegaly; carotids equal and strong, no JVD, no bruits

Thorax: symmetrical expansion without retractions; AP: lateral diameter 1:2;
And diaphragmatic excursion 4 cm bilaterally, tactile fremitus symmetrical, resonant to percussion;

Lungs: lungs clear, no rales, rhonchi, wheezes, rubs. Breath sounds vesicular

Cardiac: no lifts, thrills, or visible pulsations; PMI 5th intercostal space in the left mid-clavicular line; regular rhythm, S_1 S_2 present, no S_3 S_4, no murmur, rubs or HJR

Breasts: (Male) no swelling, masses, lesions; axilla - no rashes, no lymphadenopathy
(Female) small, symmetrical, nipples central; no dimpling, or skin discoloration; no rashes, ulceration, discharge, masses, tenderness, or axillary lymphadenopathy

Abdomen: flat, no scars or lesions; no visible peristalsis or pulsations; bowel sounds present, no bruits; liver span 8 cm in right midclavicular line; abdomen soft, no tenderness or masses; liver, spleen, kidneys not palpable; no CVA tenderness

Genitalia: (*Male*) Circumcised penis, meatus at tip, no ulcerations, no scrotal swelling or tenderness; testes of rubbery consistency, symmetrical, no masses
(*Female*) External: No swelling, rashes, or lesions

Vagina: No lesions of vaginal walls, no discharge

Cervix: nulliparous, central pink, no discharge from os, ulcerations, lesions, bleeding or friability

Bimanual: Cervix mobile, no motion tenderness. Uterus anterior, not enlarged, no masses or tenderness; adnexae- ovaries palpable, not enlarged, no masses, tenderness; Rectovaginal wall smooth without masses or tenderness

Rectal: no rashes, lesions of perianal area; good sphincter tone, no tenderness or masses; (If male) Prostate smooth, firm, not enlarged, no masses. Brown stool on glove - guaiac negative

MSS: no redness, swelling or deformity of joints; range of motion good in all joints, no tenderness; spinal curvatures intact, iliac crests symmetrical

Vascular: no calf tenderness, edema or varicosities

Pulses: (2 + = normal)

	Carotid	**Brachial**	**Radial**	**Femoral**	**Popliteal**	**PT**	**DP**
R	2+	2+	2+	2+	2+	2+	2+
L	2+	2+	2+	2+	2+	2+	2+

Neuro: Cranial Nerves

I - able to identify perfume and alcohol.

II, III, IV, VI - see eyes.

V - temporal and masseter muscles symmetrically strong, sensation intact to sharp and light touch on forehead, cheeks, jaw; corneal reflex not tested

VII - muscles of facial expression symmetric and strong

VIII - see ears

IX, X, XII - see mouth

XI - sternocleidomastoid and trapezius muscles symmetrically strong

Motor: no atrophy, fasciculations, tremor; normal tone; muscle strength 5/5 in upper and lower extremities

Cerebellar: gait stable and fluid; able to walk heel to toe, hop on one foot, walk on heels and toes, and do shallow knee bends; coordination good on rapid alternating movements and point to point testing

Sensory: sensation to sharp, light touch, vibration, position sense, stereognosis and graphesthesia intact; negative Romberg

Reflexes (2+ = nl)

	Biceps	**Triceps**	**Supinator**	**Abdominal**	**Patellar**	**Achilles**
R	2+	2+	2+	2+	2+	2+
L	2+	2+	2+	2+	2+	2+

Mental Status: patient is alert, thoughts coherent, speech clear, oriented to time, place

Appendix 2

Date:

Time:

Sarah Flemm

CC: Productive cough X 2 months

HPI: This is a 45-year old white female with no significant medical history who presents to the emergency room complaining of a constant productive cough x 2 months. She describes the cough as producing a scant amount of clear mucoid sputum, approximately 2 teaspoons per day. The cough occurs all day and night and is not painful. The patient is also complaining of fatigue and malaise which has gotten progressively worse over the last 2 months, and currently describes both as severe. In addition, she reports night sweats and feeling feverish accompanied by weight loss (amount unknown) x 1 month. The patient reports that nothing makes her symptoms better or worse and that she hasn't taken any medications or remedies to relieve symptoms. She has never had this type of illness before. She is presently living in a boarding home where other people are having similar symptoms x 6 months. She has "lived on the street" and several boarding homes x 10 yrs. There is a questionable exposure to tuberculosis approximately ten years ago when she lived with a sick uncle who may have had tuberculosis. She denies dyspnea, chest pain, hemoptysis, wheezing, and has never had a chest x-ray or a PPD test. She also denies weakness, chills, post nasal drip and heartburn.

She drinks approximately ½ pint of whiskey and one six-pack of beer daily x 20 years. Her last ETOH was a "swig" of whiskey 3hrs. ago. She experiences mild shakes when she has not had alcohol for half a day. She has a

smoking history of 1ppd x 30 years. She works in a grocery store cleaning and sweeping the floors. She denies any history of respiratory disease or recent travel and states she has not seen a health care provider in over twenty years.

The patient states she is very concerned about this illness because it has caused her to miss many days of work, and she is afraid that she will be fired if she misses any more time.

Medications: None

Allergies: Denies drug, food, seasonal, environmental, or animal allergies/intolerances

Past Medical History:

Child: General health as child was "good"

Adult: (see HPI) Denies cardiovascular disease, hypertension, heart murmurs, stroke/ TIA, respiratory diseases including COPD and asthma, kidney disease, endocrine disorders including diabetes and thyroid, autoimmune diseases, cancer, liver disease/hepatitis, HIV or mental health conditions

General: no health care provider x 20 years (see HPI)

Surgery: denies

Hospitalizations: 1997- NSVD of daughter, University Hospital x 3 days, no complications

Injuries: 1998- laceration above left eye cause by fight. Received 10 stitches in unknown ER. No follow-up.

1977- fractured lower left arm (pt. does not know specifics) from falling out of moving truck. Casted in ER. No follow-up.

Immunizations: unknown

Family History:

PGM:	unknown
PGF:	unknown
MGM:	unknown
MGF:	unknown
Mother:	unknown
Father:	unknown
Brothers x 3:	unknown
Daughter:	age 15; unknown health status
Uncle:	possible TB (see HPI)

No family history of cardiovascular disease, hypertension, TIA/stroke, asthma, kidney disease, endocrine disorders including diabetes and thyroid, autoimmune diseases, cancer, HIV, mental health conditions, migraine, bleeding disorders/ anemia, or allergies

Social History:

Born:	February 19, 1967, Irvington, NJ
Residence:	NJ entire life
Recent travel:	none
Sleep:	poor over last month due to night sweats. Previously restful, approx. 9hrs/night
Alcohol:	(see HPI)
Tobacco:	(see HPI)
Illicit drugs:	denies
Diet:	one meal a day, mostly fast food
Caffeine:	less than 1 12oz soda per week
Exercise:	denies
Safety screen:	wears seat belt in cars
	does not wear sunscreen
	smoke detectors at boarding house

does not have use for helmet
does not have access to firearms

Education: completed 10th grade of HS

Occupation: cleans and sweeps grocery store x 20-30 hours a week x 6 months. Exposure to hazards unknown. Pt. satisfied with employment.

Relationships: never in serious relationship

Sexual history: no sexual activity x 5 years; previously used condoms; no history of STIs. Unaware of HIV status.

Environment: (see HPI)

Support system: friendly with others in the boarding house but no one especially supportive

Military: none

ROS:

General: (See HPI), Ht. 5'4", weight unknown to patient

Skin: denies pruritus, rashes, color changes, tendency to bruise, lesions, excessive dryness; no change in character of hair, nails or moles; denies tattoos or piercings

Head: denies dizziness or headaches

Eyes: no glasses or contact lenses; never had eye exam; denies visual loss, injury, infection, scotomata, photophobia, excessive lacrimation, injection, glaucoma, or cataracts

Ears: denies hearing loss, tinnitus, vertigo or discharge

Nose/Sinuses:	(see HPI) no loss of smell, sinus pain, epistaxis, congestion, discharge, or frequent head colds
Oral:	last dental exam more than 10 years ago; no recent extraction or toothache; no throat soreness, bleeding, taste disturbance, hoarseness, or change in voice
Neck:	denies pain, stiffness or masses
Nodes:	denies tenderness or enlargement of cervical, axillary, epitrochlear or inguinal nodes
Breasts:	denies pain, masses, discharge; no self examination or recent examination by health care provider; never had a mammogram
Respiratory:	(see HPI)
Cardiac:	denies chest pain, palpitation, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cyanosis, syncope; never has had an EKG.
GI:	(see HPI) appetite good; denies dysphagia, postprandial or other abdominal pain, jaundice, nausea, vomiting or hematemesis; no excessive flatulence/ bloating or obstipation; BMs daily; brown and firm, no diarrhea, constipation, tenesmus, rectal conditions or hernias
GU:	denies dysuria, frequency, nocturia, hematuria, pyuria, oliguria, problems with micturition, incontinence, renal colic, history of recurrent urinary tract infections or calculi
Menstrual:	LMP 2 weeks ago; menarche age 12, cycles every 28 days, moderate flow x 5 days, no premenstrual pain, dysmenorrhea, or intermenstrual bleeding
OB:	$G_1P_{1001,}$ 1997, NSVD no complications

GYN: no vaginal discharge, dyspareunia, coital bleeding, endometriosis, uterine fibroids, ovarian cysts, last PAP smear 16 years ago; does not recall results

Extremities:

Vascular: no intermittent claudication, ulceration, color changes, coldness of extremities, hair loss, thrombophlebitis, edema or varicose veins

Joints: no pain, swelling, limitation of motion, or morning stiffness

Muscles: no pain or cramps

Back: no pain, stiffness, limitation of motion, or injury

CNS:

General: no loss in consciousness or convulsions

Mentative: no speech or memory disorders

Motor: (see HPI) no weakness, paralysis or clumsiness of movement

Sensory: no anesthesia, paresthesia or pain

Hematopoietic: denies bleeding tendencies, anemia, transfusion(s) and reaction, exposure to toxic chemicals or radiation; blood type unknown

Endocrine: denies intolerance to heat or cold, change in skin, inappropriate relationship between appetite and weight, nervousness, tremors, polyuria, polydipsia, polyphagia, hirsutism, past or present use of hormone therapy

Psychological: denies mood changes, nervousness, anxiety, excessive crying, euphoria, depression, change in sleep pattern or concentrating ability, anhedonia, or hallucinations

Unit 6

Observed Simulated Clinical Examination (OSCE)

This OSCE should be utilized prior to students going out to the clinical site to perform histories on patients. OSCE's involve the use of standardized patients. Many medical schools utilize this type of exam and have staff members who can help you to set it up. In general, the students will be divided into groups based on the number of actors, rooms and faculty you have available. For example, with 10 actors in 10 rooms, a class of 50 will have 5 different start times, each group beginning and ending together. Given that each of the station activities for this OSCE is 15 minutes, it is suggested student groups be scheduled every 40 minutes to give time between groups. In the event that professional/amateur actors are not available, you may be able to utilize students from a different year in the program, with some orientation and training, to serve as actors.

The standardized patient (actor) should be given the script ahead of time (appendix 1). He/she should also be given an evaluation sheet for each student (appendix 2). When possible, these activities/examinations should be recorded (by camera/video) so that the instructor and student can review the student's performance.

At least 24 hours before the OSCE the students should receive the instructions included in Appendix 3. Once at the exam site, the students will get instructions at each of the 2 stations Appendices 4 and 5). The first station should look like an exam room or hospital room. The second station should provide a table and chair for the student, so that he/she can write the history.

At the first station the faculty member will observe the student/patient interaction and record on the check list all of the components of the history asked appropriately by the student (Appendix 6).

In addition, comments should be made on the student's interpersonal skills.

At the second station the faculty member should have paper and pens available for the written history. These should be collected for grading and feedback.

At some point in the week or two that follow the exam, faculty should meet with each student individually to provide feedback. When appropriate (if applicable) the faculty member should review the recording with student and provide him/her with a copy for viewing.

The following six appendices include everything needed for the OSCE.

Appendix 1

OSCE - Chest Pain

STANDARD PATIENT SCRIPT

The patient is a middle age to older male or female with chest pain

Physical appearance: alert, worried appearing

History of present illness:

Chief Complaint: **Chest Pain**

Location-middle of chest (patient should put a fist over sternum)

Character/description-dull, "a funny feeling" "heaviness that is so strange"

Onset-started three weeks ago when walking dog in evening- Episodes keep happening—**today** it happened after breakfast while still sitting down-it subsided after 5 minutes

Duration-lasts 10-12 minutes after exercise

Radiation-left arm feels weak when it happens

Intensity-5 on a scale of 1-10

Relieving factors-usually seems to subside when you come home, rest and take an Alka seltzer

Worsening factors-walking

Prior history-you do not have a cardiac history, you never had pain like this before 3 weeks ago

Cardiac risk factors: hypertension, no diabetes, don't know
Cholesterol, father MI age 48, 20 pack year
Smoking history, quit last year

Associated Symptoms-you "feel winded" when the pain comes on, left arm feels weak
No nausea or sweating, no dizziness or palpitations
Pain is Non pleuritic (does not hurt upon taking a deep breath
No PND (sitting up at night to catch breath) or Orthopnea (you sleep on one pillow), no ankle swelling

Past Medical History:

General Health and immunizations-good health except hypertension, see above

Medications You have been prescribed a water pill for hypertension, Motrin for joint pains

Allergies none

Hospitalizations none

Significant Family History

Father MI age 48, died at 60, congestive heart failure

Mother hypertension alive, Age 80

Siblings sister age 50, mild hypertension

Children twin daughters alive and well

Social History:

Educational background high school education

Partner married

Sexual Partners monogamous

Habits

Alcohol occasional beers (3-4 on weekends)

Drugs none, no cocaine

Caffeine 2 cups in am

Tobacco quit one year ago-20 pack year history

Diet includes red meat, and fats

Exercise walks dog around block twice a day

Hobbies plays cards on weekends

Occupation: small business owner

Stress little

Review of Systems:

No cough, hemoptysis (coughing up blood), no wheezing

No abdominal pain, change in stool, reflux

Otherwise all negative

Student will close interview by telling patient that they are going to step out and will return in a few minutes.

Appendix 2

Student Name_____

Standard Patient (actor) Feedback checklist

Strongly agree	Agree	Disagree	Professional and Communication Skills
			Student introduced her/himself appropriately (first and last name, PA student)
			Student addressed patient as Mr or Ms
			Student clarified purpose of visit
			Interview was conducted in an organized manner
			Open ended (more than one) and focused questions were used
			No jargon and when medical terms used, defined immediately
			Student used encouraging and supportive gestures, body language, remarks and made good eye contact
			Student provided positive verbal feedback and reinforcement
			Student used deliberate techniques to check patient's understanding
			Student allowed the patient to express his emotions
			Student encouraged patient to ask questions
			Student ends interview telling patient it is time for PE (closure of interview)
			Student asked for the patient's explanation of disease/symptoms
			Student asked the impact of the disease/symptoms on patient's life

Comments:

Appendix 3

OSCE Instructions for students (UMDNJ "Chest Pain Osce")

Videotaping is an excellent method for physician assistant students to observe their actual behavior with patients. It can be an invaluable tool to discuss both interviewing techniques as well as nonverbal communication. There is much to be learned by hearing and seeing oneself react with a patient.

Objective Simulated Clinical Exercise (OSCEs) are a specialized technique to assess the skills mentioned above. OSCEs are very similar to the role plays previously done with advisors except that the patient will be a professional actor and each student will do the questioning alone. The patient/PA student interaction will be videotaped so that student and advisor can review at a later time.

How it will work:

1. A detailed schedule of when each student is interviewing will be distributed prior to the OSCE day.
2. Students should arrive for the exam dressed in professional attire including white coat. At this time, last minute questions and announcements will be made. The OSCE coordinator will review the procedures of the patient experience.
3. At your scheduled time, you will go to the exam room and read the instructions/description on the door. When you walk into the exam room, it should be as if you walked into a real patient's room. You should introduce yourself, wash your hands, and ask the patient why he/she is at the office.
4. **You will be responsible for taking the medical history necessary to complete the patient's HPI. You should take notes in an appropriate manner, as you will be responsible for writing up the HPI.**
5. The patient's chief complaint may be anything and you have 15 minutes to complete the interview. We will keep the complaint relatively simple. Keep

in mind, the point of the exercise is to have you effectively ask the proper questions, it is not for you to come up with the diagnosis.

6. Just as in the hospital, you may bring in a few small cards with the ROS questions to help jog your memory. Remember though, the more you have memorized, the smoother the interview will go. Fumbling through multiple cards is ***not*** good technique.
7. When you leave the "patient" room you will move on to the next station to write the HPI. You will have another 15 minutes to complete that task.

Appendix 4

INSTRUCTIONS for STUDENTS for STATION 1

First name, last name, a 58 year old male (female) has come to the office today because of a "funny feeling in his chest" for the past three weeks

Vital signs:

Pulse: 90

Temp: 98.

BP: 140/90

Resp: 20

1. Obtain a history pertinent to this patient's problem- Take notes!
2. At the conclusion of the interview tell the patient that you are stepping out and you will back in a few minutes.
3. After leaving the room, go to station 2 to write an HPI.

Patient Station 15 minutes

Note Station 15 minutes

Appendix 5

NOTE STATION INSTRUCTIONS (for station 2)

Write an HPI for the patient you just evaluated in the previous station.

Total time: 15 minutes

A. **History:** Write the HPI using the format you have learned in your Medical Interviewing class. Document significant positives and negatives that pertain to the history of present illness, as well as pertinent medical, family and social history.

B. The HPI will be given to your instructor for feedback.

Appendix 6

Case 1 – Chest Pain

Student Name_____

Faculty Name_____

Faculty Check list: Instructions to Examiner: Please give the students one check mark in the column when s/he elicits the historical data indicated or demonstrates the appropriate behavior.

C h e c k		Data Gathering Checklist
	1	Onset of pain
	2	Location of pain
	3	Severity of pain on a scale of 1-10
	4	Quality/character of pain
	5	Timing of pain (how often?)
	6	Radiation of pain
	7	Precipitating factors
	8	Palliating factors
	9	Cough
	10	Abdominal pain/Heartburn
	11	Nausea/vomiting
	12	Diaphoresis
	13	Dizziness
	14	SOB
	15	Syncope

	16	Palpitations
	17	Orthopnea/PND
	18	Assesses if the pain is CURRENT (do you have pain now)
	19	Past medical history (must include HTN, DM, Chol and cardiovascular disease)
	20	Family history of cardiac disease
	21	Current Meds
	22	Hospitalizations
	23	Allergies
	24	Tobacco
	25	Exercise
	26	Diet
	27	Alcohol/Drugs
Professional and Communication Skills, ********		
	28	Student introduced her/himself appropriately (first and last name, PA student)
	29	Student addressed patient as Mr
	30	Student clarified purpose of visit
	31	Interview was conducted in an organized manner
	32	Open ended (more than one) and focused questions were used
	33	No jargon and when medical terms used, defined immediately
	34	Student used encouraging and supportive gestures, body language, remarks and made good eye contact
	35	Student used deliberate techniques to check patient's

		understanding
	36	Student allowed the patient to express his emotions
	37	Student encouraged patient to ask questions
	38	Student ends interview telling patient it is time for PE (closure of interview)
	39	Student asked for the patient's explanation of disease/symptoms
	40	Student asked the impact of the disease/symptoms on patient's life

Each item is worth 2.5 points. Students must achieve a grade of 75% to Pass

Works Cited

UMDNJ, PA Program. “Chest Pain Osce.” Piscataway, NJ: UMDNJ, 2009. Print

Unit 7

The Problem List, Assessment and the Parallel Chart

This unit is designed to teach the student how to formulate a Problem List and an Assessment. Additionally it introduces the concept of the Parallel Chart. These are covered in the same unit purposefully so that the students are reminded about the humanity of the patient while learning important technical skills. The group exercise for this unit is to develop a list of pertinent positives, problem list and assessment from a case that is handed out in class.

A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

At the end of unit there are three appendices. The first appendix includes the case for the large group exercise. There is no formal homework assignment for this unit however there is a handout for students in Appendix 2 to help them to prepare for their hospital session which should follow this unit. In addition, the students should also get a copy of Appendix 3 which provides a grading rubric for the history and physical exams that the students complete at the hospital.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Given a complete history and physical exam, develop a pertinent data list and a Problem list
2. Given a complete history and physical exam, develop an Assessment
3. Value the benefit of developing a parallel chart

SLIDE 2: Key Concepts/Sections

Problem list and pertinent data list

- Assessment

- Parallel Chart

SECTION I - Problem list and pertinent data list

SLIDE 3: The Medical Write-up

Includes the following:

- History of Present Illness (HPI)
- Medical History
- Physical
- **PROBLEM LIST**
- **ASSESSMENT**
- Plan
- Orders

SLIDE 4: Development of Problem List (Palfreyman "Problem List and Assessment")

- The problem list is created after all the subjective and objective information has been gathered from the history, physical examination and any diagnostic testing
- The problem list is developed as a list that includes all of the concerns raised by the data
- The problem list enables the clinician to quickly assess the patient's history by the summary presented on this list

SLIDE 5

- This list helps the clinician to make sense of all the data that has been collected
- This is one of the first steps in the process of making an assessment and developing a treatment plan

SLIDE 6

- A problem may be defined as a concern that may or will require further evaluation or attention
- In most cases, the problem list begins with the chief complaint (the most immediate problem)
- Related history, physical examination findings and diagnostic test results should be grouped with this problem

SLIDE 7: A problem may be related to any of the following:

- A new symptom or finding of unknown significance (e.g. lymphadenopathy)
- A firmly established diagnosis (e.g. hypertension, CAD, Type 2 Diabetes)
- Unexpected and new laboratory or other diagnostic tests (e.g. anemia on routine CBC)

SLIDE 8

- Personal or social difficulties (e.g. homelessness, domestic abuse)
- Risk factors for serious conditions (e.g. smoking, family history of cancer)
- Factors important to note for the long term (e.g. allergic to Penicillin)

SLIDE 9: Suggestions for the Problem List:

- List the problems that need attention succinctly and objectively (e.g. chest pain or abdominal pain)
- Avoid vague listing of problems if the diagnosis is known or obvious (e.g. don't list shortness of breath if it is clear that it is due to a well established diagnosis of emphysema)
- Modify your problem list as appropriate (e.g. chest pain becomes acute myocardial infarction once all data is collected)

- Avoid the problems that you will not be addressing (e.g. verruca right arm, history of UTI 2 years ago)
- Prioritize the problems (e.g. chest pain should be listed first over family history of cancer)

SLIDE 10: Helpful Exercise: Create a pertinent data list

- First list **ALL** the pertinent data from the history and physical
- Group findings that are related
- List the most pertinent group of findings first and create prioritized list

NOTE: The "pertinent data" list is *not* part of the patient's actual medical record. But when you are first learning medical documentation, it is a fast way to organize the patient's information as a step forward formulating the problem list.

***Note to instructor:** At this point the instructor can move to the large group exercise by handing out the case in Appendix 1. Ask the class to take 15 minutes to carefully review the case and note all the pertinent positives in the case. Once they complete that ask for volunteers to each contribute one issue on the list. Record these on a blackboard/ whiteboard and group so the students can see how this might be done. SEE BELOW:

- blood/pus stained left sock 3 days
- fatigue and malaise x 2 days
- sense of fever x 1 day
- ball of left foot: 0.5cm x 1.0cm ulceration with active bleeding and yellow/green foul smelling discharge
- 1.5 cm smooth erythematous border surrounding ulcer
- non-tender to insertion of sterile cotton tip applicator to depth of 1cm
- current temp 102 F

- loss of hair and shiny skin on shins and feet B/L, cool to touch
- diminished sensation to sharp, light touch, vibration of both feet up to the level of the ankle bilaterally
- diminished DP, PT pulses

- Type 2 DM and HTN x 20 years
- increase in blood glucose readings at 150-200mg/dL x 5 days
- current BP readings slightly elevated

- Erectile dysfunction x 5 years
- overweight- BMI=28
- displaced PMI

- PCN allergy – rash

- FH: kidney disease, type 2 DM, MI, lung cancer, HTN
- no recent CXR, PPD
- no regular exercise
- no testicular self exam

***Note to instructor:** At this point the instructor should go on to develop a Problem list in the same fashion as the pertinent positives. SEE BELOW:

1. 0.5 x 1.0 cm bloody, pus filled ulceration on erythematous border with associated fever
2. type 2 DM with recent increase in blood glucose readings 150-200mg/dL
4. HTN x 20 years with current bp readings slightly elevated, displaced PMI
5. diminished sensation to sharp, light touch and vibration to ankle level bilaterally

6. diminished DP/PT pulses with shiny skin, cool to touch and hair loss
7. overweight with BMI=28
8. erectile dysfunction
9. PCN allergy- rash

***Note to instructor:** At this point the instructor should Stop the exercise and return to the PPT presentation to discuss the Assessment

SECTION 2- The Assessment

SLIDE 11: The Assessment

The clinician's educated assessment of the patient's condition is made by:

- Analyzing the history
- Analyzing physical
- Analyzing lab tests
- Developing a list of most probable diagnoses

SLIDE 12: Example

A person with cough:

- If they present with an acute onset of fever and green sputum, are they more likely to have an infectious process or cancer?
- If they smoke does this change the picture?

You are ruling in or out possible causes of an illness by using information obtained. Requires keen observation, medical knowledge and clinical experience

SLIDE 13: Steps to formulating assessment

- Identify findings/concerns – create the problem list
- Interpret/hypothesize - what do the findings mean

- Distinguish between more likely or less likely dignoses

Ex: Diarrhea: what would make it more likely to infectious vs. another cause such as irritable bowel syndrome?

SLIDE 14

Always consider: what supports your assessment:

- think about timing,
- related symptoms,
- how the picture all goes together

What is most acute and life threatening?

SLIDE 15

Develop Assessment

- Use all of the previous information to write your differential diagnosis (R/O list)
- R/O list is all of the diagnoses that you want to consider for a particular patient
- Often you can make the diagnosis based on history and physical
- The R/O list will be your guide to thinking about your plan (tests/labs you want to order)

Note: You don't always have to have a rule out list

Ex: Erythematous bulging tympanic membrane after 5 days of a URI= Otitis Media

Note to instructor: At this point the instructor can move back to the large group to develop the assessment as before, record these on a blackboard/whiteboard. SEE BELOW:

Assessment

1. Diabetic left foot ulcer with pus x 3 days and fever x 1day R/O osteomyelitis
   R/O abscess
2. Type 2 DM
   R/O poor control
3. Diabetic neuropathy
4. Diminished DP/PT pulses with shiny skin and hair loss
   R/O peripheral vascular disease
5. HTN x 20 years; current readings slightly elevated
   R/O poor control
6. Erectile Dysfunction x 5 years- patient not interested in pursuing tx at this point

SECTION 3 – The Parallel Chart

SLIDE 16

- Parallel Chart: There are lots of things that come up when we meet patients
- Writing them down helps us to sort out our feelings and work through things that may prevent us from providing the best care.
- It also allows us to take care of ourselves as clinicians.

SLIDE 17

What you discover about the patient that you would not put in the chart

Simple things like:

- He has three grandchildren who he doesn't see as much as he would like because they live 3 hours away
- His wife bakes the best chocolate chip cookies

SLIDE 18

Or more complicated issues:

- He is afraid that he might die if he doesn't start taking better care of himself.
- He feels guilty about ignoring his illness.

SLIDE 19

What comes up for you when you work with the patient?

- He reminds you of your grandfather who died of complications of diabetes
- This makes you sad and angry at the same time
- You genuinely like this patient

Works Cited

Palfreyman, Lori. "Problem List and Assessment." Piscataway, NJ: UMDNJ, 2011 of *PA Program*. Print.

UMDNJ, PA Program. "Alexander Bell." Piscataway, NJ: UMDNJ, nd. Print.

Appendix 1 (UMDNJ "Alexander Bell")

Date and Time

Alexander Bell

CC: blood/pus stained left sock x 3 days

HPI: This is a 64-year old white male with a history of type 2 diabetes mellitus and HTN x 20 years who presents with a bloody/pus stained left sock. The patient felt well until three days ago when he noticed a small red and yellow stain on his left sock, corresponding to the ball of his foot. Each night since, the stain has enlarged and he has had a sensation of wetness on the sole of his left foot. Last night the stain totally saturated the bottom portion of his sock with blood and now green pus. He notes that the wet feeling seems more pronounced when walking and less noticeable when elevating his foot. In addition to the wetness, he has felt fatigue and malaise over the past 2 days. Over the last 24 hours he has felt "feverish" but he has not checked his temperature. He cannot view the sole of his foot therefore he does not know the source of the wetness and he is unsure if there is an ulceration, rash or color changes to the area. This is the first time this condition has occurred. He has observed a loss of hair and shiny skin on his lower legs and shins x 2-3 years. His feet are often cold and he wears socks to bed. He denies pain or any trauma to his left foot or left leg. He further denies weakness, chills, night sweats, pruritus, tendency to bruise, excessive skin dryness, visual changes, intermittent claudication, lower extremity color changes, edema, polyuria, polydipsia or polyphagia, and anesthesia or paresthesia.

He currently checks his blood glucose every few days. Typical readings are in the 130s mg/dL, however in the last five days, they have been in the 150-200 mg/dL range. He receives routine examinations for his DM and HTN every 3 months. He regularly has his hemoglobin A1C level checked; he doesn't know the number but says 2 months ago

is was “normal or a little above”. He has been on the same drug regimen x many years. He does not follow a strict diabetic diet but tries to watch his salt and carbohydrate intake. He reports erectile dysfunction x 5 years which his PA told him was most likely related to the diabetes. His last visit to his primary care PA was 2 months ago. He was last seen by podiatrist approximately 5 years ago-there were no problems at that time.

He is concerned with the oozing as he works as a construction site manager and it may interfere with his job.

Medications: metformin 1000mg bid
glyburide 5mg bid
lisinopril 20mg QD
hydrochlorothiazide 25mg QD
one baby ASA QD

Allergies: PCN-causes rash; denies food, seasonal, environmental, animal allergies or intolerances

PMHx

Child: good childhood health

Adult: Erectile Dysfunction diagnosed 2007 (see HPI)- Specifically cannot achieve an erection; he and wife are comfortable with level of intimacy in their relationship and do not want to pursue tx at this time

Type 2 Diabetes Mellitus diagnosed 1992 (see HPI) receives yearly eye exams by ophthamologist; has not seen a nutritionist since time of dx; is not aware of any diabetic related problems except the erectile dysfunction

HTN diagnosed 1992- (see HPI) currently on 2 drug regimen (see medications) with no change in doses x 10 years; last EKG 9 months ago; reported as normal; has been told it is well controlled by diet and medication by his PA

Denies cardiovascular disease, stroke/TIA, heart murmur, respiratory diseases, kidney disease, other endocrine disorders including thyroid, autoimmune disease, cancer, liver disease/hepatitis, HIV or mental health conditions

General: Primary care providers are Charlotte Brown, MD and Angela Conserva, PA–C in Clifton, NJ; last visit 2 months ago for routine check

Surgery: 1960, appendectomy, City Hospital, hospitalized x 7 days, no transfusions, no complications; general anesthesia

Hospitalization: See Surgery

Injury: 2001, laceration to left hand, sutured at Passaic General ED, no complications

1986, fracture of right wrist; casted for 6 weeks, no complications

Immunizations: yearly flu shot every October, pneumococcal pneumonia vaccine 2008, tetanus booster 2001, cannot recall other vaccines

Family History

MGM	↓ age 60; kidney failure, possible DM
MGF	↓ age 55; MI
PGM	↓ age 89; cause unknown
PGF	↓ age 33; auto accident
Mother	↓ age 66; type 2 DM, amputee, blind
Father	↓ age 67; lung CA
Sister	↑ age 65; alive and well
Sister	↑ age 58; HTN
Brother	↑ age 55; type 2 DM, obesity, recent mild stroke
Son	↑ age 35; alive and well
Son	↑age 32; alive and well
Wife	↑ age 62; osteoarthritis

Pt denies family history of other endocrine disorders including thyroid, autoimmune diseases, HIV, mental health conditions, migraines, bleeding disorders/anemia, or allergies

SH

born:	1/1/49, Newark NJ
residence:	Clifton, NJ x 55 years
recent travel:	none
sleep:	6 hours/night, restful
alcohol:	1 glass of red wine per night
tobacco:	denies past and present use
illicit drugs:	denies past and present use
diet:	(see PMH)
caffeine:	2 – 12 oz cups of coffee per day
exercise:	nothing formal, "walks a lot on the job"
safety screen:	deferred
Education:	some college
Occupation:	construction site manager x 30 years; wears hard hat when necessary; no known exposure to hazardous materials; high job satisfaction
Relationships:	married x 37 years, very happy with relationship
Sexual History:	erectile dysfunction (see PMHx) First experience age 17; 5-10 partners before wife, all female; not hx of STIs
Environment:	happily lives in home with wife and 2 cats
Support:	close with children; several good buddies from work
Military:	none

ROS

General:	(see HPI) Ht: 6'1", Wt 240 lbs. Denies recent weight changes
Skin:	(see HPI) No change in character of hair, nails or moles; denies tattoos/piercing

Head: denies dizziness or headaches

Eyes: (see HPI and PMHx) Glasses for reading x 22 years, glasses for distance x 40 years; no known retinopathy to date; no injury, infection, scotomata, photophobia, excessive lacrimation, injection, glaucoma, cataracts

Ears: denies hearing loss, tinnitus, vertigo, discharge

Nose/Sinus: no loss of smell, sinus pain, epistaxis, congestion, discharge, postnasal drip, frequent head colds

Oral Cavity: last dental exam 2 years ago; normal; no recent toothache or extractions; denies soreness of throat, bleeding, disturbance of taste, hoarseness, or change in voice

Neck: No pain, stiffness, masses

Nodes: no tenderness or enlargement of cervical, axillary, epitrochlear or inguinal nodes

Breast: no pain, masses, discharge

Resp: no dyspnea, chest pain, cough, sputum, hemoptysis, wheezing, exposure to TB; does not recall a recent CXR or PPD

Cardiac: (see PMHx) No chest pain, palpitation, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cyanosis or syncope

GI: appetite good, no dysphagia, heartburn, postprandial or abdominal pain, jaundice, nausea, vomiting, hematemesis; no excessive flatulence or bloating, obstipation; BMs daily, brown, well formed. Denies change change in stool, diarrhea, constipation, tenesmus, rectal conditions or hernia

GU: (see PMHx) Denies dysuria, frequency, nocturia, hematuria, pyuria, oliguria, problems with micturition, incontinence, renal colic, facial edema, hx of recurrent urinary tract infections or urinary tract calculi; no testicular pain, change in scrotal size, scrotal masses; does not examine testes; no penile pain, lesions, or

discharge; no disorders of the prostate; 2004 PSA testing was WNL

Extremities:

Vascular: (see HPI) No thrombophlebitis, varicose veins

Joints: (see HPI) No swelling, limitation of motion, morning stiffness

Muscles: no pain, cramps

Back: no pain, stiffness, limitation of motion, or injury

Central Nervous System:

General: no history of any loss of consciousness, convulsions

Mentative: no speech or memory disorders

Motor: no tremor, weakness, paralysis, clumsiness of movement

Sensory: (see HPI)

Hematopoietic no bleeding tendencies, anemia, transfusions, exposure to toxic chemicals or radiation, blood type unknown

Endocrine: (see HPI) No heat/cold intolerance, change in skin, inappropriate relationship between appetite and weight; no nervousness, tremors, hirsutism, no hormone therapy

Psych: denies mood changes, nervousness, anxiety, excessive crying, euphoria, depression, change in sleep pattern or concentrating ability, anhedonia, hallucination

PHYSICAL EXAM

This is a well-developed, overweight male sitting up in bed in no distress

Vitals:	T: 102.1 F (oral) P 90 RR 16 BP R sitting 130/88 BP L sitting 130/88 HT: 6'0" Wt: 245 lbs. BMI: 28
Skin:	ball of left foot: 0.5cm x 1.0cm ulceration with active bleeding and yellow/green foul smelling discharge; non-tender to insertion of sterile cotton tip applicator to depth of 1cm; a 1.5 cm smooth erythemetous border surrounds ulcer; shins and feet are hairless and shiny, cool to touch B/L; skin on rest of body has good turgor and is warm and dry; no rashes, bruises, cyanosis or clubbing of nails
Head:	atraumatic, scalp without rashes or lesions; hair with male pattern baldness
Eyes:	acuity 20/30 OS, 20/40 OD to handheld eye chart at 14 inches with reading glasses; eyebrows evenly distributed, conjunctiva pink, sclera non icteric, no ptosis or lid lag; no swelling of lacrimal apparatus; PERRL; EOM's intact, no nystagmus; visual fields without defect; fundus- discs well delineated, no A-V nicking, hemorrhages, exudates
Ears:	acuity good to whispered voice at one foot; auricles without pain on movement; canals patent; TMs gray with good light reflex, landmarks visualized
Nose:	nasal mucosa pink, septum midline, no sinus tenderness

Mouth: lips pink; buccal mucosa and gums pink and moist, no lesions; teeth in good repair, tongue protrudes midline, palate rises symmetrically, uvula remains midline, gag reflex present; pharynx pink, no exudate; tonsils present, not enlarged

Neck: supple, trachea midline, no lymphadenopathy, no thyromegaly; carotids equal and strong, no JVD, no bruits

Thorax/Lungs: symmetrical expansion, no retractions; AP:lateral diameter 1:2; tactile fremitus symmetrical, resonant to percussion; lungs clear, no rales, rhonchi, wheezes, rubs. Breath sounds vesicular

Cardiac: no lifts, heaves, thrills, visible pulsations; PMI 6th intercostal space 1cm lateral to left mid-clavicular line; regular rhythm, S1 S2 present, no S3 S4, no murmur, rubs or HJR

Breasts: no swelling, masses, or lesions; axillae without rashes, no lymphadenopathy

Abdomen: flat, well healed oblique scar, approx. 6cm, in RLQ, no lesions; no visible peristalsis or pulsations; bowel sounds present; no bruits; liver span 11 cm in right mid clavicular line; abdomen soft, no tenderness or masses; no inguinal lymphadenopathy; liver, spleen, kidneys not palpable; no CVA tenderness

GU: circumcised penis, meatus at tip, no ulcerations, no scrotal swelling or tenderness; testes of rubbery consistency, symmetrical, no masses

Rectal: no rashes, lesions of perianal area; good sphincter tone, no tenderness or masses; prostate smooth, firm, not enlarged, no masses; brown stool on glove, guaiac negative

MSS: no redness, swelling or deformity of joints; range of motion good in all joints, no tenderness spinal curvatures intact, iliac crests symmetrical

Vascular: (see skin) No calf tenderness, edema or varicosities

Pulses: (2+ = normal)

	Carotid	Brachial	Radial	Femoral	Popliteal	PT	DP
R	2+	2+	2+	2+	not palp	1+	1+
L	2+	2+	2+	2+	not palp	1+	1+

Neuro: Cranial Nerves

I- able to identify perfume and alcohol

II, III, IV, VI- see eyes

V- temporal and masseter muscles symmetrically strong, sensation intact to light touch and sharp on forehead, cheeks, jaw; corneal reflex not tested

VII- muscles of facial expression symmetric and strong

VIII- see ears

IX, X, XII- see mouth

XI- sternocleidomastoid muscle and trapezius muscles symmetrically strong

Motor: no atrophy, fasciculations, tremor; normal tone; muscle strength 5/5 in upper and lower extremities

Cerebellar: gait stable and fluid; omitted tests that stressed ulceration such as walking heel to toe, hopping on one foot, walking on heels and toes, and doing shallow knee bends; coordination good on rapid alternating movements and point to point testing

Sensory: diminished sensation to sharp, light touch, vibration of both feet up to the level of the distal ankle bilaterally; position sense, stereognosis; and graphesthesia intact; negative Romberg

Reflexes (2+ = normal)

	Biceps	Triceps	Supinator	Abdominal	Patellar	Achilles	Plantar
R	2+	2+	2+	2+	2+	2+	↓
L	2+	2+	2+	2+	2+	2+	omitted

Mental Status: Patient is alert, thoughts coherent, speech clear, oriented to time, place, person

Appendix 2

PRE-HOSPITAL INSTRUCTIONS (for students)

1. You will be expected to complete 4 hospital visits, meeting on selected afternoons, through the semester. The first visit will be history-taking ONLY. So you don't need to bring your diagnostic tools for the first session. Thereafter you will be performing a history and physical exam.
2. Arrive between 15-30 mins prior start time - you will need time to locate your preceptor.

   Attire: pressed, clean short white coat; ID; closed-toe shoes; hair pulled back; nails trimmed; professional attire; no perfume; limit jewelry; label/bring equipment starting session 2; no gum.

   Meet your preceptor; find pt: each student has 1 patient–sharing is not allowed; address pt. properly (Mr., Ms., Mrs.), and introduce self; ideally, 2 hours with pt.

   Special cases: family present; phone calls; physician enters; pt. taken for tests; pt. tires

   If short on time, start with most important questions/symptoms (HPI, meds, allergies, PMhx); If performing PE, do by systems–most important first, then complete as much as possible.

   Do not bring check-off sheets; cards only with brief 'memory joggers'; take minimal notes; + only
3. Meet back with preceptor to discuss the patient. Beginning with session #2 you will do a case presentation for the preceptor.
4. Written Assignment:

   Black pen, no white out; initial errors with one line drawn through; follow John/Jane Doe template; if something is forgotten, write "forgot to ask" or "deferred due to time"; Hand write-up in to your instructor within 48 hours of the visit. Include parallel chart which should be a page attached to your H&P. Things to include:

- What you discover about the patient and/or about the patients feelings/concerns that you would not put in the chart?
- What comes up for you when you work with the patient in terms of your feelings, concerns about the patient/concerns about your abilities?

5. Feedback: See rubric for how H&Ps are assessed – Only those sections corresponding to your assignment will be completed. For example, for the first hospital visit, only the history section of the evaluation form will be completed. As you progress through the course and your hospital assignments increase, the appropriate sections of the form will be completed by the instructor.
6. Remember, it's not a perfect world; be flexible. But if the experience is lacking educational value, please speak to your instructor regarding significant issues.

Appendix 3

Complete H&P Grading Rubric	
H&Ps should include a thorough evaluation of History of Present Illness, Medications, Allergies, including the Pertinent Review of Systems, Past Medical History, Social History and Family History. This should be followed by a complete history including the Review of Systems, Past Medical History, Social History and Family History. The complete Physical Examination should follow. Problem List, Assessment, Plan and initial orders should be included.	
Comments	**HPI**
	Contains CC in opening sentence. Descriptive first sentence that includes CC, relevant critical Hx, Pt age, location & nature of visit. Contains comprehensive description of symptom(s) (PQRST), includes critical ROS, PMH, fam hx, social hx, in order to rule out competing diagnoses and enable author to assess patient's status and disease progression. Contains Meds/Allergies
	Contains the majority of the characteristics above. Missing minor points in HPI
	Missing significant components of the HPI and fails to convey to reader information needed to assure differential considered and/ or patient's status
	Missing major components of the HPI.
ROS, Past Hx, Social Hx, Family Hx	
	Includes the remaining ROS, PMH, fam hx, social hx, and appropriately refers to the HPI when needed.

	Contains the majority of the characteristics above. Missing minor points.
	Missing more significant components of these sections
	Missing major components of these sections
Physical Exam	
	Contains a thorough description of all positive and negative exam findings. Items in exam include a positive finding that supports impression and is consistent with history.
	Partial exam included, minor discrepancies in findings, minor inconsistencies noted
	Exam missing one or two anatomic or system areas. Findings not consistent with diagnostic impression
	Exam missing significant portions of the physical exam. No relationship between exam and impression
Problem List	
	Includes a complete Problem List starting with the CC and related issues and including all problems
	Contains the majority of the above. Missing minor points.
	Missing significant number of the problems and fails to convey to reader information needed to assure differential considered and/ or patient's status
	Missing most of the above

Assessment	
	Impression is consistent with history and physical examination. Constructs appropriate differential diagnosis. Includes other longstanding and /or significant patient assessments.
	Impression correct but may be missing consideration of some diagnostic considerations and/or missing some established problems.
	Impression incorrect and inconsistent however demonstrates student knowledge of differential for CC and established patient problems.
	Impression fails to demonstrate student knowledge of differential
Plan	
	Contains all of the following components: disposition, follow-up, patient education, Therapeutics including pharmacologic or other interventions, referrals
	Missing one or two minor components for the plan or components partially incomplete
	Missing major components of management and follow up or treatment inappropriate for impression
	Management plan is inappropriate for impression and does not include management principles conducive to patient safety or good patient outcomes
Orders	
	Uses all components: **A**dmit, **D**iagnosis,

	Condition, **A**llergies, **V**itals, **A**ctivity, **N**ursing procedures, **D**iet, **I**V Fluids, **M**edications, **L**abs, and **O**ther appropriately
	Uses all components but missing minor points or missing one major component
	Missing some components and missing minor points
	Missing many components and/or orders inappropriate for problem

Hospital Visit #1

Prior to this hospital visit, the students will have received the instructions for the visit and a grading rubric for their histories and physical exams.

In setting up hospital visits, it is often the case that the clinical sites utilized are the same as those used for student clinical rotations. The difference in this case is the level of student supervision and instruction. For this reason, clinical faculty are usually compensated separately for the hours that they spend with students in this capacity. Whether or not they are paid, preceptors should be oriented to the objectives for the hospital sessions and counseled on patient selection and instructions to patients. In addition, they should be educated about what is expected from a student case presentation and how to give students feedback.

Appendix 1 includes the preceptor evaluation of the students' performance that should be done after all of the hospital sessions are completed.

Objectives: Upon completion of this unit the student will be able to:

1. Conduct a complete medical history by obtaining necessary biological, psychological, social, and cultural information from a patient.

2. Elicit a complete history, including history of present illness, medical history, surgical history, social history, and review of systems.

3. Illustrate the components of the analysis of a symptom used in constructing the HPI.

4. Utilize the medical review of systems to evaluate a patient's health status during the prior six months.

5. Determine what additional information obtained in the review of systems is relevant to the current illness.

6. Present a complete medical history in written form.

7. Create a parallel chart for the patient encounter.

Appendix 1

Hospital Session: STUDENT EVALUATION FORM

Student: _____ Date: _____

Evaluator:_____ (please print)

Eval. Signature:_____

Rating Scale:

O - Poor
1 - Below Average
2 - Average
3 - Above Average
4 - Outstanding

CATEGORY		RATING (circle one)				
1. **History taking** (30 total) Evaluate presentation accuracy and completeness of:						
A. Chief Complaint and History of Present Illness	(10)	0	1	2	3	4
B. Past History	(5)	0	1	2	3	4
C. Family History	(5)	0	1	2	3	4
D. Social History	(5)	0	1	2	3	4
E. Review of Systems	(5)	0	1	2	3	4

CATEGORY		RATING (circle one)				
2. **Physical Examination** (35 total) Evaluate presentation of						
A. Head and Neck	(5)	0	1	2	3	4
B. Heart and Lungs	(5)	0	1	2	3	4
C. Abdomen	(5)	0	1	2	3	4
D. Musculoskeletal	(5)	0	1	2	3	4
E. Peripheral Vascular	(5)	0	1	2	3	4
F. Neurological	(5)	0	1	2	3	4
G. Mental Status	(5)	0	1	2	3	4
3. **Presentation Skills** Evaluate accuracy, completeness and organization of presentation	(35 total)	0	1	2	3	4

COMMENTS: (use back of page for additional space) Adapted from: (UMDNJ "Hospital Session Student Evaluation Form")

Works Cited

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Unit 8

Narrative Medicine and Close Reading

This unit is designed to follow-up on the introduction to Narrative Medicine presented in Unit 1. In this unit narrative analysis is explored through a small group close reading exercise. The purpose of the close reading exercise is to allow the students to do a more detailed reading of the text than they have been up to this point. It is suggested that this discussion be conducted in small groups of 8-10 students per group. Facilitators should be familiar with the reading and the objectives of the assignment. If additional faculty are not available, this can be done in a large group setting. The correlations between close reading and close listening should be emphasized in this unit. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

At the end of unit there are three appendices. The first is the narrative for the in-class close reading exercise. The second is an evaluation form for grading the close reading assignments. The third appendix is the text for the close reading homework assignment.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Define narrative competence
2. Identify the benefits of close reading
3. Recognize that close reading can help a practitioner with close listening
4. Utilizing a narrative text, execute a detailed analysis including the identification of each of the following: Frame, Form, Temporality, Plot and Desire

SLIDE 2: Key Concepts/Sections

1. Narrative Competence and Close Reading
2. Understanding Frame, Form, Temporality, Plot and Desire

Section 1 - Narrative Competence and Close Reading

SLIDE 3: Narrative competence

- The ability to acknowledge, absorb, interpret and act on stories and plights of others
- How can we obtain narrative competence?
- Can be accomplished by reading literature closely and through reflective writing exercises

SLIDE 4: Close Reading (Parker)

- "detailed, careful attention to evidence from the text itself, to the words on the page"

Section 2 Understanding Frame, Form, Temporality, Plot and Desire

SLIDE 5; Framing the Text

- Where does the text comes from and how that influenced the meaning of the text?
- Where is the writer coming from and where is he/she going?
- What's been stated and what's been left out?

SLIDE 6: Form

Includes genre, visible structure, narrator, metaphor, allusion, and diction.

- ***Genre***, or the type of text - a poem, short story, novel, etc.

- ***Visible structure*** *is how the text is presented - chapters, verses or some other structure*
- ***Narrator*** is the story-teller. Every narrator has a specific relationship to the characters in the story.

SLIDE 7: Form Cont'

- ***Identification*** of metaphor assists in understanding the writer's meaning or intent.
- ***Allusion*** is the recognition that many texts refer to other texts. requires familiarity with many texts.
- ***Diction*** is the nature of the language used and the style of writing - conversational, formal or some other style of writing

SLIDE 8: Temporality

- Discerning time in a narrative and understanding temporal relationships

SLIDE 9: Plot

- The story itself - the sequence of events

SLIDE 10: Desire

- Refers to the fulfillment experienced in the reading of the text - our appetite to read and derive satisfaction from the text.

SLIDE 11: How can close reading help me as a clinician?

- The skills of close reading relate very directly to the skills that are needed in an encounter with a patient
- Training in close reading prepares you for medical practice
- Enhances the possibility for you to develop a truly therapeutic relationship with the patient

***Note to Instructor:** Small group close reading exercise for Richard Seltzer's "Brute" (see appendix 1)

Break students up into groups of 8-10 students to share responses and discuss the homework reading. Faculty facilitators will meet with students in small groups to guide the discussion of the essay.

Guide to conducting exercise: Students can be divided into groups of 8 – 10 students. After reading the text, students in group will work together to determine the elements of the essay as noted below. Discussion should be encouraged and all students should contribute.

> ***Plot* –** Beginning and ending this short story with statements of haunting regret, Selzer recollects a traumatic event from his residency training, 25 years before the writing of the story. He tells the story of a patient, brought in by the police, drunk and agitated; a huge black man with a gash in his forehead that needs suturing. The man is trying to fight off the policemen bringing him in but is finally restrained, tied to the emergency room stretcher. It is 2 am and Selzer is exhausted having been on call all day. As Selzer tries to examine the wound, the patient is uncooperative, tossing his head back and forth, cursing at him. Giving in to his anger and exhaustion, Selzer reaches for suture material and sews the man's earlobes to the stretcher mattress so that he cannot move his head. The patient gives up the struggle and Selzer cleans and sutures the wound. He snips the earlobe sutures and returns him to the police with his wound bandaged.
>
> ***Form* –** Selzer's work is in the form of a short story or essay and takes place in the present and 25 years before the writing of the story. The narrator is the doctor, Selzer, who takes the reader back to a time in his past. This first person account allows the reader to identify with the narrator's situation.

Time – Although this is written from the present as a flashback, the timing of this story is both very brief, just a few hours, and very long, as Selzer describes an incident that occurred 25 years prior. The episode itself starts at 2 am when the patient is brought in to the emergency room and ends at 5 am when the patient is returned to the policemen who brought him in. The regret that Selzer writes about is much of a much longer duration and promises to remain with him for as long as he can remember the encounter.

Frame – Selzer writes this story to tell the reader of his regret; to ask the reader to forgive his momentary weakness. Selzer carefully describes in detail, not only the events as they occurred but his thoughts as he responds to the events of that morning in the emergency room. Since Selzer cannot ask the man in the story for forgiveness for his barbaric behavior, Selzer asks the reader to bear witness, understand his human frailty and forgive.

Desire - The aim in this type of exercise is have the student explore a text in a way that reveals feelings and emotions that might connect them to the story's characters in much the same way that they might connect with their patients.

This exercise should – allow the students to recognize that the plot, frame, desire and timing of the patient's story can assist them in closely exploring the text in order to better understand the writer's frame of reference and message. The expectation is that this will strengthen the affiliation that the student might have for their patient in practice. After learning the skills of close reading, the student can transfer these to the patient encounter. He/she will be more attuned to the patient's story as they are to the text. They will be able to better understand the perspective of the patient and his/her family.

Homework: After reading "Mistakes" by David Hilfiker, (see appendix 2) work through a close reading analysis of the text. Add a final paragraph discussing your

experience of the exercise and noting whether or not it impacted your understanding of the text.

Evaluating the close reading exercise – see rubric (Appendix 3)

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Appendix 1

BRUTE

by Richard Selzer

You must never again set your anger upon a patient. You were tired, you said, and therefore it happened. Now that you have excused yourself, there is no need for me to do it for you.

Imagine that you yourself go to a doctor because you have chest pain. You are worried that there is something the matter with your heart. Chest pain is your Chief Complaint. It happens that your doctor has been awake all night with a patient who has been bleeding from a peptic ulcer of his stomach. He is tired. That is your doctor's Chief Complaint. I have chest pain, you tell him. I am tired, he says.

Still I confess to some sympathy for you. I know what tired is.

Listen: It is twenty-five years ago in the Emergency Room. It is two o'clock in the morning. There has been a day and night of stabbings, heart attacks and automobile accidents. A commotion at the door: A huge black man is escorted by four policemen into the Emergency Room. He is handcuffed. At the door, the man rears as though to shake off the men who cling to his arms and press him from the rear. Across the full length of his forehead is a laceration. It is deep to the bone. I know it even without probing its depths. The split in his black flesh is like the white wound of an ax in the trunk of a tree. Again and again he throws his head and shoulders forward, then back, rearing, roaring. The policemen ride him like parasites. Had he horns he would gore them. Blind and trussed, the man shakes them about, rattles them. But if one of them loses his grip, the others are still fixed and sucking. The man is hugely drunk .—toxic, fuming, murderous—a great mythic beast broken loose in the city, surprised in his night raid by a phalanx of legionnaires armed with clubs and revolvers.

I do not know the blow that struck him on the brow. Or was there any blow? Here is a brow that might have burst on its own, spilling out its excess of rage, bleeding itself toward ease. Perhaps it was done by a jealous lover, a woman, or a man who will not pay

him the ten dollars he won on a bet, or still another who has hurled the one insult that he cannot bear to hear. Perhaps it was done by the police themselves. From the distance of many years and from the safety of my little study, I choose to see it thus:

The helmeted corps rounds the street corner. A shout. "There he is!" And they clatter toward him. He stands there for a moment, lurching. Something upon which he had been feeding falls from his open mouth. He turns to face the policemen. For him it is not a new challenge. He is scarred as a Zulu from his many battles. Almost from habit he ascends to the combat. One or more of them falls under his flailing arms until—there is the swing of a truncheon, a sound as though a melon has been dropped from a great height. The white wedge appears upon the sweating brow of the black man, a waving fall of blood pours across his eyes and cheeks.

The man is blinded by it; he is stunned. Still he reaches forth to make contact with the enemy, to do one more piece of damage. More blows to the back, the chest and again to the face. Bloody spume flies from his head as though lifted by a great wind. The police are spattered with it. They stare at each other with an abstract horror and disgust. One last blow, and, blind as Samson, the black man undulates, rolling in a splayfooted circle. But he does not go down. The police are upon him then, pinning him, cuffing his wrists, kneeing him toward the van. Through the back window of the wagon—a netted panther.

In the Emergency Room he is led to the treatment area and to me. There is a vast dignity about him. He keeps his own counsel. What is he thinking? I wonder. The police urge him up on the table. They put him down. They restrain his arms with straps. I examine the wound, and my heart sinks. It is twelve centimeters long, irregular, jagged and, as I knew, to the skull. It will take at least two hours.

I am tired. Also to the bone. But something else . . . Oh, let me not deny it. I am ravished by the sight of him, the raw, untreated flesh, his very wildness which suggests less a human than a great and beautiful animal. As though by the addition of the wound, his body is more than it was, more of a body. I begin to cleanse and debride the wound. At my touch, he stirs and groans. "Lie still," I tell him. But now he rolls his head from side to side so that I cannot work. Again and again he lifts his pelvis from the table,

strains against his bonds, then falls heavily. He roars something, not quite language. "Hold still," I say. "I cannot stitch your forehead unless you hold still."

Perhaps it is the petulance in my voice that makes him resume his struggle against all odds to be free. Perhaps he understands that it is only a cold, thin official voice such as mine, and not the billy clubs of half-a-dozen cops that can rob him of his dignity. And so he strains and screams. But why can he not sense that I am tired? He spits and curses and rolls his head to escape from my fingers. It is quarter to three in the morning. I have not yet begun to stitch. I lean close to him; his steam fills my nostrils. "Hold still," I say.

"You fuckin' hold still," he says to me in a clear, fierce voice. Suddenly, I am in the fury with him. Somehow he has managed to capture me, to pull me inside his cage. Now we are two brutes hissing and batting at each other. But I do not fight fairly.

I go to the cupboard and get from it two packets of heavy, braided silk suture and a large curved needle. I pass one of the heavy silk sutures through the eye of the needle. I take the needle in the jaws of a needle holder, and I pass the needle through the center of his right earlobe. Then I pass the needle through the mattress of the stretcher. And I tie the thread tightly so that his head is pulled to the right. I do exactly the same to his left earlobe, and again I tie the thread tightly so that his head is facing directly upward.

"I have sewn your ears to the stretcher," I say. "Move, and you'll rip 'em off." And leaning close I say in a whisper, "Now you fuckin' hold still."

I do more. I wipe the gelatinous clots from his eyes so that he can see. And I lean over him from the head of the table, so that my face is directly above his, upside down. And I grin. It is the cruelest grin of my life. Torturers must grin like that, beheaders and operators of racks.

But now he does hold still. Surely it is not just fear of tearing his earlobes. He is too deep into his passion for that. It is more likely some beastly wisdom that tells him that at last he has no hope of winning. That it is time to cut his losses, to slink off into high grass. Or is it some sober thought that pierces his wild brain, lacerating him in such a way that a hundred nightsticks could not? The thought of a woman who is waiting for him,

perhaps? Or a child who, the next day and the week after that, will stare up at his terrible scars with a silent wonder that will shame him? For whatever reason, he is perfectly still.

It is four o'clock in the morning as I take the first stitch in his wound. At five-thirty, I snip each of the silks in his earlobes. He is released from his leg restrainers and pulled to a sitting position. The bandage on his head is a white turban. A single drop of blood in each earlobe, like a ruby. He is a maharajah.

The police return. All this time they have been drinking coffee with the nurses, the orderlies, other policemen, whomever. For over three hours the man and I have been alone in our devotion to the wound. "I have finished," I tell them. Roughly, they haul him from the stretcher and prod him toward the door. "Easy, easy," I call after them. And, to myself, if you hit him again...

Even now, so many years later, this ancient rage of mine returns to peck among my dreams. I have only to close my eyes to see him again wielding his head and jaws, to hear once more those words at which the whole of his trussed body came hurtling toward me. How sorry I will always be. Not being able to make it up to him for that.

Appendix 2

MISTAKES

by David Hilfiker

On a warm July morning I finish my rounds at the hospital around nine o'clock and walk across the parking lot to the clinic. After greeting Jackie, I look through the list of my day's appointments and notice that Barb Daily will be in for her first prenatal examination. "Wonderful," I think, recalling the joy of helping her deliver her first child two years ago. Barb and her husband, Russ, had been friends of mine before Heather was born, but we grew much closer with the shared experience of. her birth. In a rural family practice such as mine, much of every weekday is taken up with disease; I look forward to the prenatal visit with Barb, to the continuing relationship with her over the next months, to the prospect of birth.

At her appointment that afternoon, Barb seems to be in good health, with all the signs and symptoms of pregnancy: slight nausea, some soreness in her breasts, a little weight gain. But when the nurse tests Barb's urine to determine if she is pregnant, the result is negative. The test measures the level of a hormone that is produced by a woman and shows up in her urine when she is pregnant. But occasionally it fails to detect the low levels of the hormone during early pregnancy. I reassure Barb that she is fine and schedule another test for the following week.

Barb leaves a urine sample at the clinic a week later, but the test is negative again. I am troubled. Perhaps she isn't pregnant. Her missed menstrual period and her other symptoms could be a result of a minor hormonal imbalance. Maybe the embryo has died within the uterus and a miscarriage is soon to take place. I could find out by ordering an ultrasound examination. This procedure would give me a "picture" of the uterus and of the embryo. But Barb would have to go to Duluth for the examination. The procedure is also expensive. I know the Dailys well enough to know they have a modest income. Besides, by waiting a few weeks, I should be able to find out for sure without the ultrasound: either the urine test will be positive or Barb will have a miscarriage. I call her

and tell her about the negative test result, about the possibility of a miscarriage, and about the necessity of seeing me again if she misses her next menstrual period.

It is, as usual, a hectic summer; I think no more about Barb's troubling state until a month later, when she returns to my office. Nothing has changed: still no menstrual period, still no miscarriage. She is confused and upset. "I feel so pregnant," she tells me. I am bothered, too. Her uterus, upon examination, is slightly enlarged, as it was on the previous visit. But it hasn't grown any larger. Her urine test remains negative. I can think of several possible explanations for her condition, including a hormonal imbalance or even a tumor. But the most likely explanation is that she is carrying a dead embryo. I decide it is time to break the bad news to her.

"I think you have what doctors call a 'missed abortion,' "I tell her. "You were probably pregnant, but the baby appears to have died some weeks ago, before your first examination. Unfortunately, you didn't have a miscarriage to get rid of the dead tissue from the baby and the placenta. If a miscarriage doesn't occur within a few weeks, I'd recommend a re-examination, another pregnancy test, and if nothing shows up, a dilation and curettage procedure to clean out the uterus.

Barb is disappointed; there are tears. She is college-educated, and she understands the scientific and technical aspects of her situation, but that doesn't alleviate the sorrow. We talk at some length and make an appointment for two weeks later.

When Barb returns, Russ is with her. Still no menstrual period; still no miscarriage; still another negative pregnancy test, the fourth. I explain to them what has happened. The dead embryo should be removed or there could be serious complications. Infection could develop; Barb could even become sterile. The conversation is emotionally difficult for all three of us. We schedule the dilation and curettage for later in the week.

Friday morning, Barb is wheeled into the small operating room of the hospital. Barb, the nurses, and I all know one another—it's a small town. The atmosphere is warm and relaxed; we chat before the operation. After Barb is anesthetized, I examine her pelvis again. Her muscles are now completely relaxed, and it is possible to perform a more reliable examination. Her uterus feels bigger than it did two days ago; it is perhaps

the size of a small grapefruit. But since all the pregnancy tests were negative and I'm so sure of the diagnosis, I ignore the information from my fingertips and begin the operation.

Dilation and curettage, or D & C, is a relatively simple surgical procedure performed thousands of times each day in this country. First, the cervix is stretched by pushing smooth metal rods of increasing diameter in and out of it. After about five minutes of this, the cervix has expanded enough so that a curette can be inserted through it into the uterus. The curette is another metal rod, at the end of which is an oval ring about an inch at its widest diameter. It is used to scrape the walls of the uterus. The operation is done completely by feel after the cervix has been stretched, since it is still too narrow to see through.

Things do not go easily this morning. There is considerably more blood than usual, and it is only with great difficulty that I am able to extract anything. What should take ten or fifteen minutes stretches into a half-hour. The body parts I remove are much larger than I expected, considering when the embryo died. They are not bits of decomposing tissue. These are parts of a body that was recently alive!

I do my best to suppress my rising panic and try to complete the procedure. Working blindly, I am unable to evacuate the uterus completely; I can feel more parts inside but cannot remove them. Finally I stop, telling myself that the uterus will expel the rest within a few days.

Russ is waiting outside the operating room. I tell him that Barb is fine but that there were some problems with the operation. Since I don't completely understand what happened, I can't be very helpful in answering his questions. I promise to return to the hospital later in the day after Barb has awakened from the anesthesia.

In between seeing other patients that morning, I place several almost frantic phone calls, trying to piece together what happened. Despite reassurances from a pathologist that it is "impossible" for a pregnant woman to have four consequent negative pregnancy tests, the realization is growing that I have aborted Barb's living child. I won't know for sure until the pathologist has examined the fetal parts and determined the

baby's age and the cause of death. In a daze, I walk over to the hospital and tell Russ and Barb as much as I know for sure without letting them know all I suspect. I tell them that more tissue may be expelled. I can't face my own suspicions.

Two days later, on Sunday morning, I receive a tearful call from Barb. She has just passed some recognizable body parts; what is she to do? She tells me that the bleeding has stopped now and that she feels better. The abortion I began on Friday is apparently over. I set up an appointment to meet with her and Russ to review the entire situation.

The pathologist's report confirms my worst fears: I aborted a living fetus. It was about eleven weeks old. I can find no one who can explain why Barb had four negative pregnancy tests. My meeting with Barb and Russ later in the week is one of the hardest things I have ever been through. I described in some detail what I did and what my rationale had been. Nothing can obscure the hard reality: I killed their baby.

Politely, almost meekly, Russ asks whether the ultrasound examination would have shown that Barb was carrying a live baby. It almost seems that he is trying to protect my feelings, trying to absolve me of some of the responsibility. "Yes," I answer, "if I had ordered the ultrasound, we would have known the baby was alive." I cannot explain why I didn't recommend it.

Mistakes are an inevitable part of everyone's life. They happen; they hurt—ourselves and others. They demonstrate our fallibility. Shown our mistakes and forgiven them, we can grow, perhaps in some small way become better people. Mistakes, understood this way, are a process, a way we connect with one another and with our deepest selves.

But mistakes seem different for doctors. This has to do with the very nature of our work. A mistake in the intensive care unit, in the emergency room, in the surgery suite, or at the sickbed is different from a mistake on the dock or at the typewriter. A doctor's miscalculation or oversight can prolong an illness, or cause a permanent disability, or kill a patient. Few other mistakes are more costly.

Developments in modern medicine have provided doctors with more knowledge of the human body, more accurate methods of diagnosis, more sophisticated technology to help in examining and monitoring the sick. All of that means more power to intervene in the disease process. But modern medicine, with its invasive tests and potentially lethal drugs, has also given doctors the power to do more harm.

Yet precisely because of its technological wonders and near-miraculous drugs, modern medicine has created for the physician an expectation of perfection. The technology seems so exact that error becomes almost unthinkable. We are not prepared for our mistakes, and we don't know how to cope with them when they occur.

Doctors are not alone in harboring expectations of perfection. Patients, too, expect doctors to be perfect. Perhaps patients have to consider their doctors less prone to error than other people: how else can a sick or injured person, already afraid, come to trust the doctor? Further, modern medicine has taken much of the treatment of illness out of the realm of common sense; a patient must trust a physician to make decisions that he, the patient, only vaguely understands. But the degree of perfection expected by patients is no doubt also a result of what we doctors have come to believe about ourselves, or better, have tried to convince ourselves about ourselves.

This perfection is a grand illusion, of course, a game of mirrors that everyone plays. Doctors hide their mistakes from patients, from other doctors, even from themselves. Open discussion of mistakes is banished from the consultation room, from the operating room, from physicians' meetings. Mistakes become gossip, and are spoken of openly only in court. Unable to admit our mistakes, we physicians are cut off from healing. We cannot ask for forgiveness, and we get none. We are thwarted, stunted; we do not grow.

During the days, and weeks, and months after I aborted Barb's baby, my guilt and anger grew. I did discuss what had happened with my partners, with the pathologist, with obstetric specialists. Some of my mistakes were obvious: I had relied too heavily on one test; I had not been skillful in determining the size of the uterus by pelvic examination; I should have ordered the ultrasound before proceeding to the D & C. There was no way I

could justify what I had done. To make matters worse, there were complications following the D & C, and Barb was unable to become pregnant again for two years.

Although I was as honest with the Dailys as I could have been, and although I told them everything they wanted to know, I never shared with them my own agony. I felt they had enough sorrow without having to bear my burden as well. I decided it was my responsibility to deal with my guilt alone. I never asked for their forgiveness.

Doctors' mistakes, of course, come in a variety of packages and stem from a variety of causes. For primary care practitioners, who see every kind of problem from cold sores to cancer, the mistakes are often simply a result of not knowing enough. One evening during my years in Minnesota a local boy was brought into the emergency room after a drunken driver had knocked him off his bicycle. I examined him right away. Aside from swelling and bruising of the left leg and foot, he seemed fine. An x-ray showed what appeared to be a dislocation of the foot from the ankle. I consulted by telephone with an orthopedic specialist in Duluth, and we decided that I could operate on the boy. As was my usual practice, I offered the patient and his mother (who happened to be a nurse with whom I worked regularly) a choice: I could do the operation or they could travel to Duluth to see the specialist. My pride was hurt when she decided to take her son to Duluth.

My feelings changed considerably when the specialist called the next morning to thank me for the referral. He reported that the boy had actually suffered an unusual muscle injury, a posterior compartment syndrome, which had twisted his foot and caused it to appear to be dislocated. I had never even heard of such a syndrome, much less seen or treated it. The boy had required immediate surgery to save the muscles of his lower leg. Had his mother not decided to take him to Duluth, he would have been permanently disabled.

Sometimes a lack of technical skill leads to a mistake. After I had been in town a few years, the doctor who had done most of the surgery at the clinic left to teach at a medical school. Since the clinic was more than a hundred miles from the nearest surgical center, my partners and I decided that I should get some additional training in order to be

able to perform emergency surgery. One of my first cases after training was a young man with appendicitis. The surgery proceeded smoothly enough, but the patient did not recover as quickly as he should have, and his hemoglobin level (a measure of the amount of blood in the system) dropped slowly. I referred him to a surgeon in Duluth, who, during a second operation, found a significant amount of old blood in his abdomen. Apparently I had left a small blood vessel leaking into the abdominal cavity. Perhaps I hadn't noticed the oozing blood during surgery; perhaps it had begun to leak only after I had finished. Although the young man was never in serious danger, although the blood vessel would probably have sealed itself without the second surgery, my mistake had caused considerable discomfort and added expense.

Often, I am sure, mistakes are a result of simple carelessness. There was the young girl I treated for what I thought was a minor ankle injury. After looking at her x-rays, I sent her home with what I diagnosed as a sprain. A radiologist did a routine follow-up review of the x-rays and sent me a report. I failed to read it carefully and did not notice that her ankle had been broken. I first learned about my mistake five years later when I was summoned to a court hearing. The fracture I had missed had not healed properly, and the patient had required extensive treatment and difficult surgery. By that time I couldn't even remember her original visit and had to piece together what had happened from my records.

Some mistakes are purely technical; most involve a failure of judgment. Perhaps the worst kind involve what another physician has described to me as "a failure of will." She was referring to those situations in which a doctor knows the right thing to do but doesn't do it because he is distracted, or pressured, or exhausted.

Several years ago, I was rushing down the hall of the hospital to the delivery room. A young woman stopped me. Her mother had been having chest pains all night. Should she be brought to the emergency room? I knew the mother well, had examined her the previous week, and knew of her recurring bouts of chest pains. She suffered from angina; I presumed she was having another attack.

Some part of me knew that anyone with all-night chest pains should be seen right away. But 1 was under pressure. The delivery would make me an hour late to the office, and I was frayed from a weekend on cab, spent mostly in the emergency room. This new demand would mean additional pressure. “No,” I said, “take her over to the office, and I’ll see her as soon as I’m done here.” About twenty minutes later, as I was finishing the delivery, the clinic nurse rushed into the room. Her face was pale. “Come quick! Mrs. Helgeson just collapsed.” I sprinted the hundred yards to the office, where I found Mrs. Helgeson in cardiac arrest. Like many doctors’ offices at the time, ours did not have the advanced life-support equipment that helps keep patients alive long enough to get them to a hospital. Despite everything we did, Mrs. Helgeson died.

Would she have survived if I had agreed to see her in the emergency room, where the requisite staff and equipment were available? No one will ever know for sure. But I have to live with the possibility that she might not have died if I had nor had “a failure of will.” There was no way to rationalize it: I had been irresponsible and a patient had died.

Many situations do not lend themselves to a simple determination of whether a mistake has been made. Seriously ill, hospitalized patients, for instance, require of doctors almost continuous decision-making. Although in most cases no single mistake is obvious, there always seem to be things that could have been done differently or better: administering more of this medication, starting that treatment a little sooner . . . The fact is that when a patient dies, the physician is left wondering whether the care he provided was adequate. There is no way to be certain, for it is impossible to determine what would have happened if things had been done differently. Often it is difficult to get an honest opinion on this even from another physicians most doctors nor wanting to be perceived by their colleagues as judgmental43r perhaps fearing similar judgments upon themselves. In the end, the physician has to suppress the guilt and move on to the next patient.

A few years after my mistake with Barb Daily, Maiya Martinen first came to see me halfway through her pregnancy. I did not know her or her husband well, but I knew that they were solid, hard-working people. This was to be their first child. When I examined Maiya, it seemed to me that the fetus was unusually small, and I was uncertain

about her due date. I sent her to Duluth for an ultrasound examination which was by now routine for almost any problem during pregnancy—and an examination by an obstetrician. The obstetrician thought the baby would be small, but he thought it could be safely delivered in the local hospital.

Maiya's labor was uneventful, except that in took her longer than usual to push the baby through to delivery. Her baby boy was born blue and floppy, but he responded well to routine newborn resuscitation measures. Fifteen minutes after birth, however, he had a short seizure. We checked his blood sugar level and found it to be low, a common cause of seizures in small babies who take longer than usual to emerge from the birth canal. Fortunately, we were able to put an IV easily into a scalp vein and administer glucose, and baby Marko seemed no improve. He and his mother were discharged from the hospital several days later.

At about two months of age, a few days after I had given him his first set of immunizations, Marko began having short spells. Not long after that he started no have full-blown seizures. Once again the Martinens made the trip to Duluth, and Marko was hospitalized for three days of tests. No cause for the seizures was found, but he was placed on medication. Marko continued to have seizures, however. When he returned for his second set of immunizations, in was clear to me that he was not doing well.

The remainder of Marko's short life was a tribute to the faith and courage of his parents. He proved severely retarded, and the seizures became harder and harder no control. Maiya eventually went East for a few months so Marko could be treated at the National Institutes of Health. Bun nothing seemed no help, and Maiya and her baby returned home. Marko had to be admitted frequently to the local hospital in order to control his seizures. An two o'clock one morning I was called to the hospital: the baby had had a respiratory arrest. Despite our efforts, Marko died, ending a year-and-a-half struggle with life.

No cause for Marko's condition was ever determined. Did something happen during the birth that briefly cur off oxygen to his brain? Should Maiya have delivered at the high-risk obstetric center in Duluth, where sophisticated fetal monitoring is available?

Should I have sent Marko to the Newborn Intensive Care Unit in Duluth immediately after his first seizure in the delivery room? I subsequently learned than children who have seizures should not routinely be immunized. Would it have made any difference if I had never given Marko the shots? There were many such questions in my mind and, I am sure, in the minds of the Martinens. There was no way to know the answers, no way for me to handle the guilt feelings I experienced, perhaps irrationally, whenever I saw Maiya.

The emotional consequences of mistakes are difficult enough no handle. Bun soon after I started practicing I realized I had no face another anxiety as well: it is non only in the emergency room, the operating room, the intensive care unit, or the delivery room that a doctor can blunder into tragedy. Errors are always possible, even in the midst of the humdrum routine of daily care. Was that baby with dir-rhea more dehydrated than he looked, and should I have hospitalized him? Will that nine-year-old with stomach cramps whose mother I just lectured about psychosomatic illness end up in the operating room tomorrow with a ruptured appendix? Did that Vietnamese refugee have a problem I didn't understand because of the language barrier? A doctor has to confront the possibility of a mistake with every patient visit.

My initial response to the mistakes I did make was to question my competence. Perhaps I just didn't have the necessary intelligence, judgment, and discipline to be a physician. But was I really incompetent? My University of Minnesota Medical School class had voted me one of the two most promising clinicians. My diploma from the National Board of Medical Examiners showed scores well above average. I knew that the townspeople considered me a good physician; I knew that my partners, with whom I worked daily, and the consultants to whom I referred patients considered me a good physician, too. When I looked at it objectively, my competence was not the issue. I would have to learn to live with my mistakes.

A physician is even less prepared to deal with his mistakes than is the average person. Nothing in our training prepares us to respond appropriately. As a student, I was simply not aware that the sort of mistakes I would eventually make in practice actually happened to competent physicians. As far as I can remember from my student experience

on the hospital wards, the only doctors who ever made mistakes were the much maligned "LMDs"—local medical doctors. They would transfer their patients who weren't doing well to the University Hospital. At the " U," teams of specialist physicians with their residents, interns, and students would take their turns examining the patient thoroughly, each one delighted to discover (in retrospect, of course) an "obvious" error made by the referring LMD. As students we had the entire day to evaluate and care for our five to ten patients. After we examined them and wrote orders for their care, first the interns and then the residents would also examine them and correct our orders. Finally, the supervising physician would review everything. It was pretty unlikely that a major error would slip by; and if it did, it could always be blamed on someone else on the team. We had very little feeling for what it was like to be the LMD, working alone with perhaps the same number of hospital patients plus an office full of other patients; but we were quite sure we would not be guilty of such grievous errors as we saw coming into the U.

An atmosphere of precision pervaded the teaching hospital. The uncertainty that came to seem inescapable to me in northern Minnesota would shrivel away at the U as teams of specialists pronounced authoritatively upon any subject. And when a hospital physician did make a significant mistake, it was first whispered about the halls as if it were a sin. Much later a conference would be called in which experts who had had weeks to think about the case would discuss the way it should have been handled. The embarrassing mistake was frequently not even men-toned; it had evaporated. One could almost believe that the patient had been treated perfectly. More important, only the technical aspects of the case were considered relevant for discussion. It all seemed so simple, so clear. How could anyone do anything else? There was no mention of the mistake, or of the feelings of the patient or the doctor. It was hardly the sort of environment in which a doctor might feel free to talk about his mistakes or about his emotional responses to them.

Medical school was also a very competitive place, discouraging any sharing of feelings. The favorite pastime, even between classes or at a party, seemed to be sharing with the other medical students the story of the patient who had been presented to one's

team, and then describing in detail how the diagnosis had been reached, how the disease worked, and what the treatment was. The storyteller, having spent the day re-searching every detail of the patient's disease, could, of course, dazzle everyone with the breadth and depth of his knowledge. Even though I knew what was going on, the game still left me feeling incompetent, as it must have many of my colleagues. I never knew for sure, though, since no one had the nerve to say so. It almost seemed that one's peers were the worst possible persons with whom to share those feelings.

Physicians in private practice are no more likely to find errors openly acknowledged or discussed, even though they occur regularly. My own mistakes represent only some of those of which I am aware. I know of one physician who administered a potent drug in a dose ten times that recommended; his patient almost died. Another doctor examined a child in an emergency room late one night and told the parents the problem was only a mild viral infection. Only because the parents did not believe the doctor, only because they consulted another doctor the following morning, did the child survive a life-threatening infection. Still another physician killed a patient while administering a routine test: a needle slipped and lacerated a vital artery. Whether the physician is a rural general practitioner with years of experience but only basic training or a recently graduated, highly trained neurosurgeon working in a sophisticated technological environment, the basic problem is the same.

Because doctors do not discuss their mistakes, I do not know how other physicians come to terms with theirs. But I suspect that many cannot bear to face their mistakes directly. We either deny the misfortune altogether or blame the patient, the nurse, the laboratory, other physicians, the system, fate—anything to avoid our own guilt.

The medical profession seems to have no place for its mistakes. Indeed, one would almost think that mistakes were sins. And if the medical profession has no room for doctors' mistakes, neither does society. The number of malpractice suits filed each year is symptomatic of this. In what other profession are practitioners regularly sued for hundreds of thousands of dollars because of misjudgments? I am sure the Dailys could have successfully sued me for a large amount of money had they chosen to do so.

The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our culpability, and the professional denial that mistakes happen all work together to create an intolerable dilemma for the physician. We see the horror of our mistakes, yet we cannot deal with their enormous emotional impact. Perhaps the only way to face our guilt is through confession, restitution, and absolution. Yet within the structure of modern medicine there is no place for such spiritual healing. Although the emotionally mature physician may be able to give the patient or family a full description of what happened, the technical details are often so difficult for the layperson to understand that the nature of the mistake is hidden. If an error is clearly described, it is frequently presented as "natural," "understandable," or "unavoidable" (which, indeed, it often is). But there is seldom a real confession: "This is the mistake I made; I'm sorry." How can one say that to a grieving parent? to a woman who has lost her mother

If confession is difficult, what are we to say about restitution? The very nature of a physician's work means that there are things that cannot be restored in any meaningful way. What could I do to make good the Dailys' loss?

I have not been successful in dealing with a paradox: I am a healer, yet I sometimes do more harm than good. Obviously, we physicians must do everything we can to keep mistakes to a minimum. But if we are unable to deal openly with those that do occur, we will find neurotic ways to protect ourselves from the pain we feel. Little wonder that physicians are accused of playing God. Little wonder that we are defensive about our judgments, that we blame the patient or the previous physician when things go wrong, that we yell at nurses for their mistakes, that we have such high rates of alcoholism, drug addiction, and suicide.

At some point we must all bring medical mistakes out of the closet. This will be difficult as long as both the profession and society continue to project their desires for perfection onto the doctor. Physicians need permission to admit errors. They need permission to share them with their patients. The practice of medicine is difficult enough without having to bear the yoke of perfection

Appendix 3

Grading Rubric for Close Reading Exercises

		Comments
Frame (10)	Does the student address the following: Where does the text come from? What does it answer?	
Form (60)	Does the student address the following: Genre – Type of literary text Visible structure – how the text is organized or arranged Narrator – who is narrating? Are they reliable, believable? Metaphor –identify symbolism, allegory or images in the text Allusion – Does the text allude to other well known texts? Diction – How is the language of the text written? Casual? Conversational, etc.?	

		Comments
Time (10)	Does the student address the following: Duration, order, and temporal structure of the text	
Plot (10)	Does the student address the following: What happens in the story.	
Desire (10)	Does the student address the following: What might be the at the heart of the text in terms of the desires of the narrator and reader?	

Unit 9

Case presentations

This unit is designed to teach the student how to present a patient case in the hospital or office setting. It reviews the importance of case presentation in professional communication and goes over the various types of case presentations that may be required. Examples of each type are also provided. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

At the end of unit there are four appendices. The first appendix includes the guide for the instructor role play for the small group exercise. The second appendix is the full history and physical for the instructors use. The third appendix is a handout for the student which includes all the information needed to complete the homework assignment and the last appendix is the expected responses to the homework assignment.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1 - Objectives

Upon completion of this unit the student will be able to:

1. Identify the purpose of a case presentation
2. Recognize the varying audiences for case presentations
3. Discuss the types of case presentations
4. Describe the general format of a case presentation

SLIDE 2 – Key Concepts/Sections

- Purpose of case presentation
- Types of case presentations – Grand rounds, formal and short
- General format of a presentation

SECTION 1 - Purpose of case presentation (Palfreyman "Case Presentations")

SLIDE 3

- As a student on rotation you will routinely present at least 1-2 times a day in the hospital setting. (many more in an out-patient setting)

SLIDE 4: Purpose of the case presentation

- Communicate information about a patient to other health care providers on the team
- As a student, it helps to demonstrate clinical competence to supervisors
- You must be able to present in a clear, complete but concise manner
- It is a difficult skill to master…so it requires practice

SLIDE 5: "Rounds"

- Any gathering of the health care team in which the patient is discussed

SLIDE 6: Audience

- Other students
- Interns, first year residents (PGY-1)
- Residents (usually PGY-2 or higher)
- Fellows
- Physician Assistants
- Attending Physicians
- Other members of the health care team

SECTION 2 - Types of case presentations – Grand rounds, formal and short

SLIDE 7: Types of Presentations

- Grand Rounds
- Formal Presentation
- The Short Presentation

SLIDE 8: Grand Rounds

- Departmental conferences
- Morbidity and mortality conferences
- Patient presentations are complete and long (commonly 5-10 minutes)
- Usually followed by discussion of case
- Usually cases are nearing the end and are through their treatment plan
- Done for teaching purposes

SLIDE 9: The Formal Presentation

- Morning sign-in or afternoon sign-out rounds
- Bedside or chart rounds
- Present your findings to a superior or the team so that they can comment on or take over care
- Usually about 5 minutes long
- At the end there should be clear understanding of the case
- Discussion usually follows
- Work-up, diagnosis, treatment, etc is usually included

SLIDE 10: The Short Presentation

- Used extensively as student on clinical rotation

- When a specific question is asked
- When a specific fact needs to be conveyed
- Question or info is expressed after presenting the patient scenario – that is putting it into context of the specific patient
- Very brief (less than 1 minute)
- Only includes info that is necessary to put question or information into context

SECTION 3 - General Format of Presentations

SLIDE 11

- The amount of detail warranted will depend on the type of presentation you are doing
- Needs and wants of preceptors will vary
- A good rule of thumb is to give more than less in the beginning

SLIDE 12: What is included in the presentation?

CC and first line of HPI

- Included in all types of presentations
- Should convey to team in the same way that you would write it

SLIDE 13: History

For Grand Rounds

- Paraphrase or read actual HPI
- Entire history is included

SLIDE 14

For Formal Presentation

- Paraphrase or read actual HPI

- Only include the pertinent positive and negative data that will contribute to assessment

SLIDE 15

For Short Presentation

- Most of HPI and other data omitted
- Only present what is necessary to give context to information
- Question is often what to omit not what to include

SLIDE 16: Physical

For all presentations:

- Always start with a statement on appearance and vital signs
- Focus on the body systems involved with chief complaint
- This could be multiple systems (think HTN, CAD, DM etc)
- Include all significant abnormal findings and any normal findings that help rule in or out diagnoses
- Include significant abnormalities from other systems but omit irrelevant abnormalities

SLIDE 17: Labs and Tests

- Report only normals and abnormals that aid in assessment

SLIDE 18: Pithy Sentence or Impression

- Summary statement putting all the information together
- Should only be 1-2 sentences

SLIDE 19: Assessment/Plan

- ***Briefly*** list differential
- Concisely explain how to proceed with management

SLIDE 20: Tips for Presenting

- Remember rules of good story telling
- Logical beginning, middle, end
- Speak as you would write in terms of organization, but don't include everything you would write…they can look up the details on their own
- Speak clearly

SLIDE 21

- Engage your listener
- What is special about this case?

SLIDE 22

- Be sensitive to who can hear you
- Especially be aware at nurses' station
- Be sure you are familiar with HIPAA rules

SLIDE 23

- Know your patient
- Include only the essential facts; but be ready to answer ANY questions about all aspects of your patient.
- Anticipate what your team will want to know
- Expect that your listeners will ask questions

SLIDE 24

Practice

- Look for opportunities to practice
- Be willing to accept constructive criticism

SLIDE 25: Example of Short Presentation for a problem: Post Op Patient with Fever

A nurse calls you and one of the patients you are following patients has a fever. You check out the patient and call the MD with what you want to do.

I was notified by the nurse that Sam Smith, the gentleman who is post op day one from a right hemi-colectomy has a fever of 102. I went and checked on him ….he says he has been using his incentive spirometry, he said he feels fatigued and achy but denies headache, chest pain, SOB, urinary symptoms and pain in the legs. On exam he was slightly tachycardic at 110 bpm but his remaining vitals were normal. He had no neck pain and his lungs were clear. The incision looked clean, dry and intact but it was moderately tender. No superpubic tenderness or CVS tenderness and negative for Homan's sign.

I would like to do cultures of the wound, urine and blood. I perscribed 2 extra strength tylenol for the fever. I will be back in touch when I get the culture results.

SLIDE 26: Another example where there is a specific question: Woman in labor:

A patient is in early labor and you want to give her demerol since she is too early for an epidural.

"Your patient, Mary Brooks, who was admitted for induction of labor with Pitocin is complaining of moderate pain and is exhausted. I would like her to be able to get a little rest before she progresses along too far. Her vital signs are normal. Her cervix is only 1 cm, 80% effaced, -2 station. The fetal heart tracing is reassuring…I would like to get her a some demerol via IV since she is a little early for the epidural…."

SLIDE 27: Example of Formal Presentation (based on case from last week):

This is a 64-year old white male with a history of type 2 diabetes mellitus and HTN x 20 years who presents with a bloody/pus stained left sock. The patient felt well until three days ago when he noticed a small red and yellow stain on his left sock,

corresponding to the ball of his foot. Each night since, the stain has enlarged and he has had a sensation of wetness on the sole of his left foot. Last night the stain totally saturated the bottom portion of his sock with blood and now green pus. He notes that the wet feeling seems more pronounced when walking and less noticeable when elevating his foot. In addition to the wetness, he has felt fatigue and malaise over the past 2 days.

SLIDE 28: CASE CONTINUED:

Over the last 24 hours he has felt "feverish" but he has not checked his temperature. He cannot view the sole of his foot therefore he does not know the source of the wetness and he is unsure if there is an ulceration, rash or color changes to the area. This is the first time this condition has occurred. He has observed a loss of hair and shiny skin on his lower legs and shins x 2-3 years. His feet are often cold and he wears socks to bed. He denies pain or any trauma to his left foot or left leg. He further denies weakness, chills, night sweats, pruritus, tendency to bruise, excessive skin dryness, visual changes, intermittent claudication, lower extremity color changes, edema, polyuria, polydipsia or polyphagia, and anesthesia or paresthesia.

SLIDE 29: CASE CONTINUED:

Typical blood sugar readings are in the 130s mg/dL, however in the last five days, they have been in the 150-200 mg/dL range. He receives routine examinations for his DM and HTN every 3 months.

SLIDE 30: CASE CONTINUED:

Medications: metformin 1000mg bid

- glyburide 5mg bid
- lisinopril 20mg QD
- hydrochlorothiazide 25mg QD
- one baby ASA QD

Allergies: PCN-causes rash

SLIDE 31: CASE CONTINUED:

On Physical Exam:

Vitals: T: 102.1 F (oral); P 90; RR 1; BP 130/88; HT: 6'0"; Wt: 245 lbs.; BMI: 28

Skin: ball of left foot: 0.5cm x 1.0cm ulceration with active bleeding and yellow/green foul smelling discharge; non-tender to insertion of sterile cotton tip applicator to depth of 1cm; a 1.5 cm smooth erythematous border surrounds ulcer; shins and feet are hairless and shiny, cool to touch B/L

SLIDE 32: CASE CONTINUED:

Vascular:

Pulses: (2+ = normal)(NP = Not palpable)

	Carotid	**Brachial**	**Radial**	**Femoral**	**Popliteal**	**PT**	**DP**
R	2+	2+	2+	2+	NP	1+	1+
L	2+	2+	2+	2+	NP	1+	1+

Sensory: diminished sensation to sharp, light touch, vibration of both feet up to the level of the distal ankle bilaterally; position sense, stereognosis; and graphesthesia intact

SLIDE 33: CASE CONTINUED:

Assessment

1. Diabetic left foot ulcer with pus x 3 days and fever x 1day
   R/O osteomyelitis
   R/O abscess

2. Type 2 DM
   R/O poor control
3. Diabetic neuropathy
4. Diminished DP/PT pulses with shiny skin and hair loss
   R/O peripheral vascular disease
5. HTN x 20 years; current readings slightly elevated
   R/O poor control

***Note to Instructor:** Role Play with Instructor in Small Groups: Abby Lipasito (UMDNJ "Instructor Role Play H.P.I.") (See Appendices 1 and 2)

- Students take turns asking history questions and develop the HPI together in small group
- Give students 15 - 20 minutes to complete the HPI
- Go over the HPI
- Handout to students the complete history and PE at the end of class (See Appendix C)
- Homework is to develop Pertinent Positives List, Problem List, and Assessment (See Appendix 4)

Works Cited

Palfreyman, Lori. "Case Presentations." UMDNJ, 2011. *UMDNJ PA Program*. Print.

UMDNJ, PA Program. "Instructor Role Play H.P.I." Piscataway, NJ: University of Medicine and Dentistry of NJ, n.d. Print.

Appendix 1

Role Play Guide for Instructor

CC: abdominal pain x 2 hours

34 year-old white female
Ht. 5'7", Wt. 145 pounds
ER fast track, 10:00am

Analysis of a Symptom

well until this morning
awoke at her usual time (7am)
nauseous and anorexic x 3 hours
about an hour later began to experience abdominal pain (so pain x 2 hours)
never had pain like this in the past

- onset was sudden; within hour of nausea
- relieved by lying on side with knees flexed or when leaning forward
- severe knifelike midepigastric
- midepigastric with radiation to her back
- 9 on 10 point scale
- it has been constant for past 2 hours

GI ROS: Last food or drink 15 hours ago
Dinner eaten at home last night: baked chicken, salad and glass of water
Last BM; yesterday morning (24 hours ago) described as "normal": brown and firm
The rest of GI ROS is negative

GU ROS: LMP X 2 weeks ago, no other vaginal discharge
Last PAP 6 months ago; normal
She has urinated twice since awakening stream was strong and steady

ALL the rest is negative

General ROS:

Daily fatigue attributed to the SLE. Takes afternoon nap to help. Rest is negative

Recent Illnesses:

sore throat and lymphadenopathy last week x 3 days. Gargled with salt water.; no tx sought; resolved spontaneously

Effect of Illness:

The patient is concerned that this may be due to her SLE and is upset that this may indicate a worsening of her disease. She is anxious to get home to care for her daughter.

Medications: 2 ibuprofen for tension headaches, 2x/month for "many years"
MVI c/ Fe QD

Allergies: PCN: rash**.** Denies any other allergies

Medical History:

Child: chicken pox, age 7, no complications or sequelae; general health was good

Adult**:** SLE, diagnosed 2007 during pregnancy; specific testing or results not recalled; since dx symptoms intermittently flair up; she has not required any medications or hospitalizations; currently she suffers from daily fatigue (she takes an afternoon nap to alleviate it), sometimes with accompanying knee or shoulder joint pain, and rashes and pigmentary changes with sun exposure; attends support group for SLE patients bimonthly.

General: Dr. Susan Stone; (see adult) St. Peters in New Brunswick, NJ; regular visits q 3 months; last exam 2 months ago, no change in status, no blood work or meds prescribed

Surgery: 1983, appendectomy; JFK Hospital X one week, general anesthesia, postoperative wound infection, treated successfully with antibiotics, no sequelae

Hospitalizations:

See Surgery

- 2007, NSVD of female infant, JFK Hospital, epidural anesthesia w/o complications; 4 day stay for observation secondary to recent diagnosis of SLE
- 1987, viral meningitis, JFK Hospital X 3 days, Dr. Kernig, lumbar puncture performed, therapy unknown, no complications or sequelae

Injuries: 1980; fractured L ankle due to fall, placed in cast x 4 weeks; used crutches; no complications or sequelae

Fam Hx:

MGM:	↑ 74; HTN, RA
MGF:	↓71; MI, ETOH abuse
PGM:	↑79; good health
PGF:	↑80; Alzheimer's disease
Mother:	↑56; RA, skin problem (specifics unknown)
Father:	↑58; emphysema
Sister:	↑37; RA, hyperthyroidism
Brother:	↑35; good health
Husband:	↑32; good health
Daughter:	↑ 5; good health
Mat. Aunt:	↑58; SLE

SocHx:

Sleeps:	6 hours/night fairly restful, naps 1 hour daily to prevent fatigue
ETOH:	none since college (over 10 years ago); drank beer on weekends at that time
Tobacco:	never
Illicit drugs:	marijuana, 1-2 joints per week when hanging out with friends x 10 yrs.; cocaine 2x in college, snorted, denies injecting any drugs ever

Diet: three meals/day; some snacks, lots of fruit, limits fat intake, avoids sugars

Exercise: brisk walks of 1-2 miles/day

Caffeine: none

Education: 4 year college degree

Occupation:

Journalist, works out of her home, is satisfied with her job; decreased workload since birth of daughter and diagnosis of SLE so that work is not stressful; no exposure to hazards

Relationship: Married, happy in her relationship with husband and daughter

Sexual history:

Sexually active with her husband 3x/week; uses diaphragm for contraception; first experience at age 18, has had four partners in the past, all male. Denies history of STDs or HIV testing.

Environment: Single family home in safe community. Has house cleaner weekly-housework tires her out

Support: close to family; any friends; active in support group for SLE; active in local women's group

Appendix 2

Abby Lipasito

Date:

Time:

CC: Abdominal pain and X 2 hours

HPI:

This is a 34-year old white female with a history of systemic lupus erythematosus (SLE) x 5 years who presents to the ER complaining of abdominal pain x 2 hours. The patient was well until 3 hours ago when she awoke feeling nauseous and anorexic. Approximately one hour later she began to experience constant abdominal pain, described as severe "knifelike" mid-epigastric pain that radiates to her back. She rates the pain as a 9 on a 10-point scale. She has never had pain like this before. The pain is relieved somewhat when she lies on her side with her knees flexed or when she leans forward. Her last meal (baked chicken and salad with a glass of water) was approximately 15 hours ago. Her last bowel movement was about 24 hours ago; described as brown and firm. She denies weakness, fever, chills, dysphagia, heartburn, post prandial pain, jaundice, vomiting, hematemesis, excessive flatulence/bloating, obstipation, diarrhea, constipation, tenesmus, rectal conditions or hernias. She has urinated twice since awakening; stream is strong and steady with no dysuria, nocturia, hematuria, pyuria, oliguria, incontinence, or renal colic. She has no history of renal stones or recurrent UTIs. LMP was 2 weeks ago: normal; she denies vaginal discharge.

She reports having an appendectomy as a child. She maintains a well-balanced, low fat diet. She denies any alcohol use in over 10 years. The patient is concerned that this illness may be due to her SLE and is upset that this may indicate a worsening of her disease. She is also anxious to get home to care for her daughter.

Medications: 2 ibuprofen for tension headaches, no more than 2x/month
1 multi-vitamin with Fe QD

Allergies: penicillin- gets rash
denies food, seasonal, environment, or animal allergies or intolerances

PMH

Child: + chicken pox, age 7, no complications or sequelae
general health as a child was good.

Adult: + SLE, diagnosed in 2007 during pregnancy; specific testing or results not recalled by patient at this time. Since time of dx, symptoms intermittently flair up; she has not required medications or hospitalizations at any time; currently she suffers from daily fatigue, sometimes with accompanying knee or shoulder joint pain, and rashes and skin changes with sun exposure; attends support group for SLE patients bimonthly

Denies cardiovascular disease, hypertension, heart murmur, stroke/TIA, respiratory diseases, kidney disease, endocrine disorders including diabetes and thyroid, cancer, liver disease/hepatitis, HIV, and mental health conditions

General: Dr. Susan Stone, St. Peter's Medical Center, New Brunswick, NJ; regular checkups every three months (see med hx); last exam two months ago- no change in status; no blood work done

Surgery: 1983; appendectomy; JFK Hospital x 1 week; general anesthesia tolerated well; complicated by post-operative wound infection treated with antibiotics; no sequelae

Hospitalizations:

2007; NSVD of full term female, JFK Hospital, epidural anesthesia without complications; four-day stay for observation secondary to recent diagnosis of SLE (see Adult Hx)

1987, viral meningitis, JFK Hospital x three days; dx via lumbar puncture; therapy unknown; no complications or sequelae

Injuries: 1980, fractured left ankle; casted for four weeks; no complications or sequelae

Immunizations: last tetanus in 1995; MMR, polio, DPTs given as a child; denies hepatitis, pneumococcal, hepatitis A, or influenza immunizations

Family History:

MGM	74; hypertension, rheumatoid arthritis
MGF	71; MI, h/o alcoholism
PGM	79; good health
PGF	80; Alzheimer's disease
Mother	56; rheumatoid arthritis, "skin problems" (specifics unknown)
Father	58; emphysema
Sister	37; rheumatoid arthritis, hyperthyroidism
Brother	35; good health
Husband	32; good health
Daughter	5; good health
Mat. Aunt	58; SLE

No family history of stroke/TIA, kidney disease, other endocrine disorders including diabetes, cancer, HIV, mental health conditions, migraines, tuberculosis, bleeding disorders/anemia, or allergies

Social History

born:	3/18/xx, Edison, New Jersey
residence:	New Jersey all her life
recent travel:	none
sleep:	6 hours/night, "fairly" restful, naps one hour daily to prevent fatigue
alcohol:	(see HPI)
tobacco:	denies ever using

illicit drugs: smokes approximately 1-2 marijuana "joints" per week x 10 years; experimented with snorting cocaine 2 times in college; denies injecting drugs

diet: (See HPI) three meals/day; lots of fruit, limits amount of fat intake

caffeine: none

exercise: brisk walks of 1-2 miles per day

safety screen: deferred

Education: BA; journalism

Occupation: journalist; satisfied with job; works primarily from home and has reduced workload since diagnosis of SLE in order to decrease stress; no known exposure to hazards

Relationship: married; happy in relationship with husband; denies history of abuse

Sexual Hx: sexually active approx. 3x/wk; uses diaphragm for contraception; first experience at age 18, four partners in the past, all male; denies h/o of STDs or HIV testing

Environment: single home in safe community; does not do house cleaning due to exacerbation of SLE symptoms

Support: close to family; has many friends and colleagues; active in support group for SLE patients, active in local women's group

Military: denies

Review of Systems

General: (see HPI and adult hx); height: 5' 5"; weight: 135 pounds with no recent gain or loss; denies weakness, malaise, night sweats

Skin: (see Adult Hx); tattoos or piercings, tendency to bruise, lesions, excessive dryness or change in character of hair, nails, moles

Head: tension headaches in occipital region, usually triggered by work and caring for her child, occur approximately 2x month "many years", relieved with 2 OTC ibuprofen; denies dizziness

Eyes: no use of glasses or contact lenses; last eye exam in high school; denies any visual loss, injury, infection, scotomata, photophobia, excessive lacrimation, injection, glaucoma, or cataracts

Ears: denies known hearing loss; tinnitus, vertigo, discharge

Nose/Sinuses: denies loss of smell, sinus pain, epistaxis, congestion, discharge, post nasal drip, frequent head colds

Oral Cavity: + sore throat 1 week ago x 3 days- gargled and increased fluid intake- did not seek medical advice; last dental exam three months ago for routine checkup; no recent toothaches or extractions; denies sore throat, bleeding, taste disturbance, hoarseness, or change in voice

Neck: denies pain, stiffness or masses

Nodes: + tenderness and enlargement of cervical nodes 1 week ago x 3 days- resolved spontaneously; denies tenderness or enlargement of axillary, epitrochlear or inguinal nodes

Breasts: denies pain, masses, discharge, monthly self-exam, never had a mammogram; last breast exam by health care provider 6 months ago- reported as "normal"

Respiratory: denies dyspnea, chest pain, cough, sputum, hemoptysis, wheezing, exposure to TB, last chest x-ray two years ago- negative; never had PPD

Cardiac: denies chest pain/discomfort, palpitations, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cyanosis, syncope; last EKG two years ago: normal

GI: (see HPI)

GU: (see HPI)

Menstrual: menarche age 13; cycles 28-30 days, normal flow x 6 days; denies premenstrual pain, dysmenorrhea, intermenstrual bleeding

Obstetrical: G_1, P_{1001}

Gyn: denies dyspareunia, coital bleeding, endometriosis, uterine fibroids, ovarian cysts; last PAP: 6 months ago: normal; no history of an abnormal PAP

Ext:	*Vascular:* denies intermittent claudication, ulceration, coldness of extremities, hair loss, thrombophlebitis or edema, or varicose veins *Joints:* (see Adult Hx) swelling, limitation of motion, or morning stiffness *Muscles:* denies pain or cramps
Back:	denies pain, stiffness, limitation of motion, or injury
CNS:	*General:* denies history of loss of consciousness or convulsions *Mentative:* denies speech memory disorders *Motor:* denies tremors, weakness, paralysis, or clumsiness *Sensory:* denies anesthesia, paresthesia, or pain
Hemat:	denies bleeding tendencies, anemia, transfusions, exposure to toxic agents or radiation; blood type: O+
Endo:	denies heat/cold intolerance, inappropriate relationship between appetite and weight, nervousness, tremors, polyuria, polydipsia, polyphagia, hirsutism, or past or present use hormone therapy
Psych:	denies mood changes, nervousness, anxiety, excessive crying, euphoria, depression, changes in sleep pattern or concentrating ability; anhedonia, hallucinations

PHYSICAL EXAM

This is a well-developed, well-nourished female lying supine on the exam table with knees flexed in moderate distress; she appears her stated age of 34.

Vitals:	T: 99.8 F (O); P: 102; R: 21; BP: 126/84 R arm sitting; O2 sat of room air 98% Ht. 5'7" Wt. 145lbs.
Skin:	+ erythematous, macular eruption over bridge of nose and both cheeks, no oozing or lesions; + 3 cm oblique scar RLQ, well healed; no bruises, cyanosis, or clubbing of nails; skin has good turgor, and is warm, dry
Head:	atraumatic, no rashes, lesions or alopecia
Eyes:	acuity 20/20 OU with hand held chart at 14 inches without glasses; eyebrows evenly distributed; conjunctiva pink, sclera nonicteric, no ptosis or lid lag; no swelling of lacrimal apparatus; PERRL, EOM's intact, no nystagmus; visual fields without defect; fundi-discs well delineated, no A-V nicking, hemorrhages, exudates
Ears:	acuity good to whispered voice at one foot; auricles without pain on movement; canals patent; TM's gray with good light reflex, landmarks visualized
Nose:	nasal mucosa pink, septum midline, no sinus tenderness
Mouth:	lips pink; buccal mucosa and gums pink and moist, no lesions; teeth in good repair, tongue protrudes in midline, palate rises symmetrically, uvula remains in midline, gag reflex present; pharynx pink, no exudates; tonsils present, not enlarged
Neck:	supple, trachea midline, carotids equal and strong; no lymphadenopathy, thyromegaly, bruits or JVD

Thorax &

Lungs: symmetrical expansion, no retractions; AP:lateral diameter 1:2; tactile fremitus symmetrical, resonant to percussion; lungs clear, no rales, rhonchi, wheezes, rubs; breath sounds vesicular

Heart: no lifts, heaves, thrills, visible pulsations; PMI 5th intercostal space, left MCL; regular rhythm, S1 S2 present, no S3 S4, murmurs, rubs, or HJR

Breasts: no rashes, lesions, skin dimpling or retractions; nipples central, no tenderness or discharge; breasts soft, no masses or tenderness; no axillary lymphadenopathy

Abdomen: (See Skin) Flat, + striae present over lower quadrants, no lesions or visible peristalsis or pulsations; bowel sounds hypoactive, no bruits; liver span 9 cm in right MCL; abdomen firm, tender to light palpation in midepigastrium, tender to deep palpation over entire abdomen; no rebound, referred rebound or Rovsing's, no masses; liver, spleen, kidneys not palpable; no CVA tenderness, Murphy's sign, psoas sign, obturator sign, or cutaneous hyperesthesia

Genitalia:

External: no rashes, swelling, lesions

Vagina: walls moist; no lesions or discharge

Cervix: slightly to left, parous, no lesions, or discharge from os

Bimanual: cervix mobile, nontender; uterus normal size, anterior, no palpable masses; ovaries normal size and non-tender

Rectal: no rashes, lesions of perianal area; good sphincter tone, no tenderness or masses; brown stool on glove, guaiac negative

MSS: no redness, swelling or deformity of joints; range of motion good in all joints, no tenderness; spinal curvatures intact, iliac crests symmetrical

Vascular: Denies calf tenderness, edema, varicosities

Pulses: 2 + = normal

	Carotid	Brachial	Radial	Femoral	Popliteal	PT	DP
R	2+	2+	2+	2+	2+	2+	2+
L	2+	2+	2+	2+	2+	2+	2+

Neuro:

CN:

I: Able to identify perfume and cinnamon

II, III, IV, VI: See eyes

V: Temporal and masseter muscles symmetrically strong; sensation intact to light touch and sharp on forehead, cheeks, jaw; corneal reflex not tested

VII: Muscles of facial expression symmetric and strong

VIII: See ears

IX, X, XII: See mouth

XI: Sternocleidomastoid and trapezius muscles symmetrically strong

Motor: no atrophy, fasciculations, tremor. Normal tone. Muscle strength 5/5 in upper and lower extremities

Cerebellar: Gait stable and fluid; able to walk heel to toe, hop on one foot, walk on heels and toes, and do shallow knee bends. Coordination good on rapid alternating movements and point to point testing

Sensory: Sensation to sharp, light touch, vibration, position sense, stereognosis; and graphesthesia intact. Negative Romberg

Reflexes: 2 + = normal

	Biceps	Triceps	Supinator	Abdomen	Knee	Achilles	plantar
R	2+	2+	2+	2+	2+	2+	↓
L	2+	2+	2+	2+	2+	2+	↓

Mental Status: Patient is alert, thoughts coherent, speech clear, oriented to time, place, and person

Appendix 3

Student Handout for Abby Lipasito

PMH

Child: + chicken pox, age 7, no complications or sequelae
general health as a child was good.

Adult: + SLE, diagnosed in 2007 during pregnancy; specific testing or results not recalled by patient at this time. Since time of dx, symptoms intermittently flair up; she has not required medications or hospitalizations at any time; currently she suffers from daily fatigue, sometimes with accompanying knee or shoulder joint pain, and rashes and skin changes with sun exposure; attends support group for SLE patients bimonthly

Denies cardiovascular disease, hypertension, heart murmur, stroke/TIA, respiratory diseases, kidney disease, endocrine disorders including diabetes and thyroid, cancer, liver disease/hepatitis, HIV, and mental health conditions

General: Dr. Susan Stone, St. Peter's Medical Center, New Brunswick, NJ; regular checkups every three months (see med hx); last exam two months ago- no change in status; no blood work done

Surgery: 1983; appendectomy; JFK Hospital x 1 week; general anesthesia tolerated well; complicated by post-operative wound infection treated with antibiotics; no sequelae

Hospitalizations:

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1987, viral meningitis, JFK Hospital x three days; dx via lumbar puncture; therapy unknown; no complications or sequelae

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CN:

I: Able to identify perfume and cinnamon

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Reflexes: 2 + = normal

	Biceps	Triceps	Supinator	Abdomen	Knee	Achilles	plantar
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L	2+	2+	2+	2+	2+	2+	↓

Mental Status: Patient is alert, thoughts coherent, speech clear, oriented to time, place, and person

Appendix 4

Homework Responses:

Pertinent positives from Hx. & PE

midepigastric, sharp abdominal pain radiating to the back x 2 hours
nausea x 3 hours
anorexia x 3 hours
tachycardia
tachypnea
hypoactive bowel sounds
generalized tenderness of the abdomen
S/P appendectomy

sore throat with cervical lymphadenopathy 1 week ago by history

SLE x 5 years
current malar rash
daily fatigue
joint pain in knees and shoulders

FH of SLE, rheumatoid arthritis, hyperthyroidism, alcoholism, Alzheimer's
no recent eye exam
Hx of marijuana use- 1-2 joints per week x 10 years
allergic to penicillin; gets rash

Problem List

1. acute midepigastric abdominal pain x 2 hours with nausea, anorexia and decreased bowel sounds
2. SLE

3. allergy to penicillin
4. regular marijuana usage

Assessment

1. Midepigastric bdominal pain, nausea, anorexia, hypoactive bowel sounds

R/O acute pancreatitis

R/O cholecystitis

R/O acute intestinal obstruction

R/O perforated peptic ulcer

R/O ectopic

2. SLE- stable

Hospital Visit #2

This will be the second visit to the hospital for the students. Unlike the first visit, in this visit the students will perform the history and physical exam. During this visit the students will each do a short presentation for the hospital preceptor. Their homework assignments will include a written record of the history, physical exam, pertinent positives, problem list and assessment. In addition they will create a parallel chart for this visit.

Appendix 1 includes the preceptor evaluation of the students' performance that should be done after all of the hospital sessions are completed.

Objectives

Upon completion of this unit the student will be able to:

1. Elicit a complete history, including history of present illness, medical history, surgical history, social history, and review of systems.
2. Perform a complete physical exam based on the history elicited.
3. Formulate a problem list and assessment based on the history and physical exam findings.
4. Create a parallel chart for the patient encounter.

Appendix 1

Hospital session student evaluation form

Student: _____Date: _____

Evaluator:_____ (please print)

Eval. Signature:_____

Rating Scale:

O - Poor
1 - Below Average
2 - Average
3 - Above Average
4 - Outstanding

CATEGORY		RATING (circle one)				
1. **History taking** (30 total) Evaluate presentation accuracy and completeness of:						
A. Chief Complaint and History of Present Illness	(10)	0	1	2	3	4
B. Past History	(5)	0	1	2	3	4
C. Family History	(5)	0	1	2	3	4
D. Social History	(5)	0	1	2	3	4
E. Review of Systems	(5)	0	1	2	3	4

CATEGORY		RATING (circle one)				
2. **Physical Examination** (35 total) Evaluate presentation of						
A. Head and Neck	(5)	0	1	2	3	4
B. Heart and Lungs	(5)	0	1	2	3	4
C. Abdomen	(5)	0	1	2	3	4
D. Musculoskeletal	(5)	0	1	2	3	4
E. Peripheral Vascular	(5)	0	1	2	3	4
F. Neurological	(5)	0	1	2	3	4
G. Mental Status	(5)	0	1	2	3	4
3. **Presentation Skills** (35 total) Evaluate accuracy, completeness and organization of presentation		0	1	2	3	4

(Adapted from: (UMDNJ "Hospital Session Student Evaluation Form")

COMMENTS: (use back of page for additional space)

Works Cited

UMDNJ, PA Program. “Hospital Session Student Evaluation Form.” Piscataway, NJ: UMDNJ nd. Print.

Unit 10

The Plan

This unit is designed to teach the student how to formulate the plan. Once the assessment is made a plan of action needs to be put in place. In this unit the student will learn about the components of the plan and be given specific examples. The in class review of the hospital histories and physicals will provide an opportunity for the students to practice presentation skills and to develop a problem list, assessment and plan as a group. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit.

There is no formal homework assignment for this unit.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives

Upon completion of this unit the student will be able to:

1. Given a complete medical history and physical examination, develop an appropriate plan
2. Develop a plan that includes all key components: diagnostics, therapeutics, patient education, and future plans/referrals
3. Utilize alternative Assessment/Plan format

SLIDE 2: Key Concepts/Sections

- The Plan
- Diagnostics
- Therapeutics
- Patient Education and Health Maintenance
- Future Intentions and Referrals

Section 1 - The Plan

SLIDE 3: The Plan (UMDNJ PA Program Faculty)

1. After a presumptive or differential diagnosis has been made:
    - Clinician needs to formulate a plan in order to arrive at a definitive diagnosis
2. Once the diagnosis is made:
    - Plan should be revised to include how the clinician would like to treat the illness

SLIDE 4: Example

- For a patient with chest pain the plan would include those diagnostics needed to prove or disprove the theory of MI (e.g. EKG, serum cardiac enzymes, etc.)

SLIDE 5

While the diagnosis is being established,

- therapeutics are initiated (e.g. O2, morphine, anti-thrombolytic agents, etc) in order to treat for the most likely diagnoses in the assessment and to provide supportive care
- Opportunity for the health care practitioner to document how he/she intends to handle the patient's illness
- Plan is also the document through which health care providers communicate with one another regarding patient management

SLIDE 6: Components of the Plan

The plan is comprised of four major components:

- Diagnostics
- Therapeutics
- Patient Education and Health Maintenance

- Future Intentions and Referrals

Section 2 - Diagnostics

SLIDE 7: Diagnostics

List the diagnostic studies or laboratory tests to be ordered or performed, *and* the time frame requested.

- Example: CBC in AM.
- 2-D echocardiogram within 24 hours
- CXR: PA & lateral now

Section 3 - Therapeutics

SLIDE 8: Therapeutics

- Describe the therapeutic treatment plan including rationale for any change or addition to an existing plan
- Remember that this can include medications, physical therapy, speech therapy, etc.
    - *Example: Ampicillin 2 gm IV secondary to positive culture results*
      Physical therapy daily

Section 4 - Patient Education and Health Maintenance

SLIDE 9: Patient Education and Health Maintenance

Describe health education provided or planned

- *Example: Limit sodium intake*
- *Instruction for wound care and dressing change*

Include health maintenance issues where appropriate

- *Example: Increase exercise, recommend 1-2 mi aerobic walking, 3-4 X / wk*
- *Tetanus booster today*

Section 5 - Future Intensions and Referrals

SLIDE 10: Future Intensions and Referrals

Pertains to plan for tracking patient's status

- *Example: Recheck wound in 4 hours*
- *Follow-up on laboratory studies later today*
- *Patient to be discharged home tomorrow AM*

List any referrals and indication

- *Example: Refer to nutritionist for assistance with diabetic diet*
- *Refer to cardiologist for evaluation of arrhythmia*

SLIDE 11: Example

Given this Assessment:

1. Fatigue, headache, dyspnea on exertion
   - r/o anemia
   - r/o Lyme disease
   - r/o COPD
   - r/o hypothyroidism
2. Hypertension, controlled
3. Low back pain, likely secondary to muscle strain
4. Decreased visual acuity

SLIDE 12: Plan:

5. CBC with differential, Chem 7/BMP (Na, K, Cl, BUN, CR, CO2, glucose), reticulocyte count, serum ferritin, Lyme Elisa, PFT's, CXR, TSH; RTC in 1 week for review of labs
6. Continue Prinivil 20mg po QD # 30, 5 refills; monitor BP at home, low-sodium diet and continue exercise, office recheck 6 mos.
7. Ibuprofen 400 mg qid, avoid heavy lifting, abdominal muscles strengthening via exercise, provide pt handout
8. refer patient to ophthalmology

SLIDE 13: Alternative Format

***Assessment / Plan**:*

1. Fatigue, headache, dyspnea on exertion
    - r/o anemia
    - r/o Lyme disease
    - r/o COPD
    - r/o hypothyroidism
    - CBC with differential, Chem 7 (Na, K, Cl, BUN, CR, CO2, glu), reticulocyte count, serum ferritin, Lyme Elisa, PFT's, CXR, TSH.
    - RTC 1 week to review labs results.

SLIDE 14

2. Hypertension, controlled
    - Continue Prinivil 20mg po QD #30, 5 refills
    - Office recheck BP 6 months
    - Monitor BP at home
    - Low sodium diet
    - Continue exercise

SLIDE 15

3. Low back pain, likely due to muscle strain
    - Ibuprofen, 400 mg. qid
    - Avoid heavy lifting
    - Strengthen abdominal muscles via exercise, patient handout given

SLIDE 16

4. Decreased visual acuity
    - Ophthalmology referral

REMEMBER that *ideally* your plan should be reviewed with the patient and have the patient's approval before orders are entered

***Note to the instructor**: At this point students should break up into small groups to review of second hospital visit write-up. Graded H&Ps are returned to students and they are given time to review. Instructor will prearrange to have one student present their HPI along with pertinent positives from the remainder of the history and the physical exam. Student and instructor will lead a group exercise to develop the problem list, assessment and plan. Instructor will also take this opportunity to meet with students individually to discuss write-up.

Works Cited

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Unit 11

Orders

This unit is designed to teach the student how to write medical orders. Once the assessment and plan are determined, orders need to be written in order for the plan to be carried out. In this unit the student will learn about the components of orders and be given specific examples. The in class role play exercise will provide an opportunity for the students to develop a plan and orders. There are 2 appendices for this unit. The first is the pertinent information that students will need to formulate orders and the second is the response to the exercise – the orders that should be formulated by the students. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit. The homework assignment for this unit will prepare students for next unit.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives:

Upon completion of this unit the student will be able to:

1. Given a complete medical history and physical examination, Assessment and Plan develop appropriate orders.
2. Develop orders that includes all key components: Admit, Diagnosis, Condition, Allergies, Vitals, Nursing procedures, Diet, IV Fluids, Medications, Labs and Other

SLIDE 2: Key concepts/Sections

Orders including:

- Admission
- Diagnosis
- Condition

- Allergies
- Vital Signs
- Nursing procedures
- Diet
- IV Fluids
- Medications
- Labs and Other

Section 1 - Orders

SLIDE 3: Orders (UMDNJ PA Program Faculty)

- Instructions given by the provider to other members of the health care team regarding any and all therapeutics, diagnostics, consultations, etc. to be conducted
- prepared when the patient is first admitted to the hospital and each time thereafter when he or she is transferred to another service (e.g. post op.)
- Written throughout the entire stay as necessary for the treatment of the patient
- Staff will "pick up" these orders and initiate their implementation - imperative that these orders be clear, concise, thorough, and most of all legible (when hand-written)

SLIDE 4: Mnemonic can help

- **"ADCAVANDIMLO"** is used to aid the clinician in recalling the components of the admission, transfer, & post-operative order
- It stands for **A**dmit, **D**iagnosis, **C**ondition, **A**llergies, **V**itals, **A**ctivity, **N**ursing procedures, **D**iet, **I**V Fluids, **M**edications, **L**abs, and **O**ther.

SLIDE 5: Orders

Admit to: Note room # or hospital unit, and team, attending physician, hospitalist, etc. who is responsible for patient's care

SLIDE 6

Diagnosis: Admitting/working diagnosis *or* S/P procedure-if post-operative

SLIDE 7

Condition: Stable, unstable, critical, guarded, etc. and Code Status: Full or DNR

SLIDE 8

Allergies: Note any drug reactions, food, or significant environmental allergies (ex. latex).

SLIDE 9

Vitals: Specific type of vitals to be obtained by the nursing staff and frequency. This can include temperature, pulse, blood pressure, O2 saturation, respiratory rate, and weight. It is not acceptable to state "per protocol."

SLIDE 10

Activity: Specify strict bed rest, ambulate ad lib or ambulate TID, OOB for bathroom privileges, up to chair, up with assistance only, etc.

SLIDE 11

Nursing Procedures: (as appropriate)

- ***Ins & Outs:*** Generally refers to recording the amounts of fluids that the patient takes in or puts out over a certain period of time via whatever mechanism or process. For example: I's-IV fluids, PO intake, etc; O's-urine output, vomiting, NG suctioning, etc

- ***Drains:*** List any and all drains to be monitored; may request insertion of Foley catheter if needed
- ***Bed Positions:*** Specify position of bed if relevant. For example: elevate head of bed 30 degrees; Trendelenberg; keep supine; etc.

SLIDE 12

Nursing Procedures con't

- ***Preps:*** Any special preparations such as enemas, betadine scrubs, or showers to be done
- ***Respiratory:*** Chest PT, spirometry, or tracheal suctioning and frequency
- ***Wound Care:*** May include type of dressing changes (wet to dry) and frequency
- ***Glucose:*** Frequency of finger sticks if needed
- ***Others:*** Any other pertinent information you as the provider may want to know about the patient. For example: notify house officer if: temperature > 101 F; SBP >160 or < 90 (specify systolic and diastolic parameters); pulse > 110 or < 50.

SLIDE 13

Diet: Indicate the dietary restrictions such as: NPO (nothing by mouth), clear liquids, regular diet, 1800 calorie ADA, low sodium, etc.

SLIDE 14

IV Fluids: Order specific type and rate as appropriate, for example: NS @125cc/hr.

SLIDE 15

Medications: Specify the medications you are prescribing including name, dosage, frequency, route of administration, and duration. Do not write: "as per admission orders" or "per routine" or "as tolerated"

SLIDE 16

Labs/Studies: Indicate labs or studies and specify time frame. This includes blood work, electrocardiograms, x-rays, nuclear scans, etc.

SLIDE 17

Other: Anything not included above, such as consults, physical therapy, respiratory therapy, speech therapy, social services, etc.

SLIDE 18: Example

Admit: medicine floor room #222

Diagnosis: Pyelonephritis

Condition: Stable / Code Status: Full Code

Allergies: none

Vitals: temperature, pulse, respirations, blood pressure, 0_2 saturation q 4 hrs

Activity: Up ad lib

Nursing: Vital signs every 4 hrs for 24 hrs then every shift

Notify if: T > 101.5, P > 120, BP < 90/60 or > 180/110

Daily weight:

I&O:

SLIDE 19

Diet: regular

Medications: Levaquin 500 mg IV every 24 hr

- Tylenol 650 mg PO every 4 hrs prn temp > 100/pain
- Phenergan 25 mg IV/IM every 4 hrs prn nausea
- Demerol 50 mg IM every 4 hrs prn pain
- If toxic: consider adding Gentamycin (7mg/kg/day) IVP; adjust for renal dose if indicated
- IVFluids: Dextrose 5% in 1/2 normal saline @ 100 mL/hr

Lab: blood cultures x2 prior to antibiotics, CBC, UA, urine culture, metabolic profile

- daily: CBC

Other: consider IVP or renal ultrasound

***Note to the instructor**: At this point students should break up into small groups to review the pertinent information from the case from Unit 9 – Abby Lipasito. (Appendix 1) Once completed, have them work together to develop the Plan and Orders. (Appendix 2)

Homework:

Students will be required to borrow from the school or rent the movie: "The Doctor" (Haines) to view before next class meeting. A reflection should be written about the film and consider the following:

This film is based on a 1988 book by Dr. Edward Rosenbaum: *A Taste Of My Own Medicine.* In the book Dr. Rosenbaum goes through the experience that is dramatized in the film.

1. Why do you think Dr. Rosenbaum wrote the book?
2. In terms of the film: What kind of a communication does Dr McKee have with his patients before his life-changing bout with cancer?
3. How does Dr McKee become a more empathetic communicator?

Works Cited

The Doctor. Dir. Randa Haines. Perf. William Hurt. Touchstone Pictures, 1991. DVD

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Appendix 1

Pertinent positives from Hx. & PE

midepigastric, sharp abdominal pain radiating to the back x 2 hours
nausea x 3 hours
anorexia x 3 hours
tachycardia
tachypnea
hypoactive bowel sounds
generalized tenderness of the abdomen
S/P appendectomy

sore throat with cervical lymphadenopathy 1 week ago by history

SLE x 5 years
current malar rash
daily fatigue
joint pain in knees and shoulders

FH of SLE, rheumatoid arthritis, hyperthyroidism, alcoholism, Alzheimer's
no recent eye exam
Hx of marijuana use- 1-2 joints per week x 10 years
allergic to penicillin; gets rash

Problem List

1. acute midepigastric abdominal pain x 2 hours with nausea, anorexia and decreased bowel sounds
2. SLE
3. allergy to penicillin

4. regular marijuana usage

Assessment

1. Midepigastric bdominal pain, nausea, anorexia, hypoactive bowel sounds
    - R/O acute pancreatitis
    - R/O cholecystitis
    - R/O acute intestinal obstruction
    - R/O perforated peptic ulcer
    - R/O ectopic
2. SLE- stable

Appendix 2

Assessment/Plan

1. Midepigastric bdominal pain, nausea, anorexia, hypoactive bowel sounds

R/O acute pancreatitis

R/O cholecystitis

R/O acute intestinal obstruction

R/O perforated peptic ulcer

R/O ectopic

CBC with differential, amylase and lipase, comprehensive chemistry level including LFTs, serum lactate, abdominal radiograph, RUQ abdominal U/S, EKG, Urine beta-HCG, U/A.

Consider abdominal CT with contrast depending on results of Abd x-ray and U/S

NPO, IV fluids, Demerol for pain, Reglan for nausea, Pepcid for pain

2. SLE- stable

No treatment at this time

ADMITTING ORDERS

Admit: medicine floor room #234

Diagnosis: midepigastric pain- r/o pancreatitis, SLE

Condition: guarded

Allergies: Penicillin

Vitals: temperature, pulse, respirations, blood pressure, 0_2 saturation q 4 hrs

Activity: OOB for bathroom

Nursing: Strict I&Os

- Notify HO if temp>101F, SBP>150 or <60, pulse >110 or <50

Diet: NPO

IV Fluids: NS@125cc/hr.

Medications:

- Pepcid 20 mg IV q12hrs
- Demerol 50mg IV q4 hrs prn pain
- Reglan 10mg IV q8 prn nausea

Labs/Studies:

- CBC with differential
- comprehensive chemistry (sodium, potassium, bicarb, chloride, BUN, creatinine, glucose, magnesium, phosphorus, calcium, alk phosphatase, total bilirubin, direct bilirubin, GTT, AST/ALT)
- amylase and lipase
- serum lactate
- abdominal radiograph
- RUQ abdominal U/S
- EKG, urine
- beta-HCG
- U/A

Other: none

Hospital Visit #3

This will be the third visit to the hospital for the students. Similar to the second visit, in this visit the students will perform the history and physical exam. During this visit the students will each do a short presentation for the hospital preceptor. Their homework assignments will include a written record of the history, physical exam, pertinent positives, problem list and assessment, plan and orders. In addition they will create a parallel chart for this visit.

Appendix 1 includes the preceptor evaluation of the students' performance that should be done after all of the hospital sessions are completed.

Objectives

Upon completion of this unit the student will be able to:

1. Elicit a complete history, including history of present illness, medical history, surgical history, social history, and review of systems.
2. Perform a complete physical exam based on the history elicited.
3. Formulate a problem list, assessment, plan and orders based on the history and physical exam findings.
4. Create a parallel chart for the patient encounter.

Appendix 1

HOSPITAL SESSION STUDENT EVALUATION FORM

Student: _____Date: _____

Evaluator:_____ (please print)

Eval. Signature:_____

Rating Scale:

O - Poor
1 - Below Average
2 - Average
3 - Above Average
4 - Outstanding

CATEGORY		RATING (circle one)				
1. **History taking** (30 total) Evaluate presentation accuracy and completeness of:						
A. Chief Complaint and History of Present Illness	(10)	0	1	2	3	4
B. Past History	(5)	0	1	2	3	4
C. Family History	(5)	0	1	2	3	4
D. Social History	(5)	0	1	2	3	4
E. Review of Systems	(5)	0	1	2	3	4

CATEGORY			RATING (circle one)				
2.	**Physical Examination** (35 total) Evaluate presentation of						
	A. Head and Neck	(5)	0	1	2	3	4
	B. Heart and Lungs	(5)	0	1	2	3	4
	C. Abdomen	(5)	0	1	2	3	4
	D. Musculoskeletal	(5)	0	1	2	3	4
	E. Peripheral Vascular	(5)	0	1	2	3	4
	F. Neurological	(5)	0	1	2	3	4
	G. Mental Status	(5)	0	1	2	3	4
3.	**Presentation Skills** (35 total) Evaluate accuracy, completeness and organization of presentation		0	1	2	3	4

COMMENTS: (use back of page for additional space) Adapted from: (UMDNJ "Hospital Session Student Evaluation Form")

Works Cited

UMDNJ, PA Program. “Hospital Session Student Evaluation Form.” Piscataway, NJ: UMDNJ, nd. Print.

Unit 12
Understanding and Managing the Difficult Clinical Encounter

This unit will address understanding and working with difficult situations that can arise in the patient encounter. It will describe some of these situations and discuss the roles of the patient and the clinician. It will offer a number of different techniques that can be utilized in these circumstances and remind the students about the skills of mindfulness, relationship-centered care and narrative that can be utilized to manage and understand these encounters. The in-class exercise for this class is a discussion of the film previously viewed by the students, "The Doctor." The discussion should be guided to allow students to explore how the illness experienced by the Dr. in the film taught him about humanism in medical practice and patient – doctor communication. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit. At the end of unit there are two appendices. The first is discussion points for the in-class exercise and the second is a homework article to be read in preparation for the next Unit.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives

At the completion of this Unit the student will be able to:

1. Explain that difficult encounters are multifactorial including both clinician factors and patient factors
2. Describe the dominant types of difficult patients and specify helpful approaches for each type
3. Discuss the 4 Communication Strategies to Redirect an Emotionally Charged Clinical Encounter
4. Identify and explain the 6 steps of the CALMER technique

5. Recognize that the BATHE technique is useful as a rapid psychosocial intervention for the assessment of patients
6. Identify mindfulness as a useful tool in working with difficult patients

SLIDE 2:

Key Concepts/Sections

- Patient and clinician factors in the doctor-patient relationship
- Communication strategies for difficult situations
- Mindfulness as a tool in the doctor-patient relationship

Section 1 - Patient and clinician factors in the doctor-patient relationship

SLIDE 3: Difficult Clinical Encounters (Lorenzetti)

- Difficult encounters are estimated to represent 15 to 30 percent of family physician visits
- These encounters are characterized by a disparity between the expectations, perceptions, or actions of the patient and clinician

SLIDE 4: Clinician Factors

Attitudes

- Emotional burnout Insecurity Intolerance of diagnostic uncertainty
- Negative bias toward specific health conditions
- Perceived time pressure

SLIDE 5

Conditions

- Anxiety/depression

- Exhaustion/
- overworked
- Personal health issues
- Situational stressors
- Sleep deprivation

SLIDE 6

Knowledge

- Inadequate training in psychosocial medicine
- Limited knowledge of the patient's health condition

Skills

- Difficulty expressing empathy
- Easily frustrated
- Poor communication skills

SLIDE 7: Patient factors

Behavioral issues

- Angry/argumentative/rude Demanding /entitled
- Drug-seeking behavior
- Highly anxious
- Hypervigilance to body sensations
- Manipulative
- Manner in which patient seeks medical care
- Nonadherence to treatment for chronic medical conditions
- Not in control of negative emotions
- Reluctance to take responsibility for his or her health
- Self-saboteur

SLIDE 8

Conditions

- Addiction to alcohol or drugs
- Belief systems foreign to physician's frame of reference
- Chronic pain syndromes
- Conflict between patient's and physician's goals for the visit
- Financial constraints causing difficulty with therapy adherence
- Functional somatic disorders
- Low literacy
- Multiple (more than four) medical issues per visit
- Physical, emotional, or mental abuse

SLIDE 9

Psychiatric diagnosis

- Borderline personality disorder
- Dependent personality disorder
- Underlying mood disorder

SLIDE 10: Dependent clinger

- Insecure, desperate for assurance, worried about abandonment
- Patient initially plays to physician's sympathies and praises him or her, making the physician feel special
- As the relationship develops, the patient becomes needy, wants/demands increasing personal time from the physician; the physician may feel resentful

SLIDE 11

Helpful Approach:

- Maintain a professional demeanor

- Establish boundaries early and consistently maintain them
- Involve the patient in decision making
- Assure the patient that you will not abandon him or her
- Schedule regular follow-up appointments

SLIDE 12: Entitled demander

- often angry, does not want to go through necessary steps of assessment or treatment, may be reacting to fear and loss
- physician and health system as barriers to his or her needs
- aggressive and intimidating, forges a negative relationship with the physician
- Physician may feel anger, guilt, doubt, or frustration

SLIDE 13

Helpful Approach:

- Suspend judgment, and examine your own feelings
- patient's hostility may be way of maintaining self-integrity during a devastating illness or trauma
- Do not react defensively when the patient expresses concerns
- Reinforce that the patient is entitled to good medical care, but that anger should not be misdirected at those trying to help

SLIDE 14: Manipulative help- rejecter

- Wants attention, has been rejected previously and has difficulty with trust, often has undiagnosed depression
- Engages clinician by subconscious manipulation
- returns to the office in cycles of help-seeking/rejecting treatment and does not improve despite appropriate advice
- is confident that his or her health cannot improve

- Clinician may be concerned about overlooking a serious illness

SLIDE 15

Helpful Approach:

- Recognize that patient wants to stay connected to the physician, not necessarily to recover
- Engage by sharing frustrations over poor outcomes
- set limits on expectations
- Reformulate the health plan with the patient to focus on alleviating symptoms rather than curing the condition

SLIDE 16

Self-destructive denier

- feels hopeless, unable to help himself or herself, fears failure, may have untreated anxiety or depression
- Health problems persist despite adequate counseling and treatment
- Continues self-destructive habits
- Clinician may feel ineffective and responsible for lack of progress

SLIDE 17

Helpful Approach:

- Recognize that complete resolution of issues is limited
- Set realistic expectations
- identify causes of nonadherence (e.g., money, time, etc.)
- Celebrate each small success with the patient
- Offer/arrange for psychological support

SLIDE 18

Communication Strategies to Redirect an Emotionally Charged Clinical Encounter

- Active listening

  Understand the patient's priorities, let the patient talk without interruption, recognize that anger is usually a secondary emotion (e.g., to abandonment, disrespect)

  "Please explain to me the issues that are important to you right now."

  "Help me to understand why this upsets you so much."

SLIDE 19

Validate the emotion and empathize with the patient

- Use confrontation: Name the emotion; if you are wrong, the patient will correct you

"I can see that you are angry."

"You are right—it's annoying to sit and wait in a cold room." "It sounds like you are telling me that you are scared."

SLIDE 20

Explore alternative solutions

- Find specific ways to handle the situation differently in the future

"If we had told you that appointments were running late, would you have liked a choice to wait or reschedule?"

"What else can I do to help meet your expectations for this visit?"

"Is there something else you need to tell to me so that I can help you?"

SLIDE 21

Provide closure

- Mutually agree on a plan for subsequent visits to avoid future difficulties

  "I prefer to give significant news in person Would you like early morning appointments so you can be the first patient of the day?"

  "Would you prefer to be referred to a specialist, or to follow up with me to continue to work on this problem?"

SLIDE 22: C.A.L.M.E.R. (Pomm HA)

Catalyst for change

- Identify the patient's status in the stages of change model*
- Recommend how the patient can advance to the next stage

SLIDE 23

Alter thoughts to change feelings

- Identify the negative feelings elicited by the patient
- Clarify how these feelings influence the encounter
- Strategize how to reduce your own negativity and distress

SLIDE 24

- **L**isten and then make a diagnosis
- Remove or minimize barriers to communication
- Improve working relationships
- Enhance probability of accurate diagnoses

SLIDE 25

Make an agreement

- Negotiate, agree on, and confirm a plan for health improvement

SLIDE 26

Education and follow-up

- Set achievable goals and realistic time frames and ensure follow-up

SLIDE 27

- **R**each out and discuss feelings
- Ensure a strategy for your own self-care

SLIDE 28: General Strategies

- For challenging patients, set boundaries or modify your schedule if needed.
- Try to be aware of your own inner feelings - results in fewer patients being labeled as “challenging” and to better management of difficult encounters

SLIDE 29

- Employ empathetic listening skills and a nonjudgmental, caring attitude - improves trust and adherence to treatment
- Use a patient-centered approach to interviewing, such as relationship centered care to improve the therapeutic relationship with the patient and effectively influence behavior change.

SLIDE 30

- Assess challenging patients for underlying psychological illnesses, and refer for appropriate diagnosis and treatment.
- Assess challenging patients with symptoms of functional somatic disorders for past or current sexual abuse or significant trauma

SLIDE 31: BATHE Technique (Leiblum)

(Introduced by Stuart MR, Lieberman JA. The fifteen minute hour: a short-term approach to psychotherapy in primary care, third edition, 2002)

B = Background

- "What is going on in your life?"
- This question helps elicit the context of the patient's visit.

SLIDE 32

A = Affect

- "How do you feel about that?" or
- "How would you describe your mood?"
- This question allows the patient to report on his/her current emotional state.

SLIDE 33

T = Trouble

- "What about the situation troubles you the most?" or
- "Is there anything about that troubles you?"
- Ask even when the patient's affect is positive, as they may still be stressed about something in their current life circumstances.

SLIDE 34

H = Handling

- "How are you handling that?" or
- "How could you handle that?"
- This question is asked to evaluate what psychological stress the patient may be experiencing that may be contributing to their physical complaint or affective state.

SLIDE 35

E = Empathy

- "That must be very difficult for you."
- Expressing empathy or sympathy conveys a sense of concern and of being understood, which affirms the patients and enhances positive feelings toward their health care provider.

SLIDE 36: Back to Mindfulness (Beckman)

- Beckman found: mindfulness skills improved the ability to be attentive and listen deeply to patients' concerns, respond to patients more effectively, and develop adaptive reserve developing greater self-awareness was positive and transformative yet it may difficult to attend to personal growth unless you see this as a priority

SLIDE 37: Back to RCC (Beach)

- Recognizes that the patient and the clinician are unique individuals with their own experiences and values
- Encourages empathy - the patient is supported through the emotional presence of the clinician - helps patients experience and express their emotions
- Clinicians benefit and grow from knowing their patients
- Clinicians become invested in the patient's experience and outcome - necessary if one is to serve others genuinely and be renewed from that serving

SLIDE 38: Back to Narrative Competence (R. Charon "The Patient-Physician Relationship. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust.")

- "The effective practice of medicine requires narrative competence, that is, the ability to acknowledge, absorb, interpret, and act on the stories and plights of others"
- With narrative competence, clinicians can reach and join their patients in illness, recognizing their own personal journeys through medicine and acknowledge kinship with other health care professionals

***Note to Instructor:** Small group exercise for the film "The Doctor"
Break students up into groups of 8 - 10 students to share reflections of the film. Faculty facilitators will meet with students in small groups to guide the discussion as indicated by discussion prompts in Appendix 1. Discussion should be encouraged and all students should contribute. The film is an excellent resource for teaching the concept of empathy through the themes of terminal illness, marital stress, and others.

The next part of the small group activity is to review of third hospital visit write-up. Graded H&Ps are returned to students and they are given time to review. Instructor will prearrange to have one student present their HPI along with pertinent positives from the remainder of the history and the physical exam. Student and instructor will lead a group exercise to develop the problem list, assessment and plan and orders. Instructor will also take this opportunity to meet with students individually to discuss write-up.

Homework: Read article "A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer" (Baile and Walter) (Appendix 2)

Work Cited

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Appendix 1

Class Exercise: Discussion of the Film "The Doctor" (Adler)

1. Why do you think Rosenbaum wrote the book upon which the movie is based?

2. What kind of a communication climate does McKee have with his patients before his life-changing bout with cancer?

The climate between McKee and his patients at the story's outset is cold and clinical. The key factors leading to this chill, are neutrality vs. empathy and superiority vs. equality. His aloof style is also a good example of impersonal rather than interpersonal communication. McKee's patients are shocked when he minimizes the seriousness of their physical and emotional trauma. For instance, as he visits one of his patients, it is obvious from her facial expression that she is very upset about something. McKee opens her robe, looks at the long scar in the middle of her chest and says, "Oh yeah, that healed fine. Let's just get those staples out." With tears in her eyes, the woman stumbles through an awkward question: "Doctor, um, my husband, um, he's a good man and he, I think he's a little nervous. Will the scar always be so...." McKee interrupts, "Tell your husband you look like a playboy centerfold and you have the staple marks to prove it" (then he chuckles). The woman looks very sad and hangs her head. A fellow doctor attempts to explain away McKee's style: "Dr. McKee likes to joke. That doesn't mean he's not caring--that's just his way. He is a fine doctor."

McKee seems to think that technical excellence and a sharp wit are appropriate substitutes for warmth, compassion, and a listening ear. He believes that surgical practice should be as impersonal as possible (perhaps to keep him from experiencing the pain of loss). In explaining this to a group of interns, the only thing McKee is passionate about is his description of how a surgeon should be dispassionate: "A surgeon's job is to cut . . . You go in, we fix it, and we get out . . . Caring is all about time. When you've got thirty

seconds before some guy bleeds out, I'd rather you cut straight and care less." While this approach is fine for the operating room, it translates into a lack of bedside manner when he doesn't have a scalpel in his hand--for instance, when he refers to patients by their diseases rather than their names. It's all a part of a philosophy he explains to the interns: "There is a danger in feeling too strongly about your patients."

3. How does McKee become a more empathetic communicator?

As soon as McKee is diagnosed with cancer, he experiences the first dimension of empathy: perspective taking. He learns how frustrating and frightening it is to be a patient, and he feels the pain and indignity of being treated like a number rather than a person. He also experiences the second dimension of empathy in his relationship with June: emotional contagion. He feels her fear, sadness, and sense of hopelessness--in some ways, more than she does. When June's illness becomes serious and she is unconscious in her hospital bed, he holds her hand and tells her how terrified he is.

This leads him to the third dimension of empathy: genuine concern. He must learn, however, that the best way to show his concern is not necessarily by fixing things, which has always been his style. When McKee discovers that June wants to attend a concert, he buys concert and airplane tickets for the event. They don't make the event in time and McKee is frustrated because his attempt to help has failed. "Fix it, get out, that's what I tell my residents." He realizes he can neither "fix" this problem nor "get out" of his emotional connection to the "patient" (June). As they talk together, June tells him that fixing the problem isn't as important as having him there, listening and caring: "You know what's special to me Jack--I mean truly special? This. Now."

The empathy McKee gains from his illness and his relationship with June affects his medical practice and priorities. In a scene that mirrors an earlier one in the movie, McKee walks down the hall with a group of interns and asks one of them who they will be visiting first. The intern answers, "The terminal in 1217." McKee stops in his tracks, turns to the intern, and asks angrily, "Terminal? What terminal, bus terminal?" The intern

replies, "No, the dying patient in 1217." McKee probes further: "What's the patient's name?" When the intern moves to look it up, McKee asks another intern the question. Once he learns the patient's name, McKee says, "Okay, now Mr. Winter is either alive or dead. So is Mr. Winter alive or should we advise the morgue?" He then turns to the first intern and snaps, "Call another patient terminal and that's how you'll describe your career."

Although he is curt with the offending intern, he shows compassion and concern for people he previously treated inhumanely. In one scene, McKee and some members of his practice are walking through the parking garage. The others are laughing about patients; McKee refrains from doing so and walks behind them. They notice that a man who is suing their practice having difficulty near his car. McKee walks over and, despite their troubled history, asks the man about his problem. The man has locked his keys in the car and is going to be late for speech therapy. McKee tells him to go to his appointment, saying he'll take care of the problem and have his keys waiting for him at the desk when he was finished. These are behaviors that the "old" Jack McKee never would have done.

Appendix 2

A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer

SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer

1. **Walter F. Baile**a**, Robert Buckman**b**, Renato Lenzi**a**, Gary Glober**a**, Estela A. Beale**a **and Andrzej P. Kudelka**b

Abstract

We describe a protocol for disclosing unfavorable information—"breaking bad news"—to cancer patients about their illness. Straightforward and practical, the protocol meets the requirements defined by published research on this topic. The protocol (SPIKES) consists of six steps. The goal is to enable the clinician to fulfill the four most important objectives of the interview disclosing bad news: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient's collaboration in developing a strategy or treatment plan for the future. Oncologists, oncology trainees, and medical students who have been taught the protocol have reported increased confidence in their ability to disclose unfavorable medical information to patients. Directions for continuing assessment of the protocol are suggested.

BACKGROUND

Surveys conducted from 1950 to 1970, when treatment prospects for cancer were bleak, revealed that most physicians considered it inhumane and damaging to the patient to disclose the bad news about the diagnosis [1, 2]. Ironically, while treatment advances have changed the course of cancer so that it is much easier now to offer patients hope at the time of diagnosis, they have also created a need for increased clinician skill in discussing other bad news. These situations include disease recurrence, spread of disease

or failure of treatment to affect disease progression, the presence of irreversible side effects, revealing positive results of genetic tests, and raising the issue of hospice care and resuscitation when no further treatment options exist. This need can be illustrated by information collected by an informal survey conducted at the 1998 Annual Meeting of the American Society of Clinical Oncology (ASCO), where we queried attendees at a symposium on communication skills. For this symposium several experts in teaching aspects of the doctor-patient relationship in oncology formulated a series of questions to assess attendees' attitudes and practices regarding breaking bad news. Of the 700 persons attending the symposium, which was repeated twice over a two-day period, 500 received a transponder allowing them to respond in “real time” to questions that were presented on a screen. The results were immediately analyzed for discussion and are presented in Table 1⇓. We asked participants about their experiences in breaking bad news and their opinions as to its most difficult aspects. Approximately 60% of respondents indicated that they broke bad news to patients from 5 to 20 times per month and another 14% more than 20 times per month. These data suggest that, for many oncologists, breaking bad news should be an important communication skill.

Table 1.

Results of survey of participants at Breaking Bad News Symposium, American Society of Clinical Oncology, 1998[1,2]

Questions	Day 1 (%)	Day 2 (%)	Average (%)
[1]Some questions asked on the first day were not included on day 2. Additional questions were added on day 2 based on response to questions of the previous day. [2]Presented in part at the Annual Meeting of the American Society of Clinical Oncology, New Orleans, LA, May 19-23, 2000.			
1. In an average month, how often do you have to break bad news to a patient (e.g., diagnosis, recurrence, progressive disease, etc.)?			
Less than 5 times	22.2	24.1	23.2
5 to 10 times	32.1	31.0	31.6
10 to 20 times	34.3	27.8	31.0
More than 20	11.4	17.1	14.2
2. Which do you find the most difficult task?			
Discussing diagnosis	1.8	6.3	4.0
Telling patient about recurrence	31.5	21.4	26.4
Talking about end of active treatment and beginning palliative treatment	46.1	44.2	45.2
Discussing end-of-life issues (e.g., do not resuscitate)	15.8	23.2	19.5

Questions	Day 1 (%)	Day 2 (%)	Average (%)
Involving family/friends of patient	4.8	4.9	4.9
3. Have you had any specific teaching or training for breaking bad news?			
Formal teaching	5.6	4.0	4.8
Sat in with clinicians in breaking bad news interviews	41.5	35.9	38.7
Both	15.2	12.1	13.6
Neither	37.7	48.0	42.0
4. How do you feel about your own ability to break bad news?			
Very good	11.7	14.3	13.0
Good	40.9	39.4	40.2
Fair	40.9	37.1	39.0
Poor	6.5	8.8	7.6
Very poor	0.0	0.4	0.25
5. What do you feel is the most difficult part of discussing bad news?			
Being honest but not taking away hope	54.9	61.1	58.0
Dealing with the patient's emotion (e.g., crying, anger)	28.8	21.5	25.1
Spending the right amount of time	10.6	10.1	10.3
Involving friends and family of the patient	5.7	7.3	6.5
6. Have you had any training in the techniques of responding to patient's emotions?			
Formal teaching	9.1	6.4	7.8
Sat in with practicing clinician	32.5	34.4	33.5
Both	10.3	9.6	9.9
Neither	48.1	49.6	48.8
7. How would you rate your own comfort in dealing with patient's emotions (e.g., crying, anger, denial, etc.)?			
Quite comfortable	35.8	29.6	32.7
Not very comfortable	46.1	47.2	46.7
Uncomfortable	18.1	23.2	20.6
8. Did you find that the SPIKES made sense to you?			
Yes	94.3	95.4	94.8
No	5.7	4.6	5.2
9. Would a strategy or approach to breaking bad news interviews be helpful to you in your practice?			
Yes	88.2		
No	11.8		
10. Do you feel that the SPIKES is practical and can be used in your clinical practice?			
Yes	95.4		
No	4.6		
11. When you break bad news to your patients, do you have a consistent plan or strategy in mind?			
Have a consistent plan or strategy		26.1	
Several techniques/tactics but no overall plan		51.9	
No consistent approach to task		22.0	

Questions	Day 1 (%)	Day 2 (%)	Average (%)
12. 12. Which element of the SPIKES protocol do you think you would find most easy?			
S-Setting		36.1	
P-Patient's perception		13.6	
I-Invitation		11.4	
K-Knowledge		17.5	
E-Exploring/Empathy		7.5	
S-Strategy/Summary		13.9	
13. Which element of the SPIKES protocol do you think you would find most difficult?			
S-Setting		1.9	
P-Patient's perception		16.4	
I-Invitation		18.6	
K-Knowledge		7.4	
E-Exploring/Empathy		52.4	
S-Strategy/Summary		3.3	

[1]Some questions asked on the first day were not included on day 2. Additional questions were added on day 2 based on response to questions of the previous day. [2]Presented in part at the Annual Meeting of the American Society of Clinical Oncology, New Orleans, LA, May 19-23, 2000.

However, breaking bad news is also a complex communication task. In addition to the verbal component of actually giving the bad news, it also requires other skills. These include responding to patients' emotional reactions, involving the patient in decision-making, dealing with the stress created by patients' expectations for cure, the involvement of multiple family members, and the dilemma of how to give hope when the situation is bleak. The complexity of the interaction can sometimes create serious miscommunications [3-6] such as patient misunderstanding about the prognosis of the illness or purpose of care [7-12]. Poor communication may also thwart the goal of understanding patient expectations of treatment or involving the patient in treatment planning.

The task of breaking bad news can be improved by understanding the process involved and approaching it as a stepwise procedure, applying well-established principles of communication and counseling. Below we describe a six-step protocol, which incorporates these principles.

A Definition of Bad News

Bad news may be defined as “any information which adversely and seriously affects an individual's view of his or her future” [13]. Bad news is always, however, in the “eye of the beholder,” such that one cannot estimate the impact of the bad news until one has first determined the recipient's expectations or understanding. For example, a patient who is told that her back pain is caused by a recurrence of her breast cancer when she was expecting to be told it was a muscle strain is likely to feel shocked.

Breaking Bad News: Why Is It Important?

A Frequent but Stressful Task

Over the course of a career, a busy clinician may disclose unfavorable medical information to patients and families many thousands of times [14]. Breaking bad news to cancer patients is inherently aversive, described as “hitting the patient over the head” or “dropping a bomb” [6]. Breaking bad news can be particularly stressful when the clinician is inexperienced, the patient is young, or there are limited prospects for successful treatment [3].

Patients Want the Truth

By the late 1970s most physicians were open about telling cancer patients their diagnosis [15]. However, studies began to indicate that patients also desired additional information. For example, a survey published in 1982 of 1,251 Americans [16] indicated that 96% wished to be told if they had a diagnosis of cancer, but also that 85% wished, in cases of a grave prognosis, to be given a realistic estimate of how long they had to live. Over many years a number of studies in the United States have supported these findings [17-23], although patient expectations have not always been met [24-27]. European patients' wishes have been found to be similar to those of American patients. For example, a study of 250 patients at an oncology center in Scotland showed that 91% and 94% of patients,

respectively, wanted to know the chances of cure for their cancer and the side effects of therapy [28].

Ethical and Legal Imperatives

In North America, principles of informed consent, patient autonomy, and case law have created clear ethical and legal obligations to provide patients with as much information as they desire about their illness and its treatment [29, 30]. Physicians may not withhold medical information even if they suspect it will have a negative effect on the patient. Yet a mandate to disclose the truth, without regard or concern for the sensitivity with which it is done or the obligation to support the patients and assist them in decision-making, can result in the patients being as upset as if they were lied to [4]. As has been aptly suggested, the practice of deception cannot instantly be remedied by a new routine of insensitive truth telling [31].

Clinical Outcomes

How bad news is discussed can affect the patient's comprehension of information [32], satisfaction with medical care [33, 34], level of hopefulness [35], and subsequent psychological adjustment [36-38]. Physicians who find it difficult to give bad news may subject patients to harsh treatments beyond the point where treatment may be expected to be helpful [39]. The idea that receiving unfavorable medical information will invariably cause psychological harm is unsubstantiated [40, 41]. Many patients desire accurate information to assist them in making important quality-of-life decisions. However, others who find it too threatening may employ forms of denial, shunning or minimizing the significance of the information, while still participating in treatment.

WHAT ARE THE BARRIERS TO BREAKING BAD NEWS?

Tesser [42] and others conducted psychological experiments that showed that the bearer of bad news often experiences strong emotions such as anxiety, a burden of responsibility for the news, and fear of negative evaluation. This stress creates a reluctance to deliver

bad news, which he named the “MUM” effect. The MUM effect is particularly strong when the recipient of the bad news is already perceived as being distressed [43]. It is not hard to imagine that these factors may operate when bad news must be given to cancer patients [44, 45].

The participants in our previously mentioned ASCO survey identified several additional stresses in giving bad news. Fifty-five percent ranked “how to be honest with the patient and not destroy hope” as most important, whereas “dealing with the patient's emotions” was endorsed by 25%. Finding the right amount of time was a problem for only 10%.

Despite these identified challenges, less than 10% of survey respondents had any formal training in breaking bad news and only 32% had the opportunity during training to regularly observe interviews where bad news was delivered. While 53% of respondents indicated that their ability to break bad news was good to very good, 39% thought that it was only fair, and 8% thought it was poor.

From this information and other studies we may conclude that for many clinicians additional training in disclosing unfavorable information to the patient could be useful and increase their confidence in accomplishing this task. Moreover, techniques for disclosing information in a way that addresses the expectations and emotions of the patients also seem to be strongly desired, but rarely taught.

HOW CAN A STRATEGY FOR BREAKING BAD NEWS HELP THE CLINICIAN AND THE PATIENT?

When physicians are uncomfortable in giving bad news they may avoid discussing distressing information, such as a poor prognosis, or convey unwarranted optimism to the patient [46]. A plan for determining the patient's values, wishes for participation in decision-making, and a strategy for addressing their distress when the bad news is disclosed can increase physician confidence in the task of disclosing unfavorable medical information [47, 48]. It may also encourage patients to participate in difficult treatment decisions, such as when there is a low probability that direct anticancer treatment will be

efficacious. Finally, physicians who are comfortable in breaking bad news may be subject to less stress and burnout [49].

A SIX-STEP STRATEGY FOR BREAKING BAD NEWS

The authors of several recent papers have advised that interviews about breaking bad news should include a number of key communication techniques that facilitate the flow of information [3, 13, 50-54]. We have incorporated these into a step-by-step technique, which additionally provides several strategies for addressing the patient's distress.

Complex Clinical Tasks May Be Considered as a Series of Steps

The process of disclosing unfavorable clinical information to cancer patients can be likened to other medical procedures that require the execution of a stepwise plan. In medical protocols, for example, cardiopulmonary resuscitation or management of diabetic ketoacidosis, each step must be carried out and, to a great extent, the successful completion of each task is dependent upon the completion of the step before it.

Goals of the Bad News Interview

The process of disclosing bad news can be viewed as an attempt to achieve four essential goals. The first is gathering information from the patient. This allows the physician to determine the patient's knowledge and expectations and readiness to hear the bad news. The second goal is to provide intelligible information in accordance with the patient's needs and desires. The third goal is to support the patient by employing skills to reduce the emotional impact and isolation experienced by the recipient of bad news. The final goal is to develop a strategy in the form of a treatment plan with the input and cooperation of the patient.

Meeting these goals is accomplished by completing six tasks or steps, each of which is associated with specific skills. Not every episode of breaking bad news will require all of the steps of SPIKES, but when they do they are meant to follow each other in sequence.

THE SIX STEPS OF SPIKES

STEP 1: S—SETTING UP the Interview

Mental rehearsal is a useful way for preparing for stressful tasks. This can be accomplished by reviewing the plan for telling the patient and how one will respond to patients' emotional reactions or difficult questions. As the messenger of bad news, one should expect to have negative feelings and to feel frustration or responsibility [55]. It is helpful to be reminded that, although bad news may be very sad for the patients, the information may be important in allowing them to plan for the future.

Sometimes the physical setting causes interviews about sensitive topics to flounder. Unless there is a semblance of privacy and the setting is conducive to undistracted and focused discussion, the goals of the interview may not be met. Some helpful guidelines:

- *Arrange for some privacy*. An interview room is ideal, but, if one is not available, draw the curtains around the patient's bed. Have tissues ready in case the patient becomes upset.
- *Involve significant others*. Most patients want to have someone else with them but this should be the patient's choice. When there are many family members, ask the patient to choose one or two family representatives.
- *Sit down*. Sitting down relaxes the patient and is also a sign that you will not rush. When you sit, try not to have barriers between you and the patient. If you have recently examined the patient, allow them to dress before the discussion.
- *Make connection with the patient*. Maintaining eye contact may be uncomfortable but it is an important way of establishing rapport. Touching the patient on the arm or holding a hand (if the patient is comfortable with this) is another way to accomplish this.

- *Manage time constraints and interruptions*. Inform the patient of any time constraints you may have or interruptions you expect. Set your pager on silent or ask a colleague to respond to your pages.

STEP 2: P—ASSESSING THE PATIENT'S PERCEPTION

Steps 2 and 3 of SPIKES are points in the interview where you implement the axiom "before you tell, ask." That is, before discussing the medical findings, the clinician uses open-ended questions to create a reasonably accurate picture of how the patient perceives the medical situation—what it is and whether it is serious or not. For example, "What have you been told about your medical situation so far?" or "What is your understanding of the reasons we did the MRI?". Based on this information you can correct misinformation and tailor the bad news to what the patient understands. It can also accomplish the important task of determining if the patient is engaging in any variation of illness denial: wishful thinking, omission of essential but unfavorable medical details of the illness, or unrealistic expectations of treatment [56].

STEP 3: I—OBTAINING THE PATIENT'S INVITATION

While a majority of patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. When a clinician hears a patient express explicitly a desire for information, it may lessen the anxiety associated with divulging the bad news [57]. However, shunning information is a valid psychological coping mechanism [58, 59] and may be more likely to be manifested as the illness becomes more severe [60]. Discussing information disclosure at the time of ordering tests can cue the physician to plan the next discussion with the patient. Examples of questions asked the patient would be, "How would you like me to give the information about the test results? Would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan?". If patients do

not want to know details, offer to answer any questions they may have in the future or to talk to a relative or friend.

STEP 4: K—GIVING KNOWLEDGE AND INFORMATION TO THE PATIENT

Warning the patient that bad news is coming may lessen the shock that can follow the disclosure of bad news [32] and may facilitate information processing [61]. Examples of phrases that can be used include, “Unfortunately I've got some bad news to tell you” or “I'm sorry to tell you that…”.

Giving medical facts, the one-way part of the physician-patient dialogue, may be improved by a few simple guidelines. First, start at the level of comprehension and vocabulary of the patient. Second, try to use nontechnical words such as “spread” instead of “metastasized” and “sample of tissue” instead of “biopsy.” Third, avoid excessive bluntness (e.g., “You have very bad cancer and unless you get treatment immediately you are going to die.”) as it is likely to leave the patient isolated and later angry, with a tendency to blame the messenger of the bad news [4, 32, 61]. Fourth, give information in small chunks and check periodically as to the patient's understanding. Fifth, when the prognosis is poor, avoid using phrases such as “There is nothing more we can do for you.” This attitude is inconsistent with the fact that patients often have other important therapeutic goals such as good pain control and symptom relief [35, 62].

STEP 5: E—ADDRESSING THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES

Responding to the patient's emotions is one of the most difficult challenges of breaking bad news [3, 13]. Patients' emotional reactions may vary from silence to disbelief, crying, denial, or anger.

When patients get bad news their emotional reaction is often an expression of shock, isolation, and grief. In this situation the physician can offer support and solidarity to the patient by making an empathic response. An empathic response consists of four steps [3]:

1. First, observe for any emotion on the part of the patient. This may be tearfulness, a look of sadness, silence, or shock.

2. Second, identify the emotion experienced by the patient by naming it to oneself. If a patient appears sad but is silent, use open questions to query the patient as to what they are thinking or feeling.

3. Third, identify the reason for the emotion. This is usually connected to the bad news. However, if you are not sure, again, ask the patient.

4. Fourth, after you have given the patient a brief period of time to express his or her feelings, let the patient know that you have connected the emotion with the reason for the emotion by making a connecting statement. An example:

    - ***Doctor***: I'm sorry to say that the x-ray shows that the chemotherapy doesn't seem to be working [pause]. Unfortunately, the tumor has grown somewhat.

    - ***Patient***: I've been afraid of this! [Cries]

    - ***Doctor***: [Moves his chair closer, offers the patient a tissue, and pauses.] I know that this isn't what you wanted to hear. I wish the news were better.

In the above dialogue, the physician observed the patient crying and realized that the patient was tearful because of the bad news. He moved closer to the patient. At this point he might have also touched the patient's arm or hand if they were both comfortable and paused a moment to allow her to get her composure. He let the patient know that he understood why she was upset by making a statement that reflected his understanding. Other examples of empathic responses can be seen in Table 2⇓.

Until an emotion is cleared, it will be difficult to go on to discuss other issues. If the emotion does not diminish shortly, it is helpful to continue to make empathic responses

until the patient becomes calm. Clinicians can also use empathic responses to acknowledge their own sadness or other emotions ("I also wish the news were better"). It can be a show of support to follow the empathic response with a validating statement, which lets the patient know that their feelings are legitimate (Table 3⇓).

Table 2.

Examples of empathic, exploratory, and validating responses

Empathic statements	Exploratory questions	Validating responses
"I can see how upsetting this is to you."	"How do you mean?"	"I can understand how you felt that way."
"I can tell you weren't expecting to hear this."	"Tell me more about it."	"I guess anyone might have that same reaction."
"I know this is not good news for you."	"Could you explain what you mean?"	"You were perfectly correct to think that way."
"I'm sorry to have to tell you this."	"You said it frightened you?"	"Yes, your understanding of the reason for the tests is very good."
"This is very difficult for me also."	"Could you tell me what you're worried about?"	"It appears that you've thought things through very well."
"I was also hoping for a better result."	"Now, you said you were concerned about your children. Tell me more."	"Many other patients have had a similar experience."

Table 3.

Changes in confidence levels among participants in workshops on communicating bad news

Breaking bad news	Fellows		Faculty	
	p-value	*t* score	*p*-value	*t* score
*Not significant.				
Plan the discussion in advance	.010	-3.087	.001	-4.01
Create a comfortable setting	.037	-2.377	.007	-3.08
Encourage family/friend presence	.101*	-1.792	.396	.87*
Assess patient's ability to discuss bad news	.016	-2.836	<.001	-4.49
Confirm patient's understanding of cancer	.005	-3.553	.002	-3.66
Assess how much patient wants to know	.003	-3.734	.019	-2.62
Organize a strategy for disclosing information	.002	-4.025	.004	-3.32
Include family/caregiver in discussion	.043	-2.293	.038	-2.26
Provide information in small increments	.005	-3.512	.027	-2.43
Avoid medical jargon	.057*	-2.125	.006	-3.13
Check to see if information was correctly received by patient	.059*	-2.107	.001	-4.18
Reinforce and clarify information	.016	-2.829	.020	-2.58
Detect anxiety	.003	-3.817	.004	-3.41
Detect sadness	.030	-2.485	.009	-2.96
Handle the patient's emotional reactions	.004	-3.676	.020	-2.58

Breaking bad news	Fellows		Faculty	
	p-value	*t* score	*p*-value	*t* score
Respond empathetically	.034	-2.420	.023	-2.53

Again, when emotions are not clearly expressed, such as when the patient is silent, the physician should ask an exploratory question before he makes an empathic response. When emotions are subtle or indirectly expressed or disguised as in thinly veiled disappointment or anger (“I guess this means I'll have to suffer through chemotherapy again”) you can still use an empathic response (“I can see that this is upsetting news for you”). Patients regard their oncologist as one of their most important sources of psychological support [63], and combining empathic, exploratory, and validating statements is one of the most powerful ways of providing that support [64-66] (Table 2⇑). It reduces the patient's isolation, expresses solidarity, and validates the patient's feelings or thoughts as normal and to be expected [67].

STEP 6: S—STRATEGY AND SUMMARY

Patients who have a clear plan for the future are less likely to feel anxious and uncertain. Before discussing a treatment plan, it is important to ask patients if they are ready at that time for such a discussion. Presenting treatment options to patients when they are available is not only a legal mandate in some cases [68], but it will establish the perception that the physician regards their wishes as important. Sharing responsibility for decision-making with the patient may also reduce any sense of failure on the part of the physician when treatment is not successful. Checking the patient's misunderstanding of the discussion can prevent the documented tendency of patients to overestimate the efficacy or misunderstand the purpose of treatment [7-9, 57].

Clinicians are often very uncomfortable when they must discuss prognosis and treatment options with the patient, if the information is unfavorable. Based on our own observations and those of others [1, 5, 6, 10, 44-46], we believe that the discomfort is based on a number of concerns that physicians experience. These include uncertainty about the

patient's expectations, fear of destroying the patient's hope, fear of their own inadequacy in the face of uncontrollable disease, not feeling prepared to manage the patient's anticipated emotional reactions, and sometimes embarrassment at having previously painted too optimistic a picture for the patient.

These difficult discussions can be greatly facilitated by using several strategies. First, many patients already have some idea of the seriousness of their illness and of the limitations of treatment but are afraid to bring it up or ask about outcomes. Exploring the patient's knowledge, expectations, and hopes (step 2 of SPIKES) will allow the physician to understand where the patient is and to start the discussion from that point. When patients have unrealistic expectations (e.g., "They told me that you work miracles."), asking the patient to describe the history of the illness will usually reveal fears, concerns, and emotions that lie behind the expectation. Patients may see cure as a global solution to several different problems that are significant for them. These may include loss of a job, inability to care for the family, pain and suffering, hardship on others, or impaired mobility. Expressing these fears and concerns will often allow the patient to acknowledge the seriousness of their condition. If patients become emotionally upset in discussing their concerns, it would be appropriate to use the strategies outlined in step 5 of SPIKES. Second, understanding the important specific goals that many patients have, such as symptom control, and making sure that they receive the best possible treatment and continuity of care will allow the physician to frame hope in terms of what it is possible to accomplish. This can be very reassuring to patients.

EXPERIENCE WITH THE SPIKES PROTOCOL

Oncologists' Assessment of SPIKES

In the ASCO survey mentioned previously, we asked participants if they felt the SPIKES protocol would be useful in their practice. Ninety-nine percent of those responding found that the SPIKES protocol was practical and easy to understand. They reported, however,

that using empathic, validating, and exploring statements to respond to patient emotions would be the greatest challenge of the protocol (52% of respondents).

In teaching, the SPIKES protocol has been incorporated into filmed scenarios, which appear as part of a CD-ROM on physician-patient communication [67]. These scenarios have proven useful in teaching the protocol and in initiating discussion of the various aspects of breaking bad news.

Does the SPIKES Protocol Reflect the Consensus of Experts?

Very few studies have sampled patient opinion as to their preferences for disclosure of unfavorable medical information [69]. However, of the scarce information available, the content of the SPIKES protocol closely reflects the consensus of cancer patients and professionals as to the essential elements in breaking bad news [3, 13, 50-54]. In particular, SPIKES emphasizes the techniques useful in responding to the patient's emotional reactions and supporting the patient during this time.

Can Students and Clinicians Learn to Use the Protocol?

Most medical undergraduate and postgraduate programs do not usually offer specific training in breaking bad news [70] and most oncologists learn to break bad news by observing more experienced colleagues in clinical situations [39]. At the University of Texas M.D. Anderson Cancer Center we used the SPIKES protocol in interactive workshops for oncologists and oncology fellows. As an outcome, before and after the workshop we used a paper and pencil test to measure physician confidence in carrying out the various skills associated with SPIKES. We found that the SPIKES protocol in combination with experiential techniques such as role play can increase the confidence of faculty and fellows in applying the SPIKES protocol [47] (Table 3⇑). Undergraduate teaching experience also showed that the protocol increased medical students' confidence in formulating a plan for breaking bad news [71].

DISCUSSION

In clinical oncology the ability to communicate effectively with patients and families can no longer be thought of as an optional skill [72]. Current ASCO guidelines for curriculum development do not yet include recommendations for training in essential communication skills [73]. However, a study by *Shea* of 2,516 oncologists showed interest in additional training in this area [74]. *Shea's* findings regarding communication skills were echoed by our ASCO survey participants, many of whom reported a lack of confidence in ability to break bad news. A specific lack of training opportunities appeared to play a major role in leading to this problem, as almost 40% of respondents not only had no didactic training but also did not have an opportunity to gain experience from observing other clinicians breaking bad news.

Several papers have clearly demonstrated that communication skills can be taught and are retained [47, 48, 71, 75, 76]. The SPIKES protocol for breaking bad news is a specialized form of skill training in physician-patient communication, which is employed in teaching communication skills in other medical settings [77]. These key skills are an important basis for effective communication [78]. Employing verbal skills for supporting and advocating for the patient represents an expanded view of the role of the oncologist, which is consistent with the important objective of medical care of reducing patient suffering. They form the basis for patient support, an essential psychological intervention for distress.

We recognize that the SPIKES protocol is not completely derived from empirical data, and whether patients will find the approach recommended as useful is still an important question. However, its implementation presupposes a dynamic interaction between physician and patient in which the clinician is guided by patient understanding, preferences, and behavior. This flexible approach is more likely to address the inevitable differences among patients than a rigid recipe that is applied to everyone.

FUTURE DIRECTIONS

We are currently in the process of determining how the bearer of bad news is affected psychophysiologically during the process of disclosure. We plan to determine empirically whether the SPIKES protocol can reduce the stress of breaking bad news for the physician, and also improve the interview and the support as experienced by the patient. We are further investigating patient preferences for bad news disclosure, using many of the steps recommended in SPIKES, across a variety of disease sites and by age, gender, and stage of disease. Preliminary data indicate that, as recommended in SPIKES, patients wish the amount of information they receive to be tailored to their preferences. We are also conducting long-term follow-up of workshops in which the protocol has been taught to oncologists and oncology trainees to determine empirically how it is implemented.

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Unit 13

Breaking Bad News

In this Unit the Class will view the film "Wit" after which they will break up into small groups for a 1 hour discussion of the film, death and dying, palliative care, empathy and DNR. Students are expected to have read the homework reading prior to this class: "SPIKES Protocol for Delivering Bad News." A review of the unit objectives which are presented in Appendix 1 - student handout provide the instructor with a guide to the unit. There are no PowerPoint slides for this unit. At the end of unit there are two additional appendices. The first is a facilitator's guide and the second is a summary of the film as it may relate to the discussion. There is no formal homework assignment for this unit.

Appendix 1

Student Handout

Objectives

At the end of this unit the student will be able to:

1. Discuss the critical nature of breaking bad news
2. Describe what DNR status means for a patient's treatment plan (what it includes and what it excludes)
3. Describe palliative care
4. Recognize that informed consent is necessary when enrolling a patient in a research protocol
5. Consider actions that promote empathy versus those that work against the therapeutic relationship
6. Explain the SPIKES six step protocol for delivering bad news

Appendix 2

Death, Dying, and DNR: "Wit" Facilitator's Guide

adapted from (Spike J and Sain C)

I. Summary of the class

The students will view the film "Wit" (1 hour 40 min) (Nichols) prior to which they will be asked to take a few notes while they watch to help remind them of the issues presented to use in the small group discussion.

The small groups will meet for one hour. Each question should be discussed for about 10 -15 mins giving you a few minutes to give them some conclusions and make some observations based on your own experiences or what the students have offered.

Below are the topics and some thoughts in response. There is also a summary of the film included.

1. While the bad news is delivered within the first five seconds of the movie, it is a very powerful first statement. Do you feel that Dr. Kelekian did a good job in breaking the news to Dr. Bearing? What would you have done differently?
2. Some of the potential "mistakes" in Dr. Kelekian's approach include standing while delivering the news and not allowing the patient enough time to react. While Dr. Bearing did encourage Dr. Kelekian to continue – which he did in a very fast pace – she also looked very stunned and may have needed Dr. Kelekian to notice her reaction and act on that rather than continue explaining her condition and possible treatment.
3. In breaking bad news, it is important to keep straight the distinction between death and dying. "Death" is an impersonal, objective event, whereas "dying" is a subjectively experienced process a conscious person lives through, endures, or suffers.

   As an academic professor, Dr. Bearing could talk about death in a very unemotional way. However, while being treated for cancer, death becomes a

threat to everything she ever was in life. She is represented throughout the film as a very successful professor of English who is uncompromising in her "scholarly standards." Isn't death also rather uncompromising? However, in dying, there is more room for compromise. How do you think she would have liked to spend her last months if she had been given more options? Why are so many physicians afraid to discuss the dying process with their patients? Is it fear? Or is it our desire to never give up hope? This is a good time to point out the common stereotype that oncologists seem to be the worst about never wanting to give up. How can we, as physicians, do a better job of accepting death and of helping our patients who are dying?

4. If you were to give her the diagnosis, how would you break the bad news using the SPIKES protocol?

Following SPIKES: (Baile and Walter)

SET UP THE INTERVIEW

Review the plan for telling the patient and how one will respond to patients' emotional reactions or difficult questions. It is helpful to be reminded that, although bad news may be very sad for the patients, the information may be important in allowing them to plan for the future. Find a setting that affords privacy and is conducive to undistracted and focused discussion, the goals of the interview may not be met. Some helpful guidelines:

- ***Involve significant others.*** Most patients want to have someone else with them but this should be the patient's choice. When there are many family members, ask the patient to choose one or two family representatives.
- ***Sit down.*** Sitting down relaxes the patient and is also a sign that you will not rush. When you sit, try not to have barriers between you and the patient. If you have recently examined the patient, allow them to dress before the discussion.

- ***Make connection with the patient.*** Maintaining eye contact may be uncomfortable but it is an important way of establishing rapport. Touching the patient on the arm or holding a hand (if the patient is comfortable with this) is another way to accomplish this.
- ***Manage time constraints and interruptions.*** Inform the patient of any time constraints you may have or interruptions you expect. Set your pager on silent or ask a colleague to respond to your pages.

ASSESS THE PATIENT'S PERCEPTION

"Before you tell, ask." That is, before discussing the medical findings, the clinician uses open-ended questions to create a reasonably accurate picture of how the patient perceives the medical situation— what it is and whether it is serious or not. For example, "What have you been told about your medical situation so far?" or "What is your understanding of the reasons we did the MRI?". Based on this information you can correct misinformation and tailor the bad news to what the patient understands.

OBTAIN THE PATIENT'S INVITATION

While a majority of patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. When a clinician hears a patient express explicitly a desire for information, it may lessen the anxiety associated with divulging the bad news. If patients do not want to know details, offer to answer any questions they may have in the future or to talk to a relative or friend.

GIVE KNOWLEDGE AND INFORMATION TO THE PATIENT

Warning the patient that bad news is coming may lessen the shock that can follow the disclosure of bad news and may facilitate information processing. Examples of phrases that can be used include, "Unfortunately I've got some bad news to tell you" or "I'm sorry to tell you that…".

Start at the level of comprehension and vocabulary of the patient. Try to use nontechnical words such as "spread" instead of "metastasized" and "sample of tissue" instead of "biopsy." Avoid excessive bluntness. Give information in small chunks and check periodically as to the patient's understanding. When the prognosis is poor, avoid using negative phrases and discuss what hop is reasonable and other important therapeutic goals such as good pain control and symptom relief.

ADDRESS THE PATIENT'S EMOTIONS WITH EMPATHIC RESPONSES

Patients' emotional reactions may vary from silence to disbelief, crying, denial, or anger.

When patients get bad news their emotional reaction is often an expression of shock, isolation, and grief. In this situation the physician can offer support and solidarity to the patient by making an empathic response. The following guidelines may be helpful:

1. First, observe for any emotion on the part of the patient. This may be tearfulness, a look of sadness, silence, or shock.
2. Second, identify the emotion experienced by the patient by naming it to oneself. If a patient appears sad but is silent, use open questions to query the patient as to what they are thinking or feeling.
3. Third, after you have given the patient a brief period of time to express his or her feelings, let the patient know you understand that this is difficult news.

Example:

Doctor: I'm sorry to say that the x-ray shows that the chemotherapy doesn't seem to be working. Unfortunately, the tumor has grown somewhat.

Patient: I've been afraid of this!

Doctor: Moves his chair closer, offers the patient a tissue, and pauses. I know that this isn't what you wanted to hear. I wish the news were better.

In the above dialogue, the physician observed the patient and realized that the patient was tearful because of the bad news. He moved closer to the patient. At this point he might have also touched the patient's arm or hand if they were both comfortable and paused a moment to allow her to get her composure. He let the patient know that he understood why she was upset by making a statement that reflected his understanding.

4. Six months have gone by. Nurse Monahan has come to you and said someone has to talk to Dr. Bearing about her code status. What you would say to her and how would you document the results of your conversation in the chart.

You should be able to have had a good discussion of the meaning of DNR and whether DNR means "provide no care," the importance of timing in discussing DNR orders and the concept of DNR orders as advance directives, the relation of DNR to hospice and how one might ease the psychological transition from hoping for a cure to palliative care or hospice. (see below for a guide to this content.)

There should have been at least an initial discussion regarding DNR at a much earlier date. By waiting to address the issue, all parties involved (including Dr. Posner) weren't made aware of it in time for it to be appropriately implemented. It might help if our future physicians remember that a DNR is a type of "Advance Directive." The term "Advance Directive" more clearly illustrates the importance of timing in discussing DNR orders.

Dr. Bearing is alone while undergoing treatment and expresses to Nurse Monahan that it "won't be necessary" to contact any friends or family about her condition. This is yet another factor in deciding *when* to discuss DNR orders. Without a health care surrogate (other than the courts), it is important to approach Dr. Bearing while she is still capable to make decisions about her health care (assuming the cancer treatment or other factors may influence her decision-making capacity). This way she retains her autonomy and can continue to make her own decisions (even if incapacitated).

For this reason, it would have been appropriate for Dr. Kelekian to have discussed the orders in addition to Nurse Monahan. While the nurses sometimes assume this role, it is important that the physician inform the patient that the orders have been completed and are understood by all parties.

Paternalism is often contrasted to Autonomy. One example of paternalism is Dr. Kelekian's order for a morphine drip instead of the PCA suggested by Nurse Monahan. What is a morphine drip? Are they still used today? If so, why? With the availability of PCA pumps, patients can maintain a sense of self-control and can preserve their coherence for a longer period of time. Why wouldn't Dr. Kelekian want that for his patient? Maybe had Dr. Bearing been afforded a PCA pump she would have had one more "coherent line." Is paternalism still part of today's medical culture? If so, does paternalism represent a 'generation gap' in medical society (that is, will paternalism slowly phase out as the older generation of physicians retires)?

At what point should Dr. Kelekian or Dr. Posner have discussed whether the treatment was helping or not? At what point should palliative care become an issue? In this film, palliative care is never even considered. How much does that result from Dr. Kelekian and Dr. Posner's desire to keep pushing forward with their research regardless of what the patient might want? It is obvious that her physicians want her to continue treatment, at the "full dose," so that they can complete their research.

Appendix 3

Summary of the Film

Listed below is a chronology of statements made in the movie which students could identify in their small group discussions.

1. "You have cancer." *(The very first line, which Dr. Kelekian tells Vivian Bearing while standing over her. A very abrupt and intimidating way to start breaking bad news. And the way he seems to handle most of his interaction with her.)*
2. He then goes on to very quickly explain her diagnosis and treatment, then stops after "pernicious side effects." He sees the distant look on Dr. Bearing's face and asks if she has any questions. He also asks, "Perhaps some of these terms are new?" And she replies, "No, no. You are being very thorough," to which he responds, "I make a point of it." *(This is an important exchange in that "thorough" is a theme that comes up a few times in the film – e.g. Grand Rounds. Dr. Kelekian and Dr. Bearing then go on to exchange a rather scholarly dialogue about emphasizing the importance of "thoroughness" to their students. This is an important representation of how they both use knowledge and language to keep the emotional reality of the situation at bay. Again, a theme that will be repeated throughout the movie as we learn that Dr. Bearing did much the same thing in her classes on John Donne..)*
3. Dr. Kelekian later states that "This treatment is the strongest thing we have to offer you. As for our research, it will make a significant contribution to our knowledge." *(This statement bears a lot of weight in two ways – first, he doesn't really discuss any of the other treatment options; and secondly, the theme that the research comes first is an ongoing issue throughout the movie. Note too she will contribute to knowledge, which appeals to her as a professor, but it isn't her mind that will make the contribution, but how her body responds to the treatment.)*

4. Dr. Kelekian also states that "The important thing is to take the full dose of chemotherapy." *(Again, this is a common thread that runs throughout the movie. Is this really the "important thing?" For whom?)*
5. Near the end of the breaking of bad news, Dr. Kelekian asks Vivian Bearing to sign the informed consent form. She does so without really reading the form. *(Is this really informed consent? Were alternative therapies discussed? Or do you think she was pressured into making a commitment by a biased presentation, such as telling her "I know you understand. I know you can do this."? In the next scene, Vivian Bearing actually states, "I should have asked more questions…)*

Note: Obviously, the first scene is extremely powerful and really is the prelude to the rest of the movie. So much dialogue exists in that scene alone that contributes to the patient's condition, her understanding of the condition, her decision about treatment, and the physician's role in the patient's decision-making process.

6. "Hi, how are you feeling today?" *(Vivian Bearing's description of how she is treated on a daily basis reveals that although everyone asks her that question, no one really ever listens to the answer.)*
7. The scene displaying the interaction between Professor Ashford and Vivian Bearing reveals Dr. Bearing's initial understanding of death as it contributes to poetry. Professor Ashford explains, through John Donne's eyes, "life, death, soul, God, past, present … not insuperable barriers." *(Although this scene shows Dr. Bearing's professional beginnings, it is also demonstrates her difficulty in appreciating death during her early life and the way Dr. Bearing now interprets her own futility and the possibility of dying from her disease.)*
8. "Simple human truth … Uncompromising scholarly standards … They are connected …" *(Dr. Bearing pauses. This is an important statement in that it reveals the constant struggle she displays throughout the film in the professional image and standards she holds for herself versus the need for her*

emotions to be validated by the healthcare professionals surrounding her – even though the latter isn't revealed until a later scene.)

9. "Name? Doctor?" And Dr. Bearing's response, "Lucy, Countess of Bedford," which the technician doesn't even realize is a joke. *(This is another running theme in the movie – Dr. Bearing's desire to be recognized as the intellectual "force" she has worked so hard to become, and the medical community's lack of recognition for who she is as a person. Remember the first time they ask "Doctor?" She replies "Yes." This is her second response. The third time she just says "Kalekian." By the end of the film, this gap between Dr. Bearing and the medical technicians becomes symbolic of her medical condition – the weaker she becomes, the less she cares whether or not they recognize who she is as a person.)*
10. Note the first meeting between Dr. Bearing and Dr. Jason Posner, her former student. Several issues can be discussed here: his obvious discomfort in having to ask personal questions to his former professor (lack of eye contact, fumbling through the sexual history), his leaving her undressed and in stirrups when he realizes he needs to find a female chaperone, his response upon feeling the tumor on exam (says "Jesus!" out loud and then doesn't apologize for his outburst), and his quick escape from the exam room after feeling the tumor (saying "I gotta go" and then hurriedly leaving the room). *(This is another common theme throughout the movie. Dr. Posner never really becomes comfortable having Dr. Bearing as his patient. How do you think this affects his medical judgment/treatment towards her? What might this tell us about being the doctor for people we know, even if only professionally, let alone personally like family members?)*
11. A good example of the use of medical terminology is during the interaction between Dr. Bearing and Dr. Posner in his use of the word "ethanol," which he has to explain is "alcohol," to which Dr. Bearing says, "wine." *(This sequence of words illustrates how we as physicians use language that our*

patients – even our most educated patients – can't understand. This is demonstrated throughout the film, especially during Grand Rounds, as a means for physicians to talk about patients without the patients understanding what is being said.)

12. Note that the first person to show true compassion is her nurse, Susie Monahan. Nurse Monahan asks if Dr. Bearing is "O.K. all by herself" in her room and asks if there is anyone she can notify for her. *(This is the first chance that Dr. Bearing has to express her feelings, even though she doesn't open up much. It is also a chance for the audience to realize that Dr. Bearing is going through the experience alone.)*
13. "Grand rounds" Note the interactions of the residents, the patient, and Dr. Kelekian. Depression is mentioned and quickly dismissed. No other psychosocial or spiritual issues are raised. (*While this may be typical of Professor's rounds in many settings, it is important to note three things: First, the way the residents talk over her as if she's an object to be studied instead of a person, and the aggressiveness of their physical exam such as when they lift her shirt to listen to her heart; second, the use of language to talk about the patient seemingly without the patient knowing what is being said; and third, the fact that Dr. Posner has to be told to thank Dr. Bearing for her time and then does so rather begrudgingly. As our medical students approach third year, these are important failures of the ethical principle of Respect for Persons to point out.)*
14. The use of language should be emphasized here. Phrases and words, such as "frankly palpable," "nephrotoxicity," and "neutropenia," all become part of Dr. Bearing's vocabulary, but only after she looks them up herself. *(How often do we as doctors hide behind our words? Using such terms as "nephrotoxicity" allows us to talk about things that can cause death without the patient even realizing it. And in Dr. Bearing's case, "nephrotoxicity" later becomes an imminent sign that the end is near.)*

15. "I want to know what it means when the doctors anatomize me. My only defense is the acquisition of vocabulary." *(What a nice use of the word "anatomize" as a verb, bringing together Anatomy class and breaking down into subatomic—or subhuman, dehumanized—parts. Again, because so little is explained to Dr. Bearing, she takes it upon herself to understand her condition. What if she wasn't as knowledgeable as she is? What if she was the average American with an eighth grade reading level?)*
16. Dr. Bearing comes in with a neutropenic fever. Note the interaction between the nurse and Dr. Bearing versus Dr. Posner and Dr. Bearing. *(Dr. Posner keeps his hand on the door handle at all times, hardly enters the room, barely looks at Dr. Bearing, and definitely doesn't perform any type of exam. Yet another example of Dr. Posner's inability to empathize with the patient. Also note, again, Dr. Posner's resistance to lowering the chemotherapy dose. He states, "No way" when the nurse suggests lowering the dose given the patient's condition.)*
17. Dr. Bearing is placed in isolation. Dr. Kelekian's response is "Isolation? No problem. Couple of days. Think of it as a vacation." Dr. Posner's response to the isolation precautions is "I really have not got the time for this." *(It's also interesting to note that the scene is shot from Dr. Bearing's perspective, with her very clearly in the front of the shot. The physicians are so out of focus that you recognize them mainly by their voices. This might be one way to represent that her perspective of "isolation" is much different than theirs. Also a way to symbolize that she is listening to them less and less – they keep saying the same things, and she is starting to ignore them.)*
18. "This is my play's last scene. I am becoming very sick; very, very sick; ultimately sick." *(Dr. Bearing is realizing that the treatment is not workingt her condition is worsening, and her death is near. This is an important change in the way she views herself, her life, and what is to come. She also*

realizes now that she is just a journal article to Dr. Kelekian and Dr. Posner, and that they really have no interest in her as a person.)

19. Dr. Bearing finally breaks ground with Dr. Posner by talking about his research. You see him sit down with her for the first time, spend ample time talking to her on a more personal level (even though it's mostly about his work), and smile at her for the first time. He states, ironically, "Cancer is the only thing I ever wanted" and "Cancer is awesome." *(What do you think he would say if he actually had cancer?)* He also talks about how much he likes the phrase, "immortality in culture" when referring to cancer cells. Dr. Bearing sees a *double entendre* and replies, "Sounds like a symposium." *(Here, again, the use of language is demonstrated to mean different things to different people.)*
20. In the same scene, we see how out of touch with humanity Dr. Posner is and how in touch with humanity Dr. Bearing has become. She asks things such as "Do you ever miss people?" Dr. Posner says that people always ask him that, especially girls, and that he "tells them 'yes'" but implies "no." Then Dr. Bearing asks, "What do you say when a patient is frightened?" And he answers, "Of who?" *(He also states that "clinicians are such troglodytes" and that he resents having "to be taught to converse with the clinicians." This brings out the dichotomy between clinicians and researchers—or, one hopes, exaggerates it. But Dr. Posner seems to have a problem with anything having to do with empathy, feelings, and dealing with people– much like Dr. Bearing, before she was diagnosed with cancer.)*
21. In the evolution of Dr. Bearing's disease, she feels scared and lonely for the first time and deliberately occludes her line so that Nurse Monahan will come in to see her. This is the first time anyone talks to Dr. Bearing about her fears, and it is also the first time that anyone talks to her about her DNR status. *(Is this an appropriate role for a nurse? Do you think that, in this conversation, enough is said to be considered informed consent? Why or why not? Note*

here is where Dr. Bearing knows a technical term her nurse doesn't—soporific—reminding us of the one time we saw her with her father and she learned of her love of words.)

22. Note the interaction between Nurse Monahan and Dr. Kelekian. He overrules her request for patient-controlled analgesics by ordering a morphine drip. *(Again, this is an important take home point for our soon-to-be third years – LISTEN TO YOUR NURSES!!! Many times they know much more about your patients than you do!!! Could Nurse Monahan have pulled Dr. Posner aside once Dr. Kelekian left to see about changing the order to a patient-controlled pump? Could Dr. Bearing have done anything in her own defense once she started to feel less pain?)*
23. After the order is written and the staff leaves the room Dr. Bearing turns to the camera and says, "These are my last coherent lines." *(This is a powerful statement in that this usually isn't something a patient would know with such certainty. In reality, it is probably just the need, through script writing, to let the audience understand the scenes to follow.)*
24. Next scene shows Dr. Bearing asleep, and Dr. Posner and Nurse Monahan discussing Dr. Bearing in front of her. Nurse Monahan leans over and talks to Dr. Bearing as though she is awake, and Dr. Posner states, "Like she can hear you." *(Do you think she can hear what they are saying? Even if she can't hear them, what about respect for your patients. Does the conversation in this scene seem at all disrespectful to you? One can be disrespectful to someone who is not aware of it, and even to someone who is dead.)*
25. Dr. Bearing's long-time mentor and colleague, Dr. Ashford comes to visit her in the hospital. It seems that this is closest to a mother figure that Dr. Bearing has. *(Discuss the regression to childhood that seeing Dr. Ashford seems to elicit from Dr. Bearing. Dr. Bearing even refuses her favorite John Donne poetry in favor of "The Runaway Bunny." Discuss also the possibility that*

Dr. Ashford's visit is all a dream, given the previous scene when Dr. Bearing states "these are my last coherent lines" and she is now on a morphine drip)

26. The last scene shows many complex issues of a DNR order that is not acted upon. *(Why didn't the code team check the chart upon entering the room? Why didn't they stop to listen to Nurse Monahan declare Dr. Bearing's wishes? What could have prevented this series of events from occurring? What would you have done differently? Overall, given 20-20 hindsight, do you think it would have been better if she had never enrolled in the protocol?)*

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Hospital Visit #4

This will be the fourth and final visit to the hospital for the students. Similar to the third visit, in this visit the students will perform the complete history and physical exam. During this visit the students will each again do a short presentation for the hospital preceptor. Their homework assignments will include a written record of the history, physical exam, pertinent positives, problem list and assessment, plan and orders. In addition they will create a parallel chart for this visit.

Appendix 1 includes the preceptor evaluation of the students' performance that should be done after this session is completed.

Objectives

Upon completion of this unit the student will be able to:

1. Elicit a complete history, including history of present illness, medical history, surgical history, social history, and review of systems.
2. Perform a complete physical exam based on the history elicited.
3. Formulate a problem list, assessment, plan and orders based on the history and physical exam findings.
4. Create a parallel chart for the patient encounter.

Appendix 1

HOSPITAL SESSION STUDENT EVALUATION FORM

Student: _____ Date: _____

Evaluator:_____ (please print)

Eval. Signature:_____

Rating Scale:

O - Poor
1 - Below Average
2 - Average
3 - Above Average
4 - Outstanding

CATEGORY		RATING (circle one)				
1. **History taking** (30 total) Evaluate presentation accuracy and completeness of:						
A. Chief Complaint and History of Present Illness	(10)	0	1	2	3	4
B. Past History	(5)	0	1	2	3	4
C. Family History	(5)	0	1	2	3	4
D. Social History	(5)	0	1	2	3	4
E. Review of Systems	(5)	0	1	2	3	4
2. **Physical Examination** (35 total) Evaluate presentation of						
A. Head and Neck	(5)	0	1	2	3	4
B. Heart and Lungs	(5)	0	1	2	3	4

CATEGORY		RATING (circle one)					
C.	Abdomen	(5)	0	1	2	3	4
D.	Musculoskeletal	(5)	0	1	2	3	4
E.	Peripheral Vascular	(5)	0	1	2	3	4
F.	Neurological	(5)	0	1	2	3	4
G.	Mental Status	(5)	0	1	2	3	4
3.	**Presentation Skills**	(35 total)					
	Evaluate accuracy, completeness and organization of presentation		0	1	2	3	4

COMMENTS: (use back of page for additional space) Adapted from: (UMDNJ "Hospital Session Student Evaluation Form")

Works Cited

UMDNJ, PA Program. “Hospital Session Student Evaluation Form.” Piscataway, NJ: UMDNJ, nd. Print.

Unit 14

Culturally Competent Clinical Practice and Working with an Interpreter

This unit is designed to provide additional content on cultural competence which was introduced in Unit 1. This unit takes a closer look at health disparities and introduces a model of culturally competent medical care. The homework for this unit is a narrative analysis explored through a reading exercise. The purpose of the close reading exercise is to allow the students to do a more detailed reading of the text in order to better understand the plight of the characters in the story. A review of the unit objectives which are presented in slide 1 will provide the instructor with a guide to the unit. There are two appendices at the end of this unit. The first is the homework reading assignment and the second is the narrative analysis that the student is expected to complete.

The following is an outline of the material on the PowerPoint slides for this unit:

SLIDE 1: Objectives

At the end of this class students will be able to:

1. distinguish between features of cultural competence within healthcare systems and features within interpersonal interactions
2. recognize that disparities in health care can be improved through cultural competence
3. recognize that cultural beliefs have an impact on the way a patient approaches the healthcare system and their providers
4. describe ways to manage the discrepancies between the practitioner's and patient's approach to health, illness, and health care
5. utilize interviewing techniques in order to elicit the patient's health beliefs and incorporate these beliefs into the treatment plan
6. work more effectively with interpreters

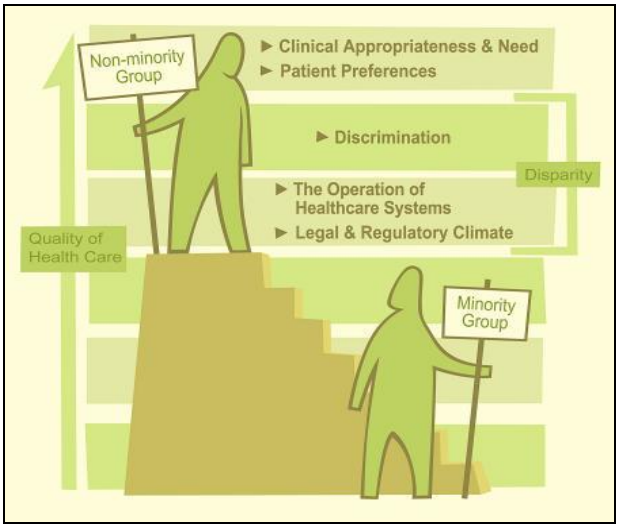
SLIDE 2: Key Concepts/Sections

- Health disparities
- Cultural competence
- ETHNIC model
- Working with an interpreter

SLIDE 3: Disparities in HealthCare (adapted from Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003) – report commissioned by the IOM) (IOM)

- Studies show that when we control for social determinants, access to care and level of health care there are still disparities in care based on race
- Examples include fewer mammograms, kidney transplants, cardiac caths, bypass surgeries and more…
- http://www.nap.edu/books/030908265X/html/

SLIDE 4: Many factors play a role



from: The Coming of Age of Multicultural Medicine by Gail McBride

SLIDE 5

Why do these disparities occur?

- Differences in patient's recognition of symptoms
- Differing thresholds for seeking care

Communication problems:

- provider's understanding of symptoms
- patient's understanding of treatment

SLIDE 6: What is Cultural Competence?

- Understanding importance of social and cultural influences on patients health beliefs and behaviors
- Considering how these factors interact/ impact the health care process
- Utilizing interventions that take these into account to assure quality health care

SLIDE 7: Cultural Competence: How does it look? (Saha, Beach and Cooper)

Within healthcare organizations:

1. Diverse workforce reflecting patient population
2. Healthcare facilities convenient and attentive to the community
3. Language assistance available for patients with limited English proficiency
4. Ongoing staff training regarding delivery of culturally and linguistically appropriate services

SLIDE 8: Within Interpersonal Interactions:

1. Explores and respects patient beliefs, values, meaning of illness, patient preferences
2. Builds rapport and trust
3. Finds common ground
4. Aware of own biases/assumptions

5. Knowledgeable about different cultures
6. Aware of health disparities and discrimination affecting minority groups
7. Effectively uses interpreter services when needed

SLIDE 9: What Can Culturally Competent Care Provide?

Better communication → greater patient satisfaction, adherence to treatment → better health outcomes

SLIDE 10: Models for Cultural Competence (review from previous lecture)

LEARN

- Listen
- Explain
- Acknowledge differences
- Recommend treatment
- Negotiate Agreement

SLIDE 11: How do models help us?

Understand the patient as unique person

- Explore and respect patient beliefs, values, meaning of illness, preferences and needs
- Build rapport and trust
- Find common ground
- Become aware of one's own biases/assumptions
- Maintain and convey unconditional positive regard
- Allow involvement of friends/family when desired
- Provide information and education tailored to patient's level of understanding

SLIDE 12: **ELICITING PATIENTS' HEALTH BELIEFS:**

ETHNIC: A Framework for Culturally Competent Clinical Practice (Like)

Helps us to:

- understand the patients' perceptions of their health problems
- determine what patients are expecting from the medical encounter and negotiate treatment plans

ETHNIC Model

- is especially helpful with people from diverse cultures
- but concept is important for all patients
- suggested questions would be asked after the routine introductory questions

SLIDE 13: E.T.H.N.I.C.

E: Explanation

- What do you think may be the reason you have these symptoms?
- What do friends, family, others say about these symptoms?
- Do you know anyone else who has had or who has this kind of problem?
- Have you heard/read/seen it on radio, newspaper, T.V.?
- (If patient cannot offer explanation, ask what most concerns them about their problem.)

SLIDE 14

T: Treatment

- What kinds of medicines, home remedies or other treatments have you tried?
- Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy?
- Tell me about it.
- *What kind of treatment are you seeking from me?*

SLIDE 15

H: Healers

- Have you sought any advice from friends or other people (*alternative providers*) for help with your problems? Tell me about it.

SLIDE 16

N: Negotiate

- Negotiate options that will be mutually acceptable to you and your patient that do not contradict, but rather incorporate your patient's beliefs.
- What are the most important results your patient hopes to achieve from this intervention?

SLIDE 17

I: Intervention /Incorporation

- Determine an intervention with your patient. Incorporate alternative treatments, spirituality and healers as well as other cultural practices

SLIDE 18

C. Collaborate

- Collaborate *with the patient, family members*, other health care team members, healers and community resources.

SLIDE 19: DVD: Communicating Effectively Through an Interpreter (vanderHoff and Media)

- Why do we need interpreters?
- Who is the interpreter? Untrained vs. professional
- How can we maximize the effectiveness of the interview when we use interpreters?

Note to the instructor: This DVD is a designed as a teaching tool for practitioners who will need to work with interpreters. It is designed with "STOP" points for discussion

throughout. The DVD should be viewed by the instructor ahead of time in order to assure appropriate discussion. The DVD will take the students through a problematic scenario of interpretation with a non-professional interpreter and ask them to identify the problems. This is followed by a scenario with a professional interpreter which goes well and the students are asked to identify why this went well. Finally the tape goes back to the first scenario with the non-professional interpreter and demonstrates how this situation can be maximized to ensure effective communication.

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Saha, Somnath, Mary Catherine Beach, and Lisa A. Cooper. "Patient Centeredness, Cultural Competence and Healthcare Quality." *Journal of the National Medical Association* 100.11 (2008): 1275-85. Print.

Roat, Cynthia. *Communicating Effectively through an Interpreter*. Seattle, WA: Cross Cultural Health Care Program,1998.

Appendix 1
HOMEWORK

Complete a close reading exercise for:

Birth – Chapter One
"The Spirit Catches You and You Fall Down"
by Anne Fadiman

If Lia Lee had been born in the highlands of northwest Laos, where her parents and twelve of her brothers and sisters were born, her mother would have squatted on the floor of the house that her father had built from ax-hewn planks thatched with bamboo and grass. The floor was dirt, but it was clean. Her mother, Foua, sprinkled it regularly with water to keep the dust down and swept it every morning and evening with a broom she had made of grass and bark. She used a bamboo dustpan, which she had also made herself, to collect the feces of the children who were too young to defecate outside, and emptied its contents in the forest. Even if Foua had been a less fastidious housekeeper, her newborn babies wouldn't have gotten dirty, since she never let them actually touch the floor. She remains proud to this day that she delivered each of them into her own hands, reaching between her legs to ease out the head and then letting the rest of the body slip out onto her bent forearms. No birth attendant was present, though if her throat became dry during labor, her husband, Nao Kao, was permitted to bring her a cup of hot water, as long as he averted his eyes from her body. Because Foua believed that moaning or screaming would thwart the birth, she labored in silence, with the exception of an occasional prayer to her ancestors. She was so quiet that although most of her babies were horn at night, her older children slept undisturbed on a communal bamboo pallet a few feet away, and woke only when they heard the cry of their new brother or sister. After each birth, Nao Kao cut the umbilical cord with heated scissors and tied it with string. Then Foua washed the baby with water she had

carried from the stream, usually in the early phases of labor, in a wooden and bamboo pack-barrel strapped to her back.

Foua conceived, carried, and bore all her children with ease, but had there been any problems, she would have had recourse to a variety of remedies that were commonly used by the Hmong, the hilltribe to which her family belonged. If a Hmong couple failed to produce children, they could call in a *txiv neeb,* a shaman who was believed to have the ability to enter a trance, summon a posse of helpful familiars, ride a winged horse over the twelve mountains between the earth and the sky, cross an ocean inhabited by dragons, and (starting with bribes of food and money and, if necessary, working up to a necromantic sword) negotiate for his patients' health with the spirits who lived in the realm of the unseen. A *txiv neeb* might be able to cure infertility by asking the couple to sacrifice a dog, a cat, a chicken, or a sheep. After the animal's throat was cut, the *txiv neeb* would string a rope bridge from the doorpost to the marriage bed, over which the soul of the couple's future baby, which had been detained by a malevolent spirit called a *dab,* could now freely travel to earth. One could also take certain precautions to avoid becoming infertile in the first place. For example, no Hmong woman of childbearing age would ever think of setting foot inside a cave, because a particularly unpleasant kind of *dab* some- times lived there who liked to eat flesh and drink blood and could make his victim sterile by having sexual intercourse with her.

Once a Hmong woman became pregnant, she could ensure the health of her child by paying close attention to her food cravings. If she craved ginger and failed to eat it, her child would be born with an extra finger or toe. If she craved chicken flesh and did not eat it, her child would have a blemish near its ear. If she craved eggs and did not eat them, her child would have a lumpy head. When a Hmong woman felt the first pangs of labor, she would hurry home from the rice or opium fields, where she had continued to work throughout her pregnancy. It was important to reach her own house, or at least the house of one of her husband's cousins, because if she gave birth anywhere else a *dab* might injure her. A long or arduous labor could be

eased by drinking the water in which a key had been boiled, in order to unlock the birth canal; by having her family array bowls of sacred water around the room and chant prayers over them; or, if the difficulty stemmed from having treated an elder member of the family with insufficient respect, by washing the offended relative's fingertips and apologizing· like crazy until the relative finally said, "l forgive you."

Soon after the birth, while the mother and baby were still lying together next to the fire pit, the father dug a hole at least two feet deep in the dirt floor and buried the placenta. **If** it was a girl, her placenta was buried under her parents' bed; if it was a boy, his placenta was buried in a place of greater honor, near the base of the house's central wooden pillar, in which a male spirit, a don1estic guardian who held up the roof of the house and watched over its residents, made his home. The placenta was always buried with the smooth side, the side that had faced the fetus inside the womb, turned upward, since if it was upside down, the baby might vomit after nursing. **If** the baby's face erupted in spots, that meant the placenta was being attacked by ants underground, and boiling· water was poured into the burial hole as an insecticide. In the Hmong language, the word for placenta means "jacket." It is considered one's first and finest garment. When a Hmong dies, his or her soul must travel back from place to place, retracing the path of its life geography, until it reaches the burial place of its placental jacket, and puts it on. Only after the soul is properly dressed in the clothing in which it was born can it continue its dangerous journey, past murderous *dabs* and giant poisonous caterpillars, around man-eating rocks and impassable oceans, to the place beyond the sky where it is reunited with its ancestors and from which it will someday be sent to be reborn as the soul of a new baby. **If** the soul cannot find its jacket, it is condemned to an eternity of wandering, naked and alone.

Because the Lees are among the 150,000 Hmong who have fled Laos since their country fell to communist forces in 1975, they do not know if their house is still standing, or if the five male and seven female placentas that Nao Kao buried

under the dirt floor are still there. They believe that half of the placentas have already been put to their final use, since four of their sons and two of their daughters died of various causes before the Lees came to the United States. The Lees believe that someday the souls of most of the rest of their family will have a long way to travel, since they will have to retrace their steps from Merced, California, where the family has spent fifteen of its seventeen years in this country; to Portland, Oregon, where they lived before Merced; to Honolulu, Hawaii, where their airplane from Thailand first landed; to two Thai refugee camps; and finally back to their home village in Laos.

The Lees' thirteenth child, Mai, was born in a refugee camp in Thailand. Her placenta was buried under their hut. Their fourteenth child, Lia, was born in the Merced Community Medical Center, a modern public hospital that serves an agricultural county in California's Central Valley, where many Hmong refugees have resettled. Lia's placenta was incinerated. Some Hmong women have asked the doctors at MCMC, as the hospital is commonly called, if they could take their babies' placentas horne. Several of the doctors have acquiesced, packing the placentas in plastic bags or take-out containers from the hospital cafeteria; most have refused, in some cases because they have assumed that the women planned to eat the placentas, and have found tl1at idea disgusting, and in some cases because they have feared the possible spread of hepatitis B, which is carried by at least fifteen percent of the Hmong refugees in the United States. Foua never thought to ask, since she speaks no English, and when she delivered Lia, no one present spoke Hmong. In any case, the Lees' apartment had a wooden floor covered with wall-to-wall carpeting, so burying the placenta would have been a difficult proposition.

When Lia was born, at 7:09p.m. on July 19, 1982, Foua was lying on her back on a steel table, her body covered with sterile drapes, her genital area painted with a brown Betadine solution, with a high-wattage lamp trained on her perineum. There were no family members in the room. Gary Thueson, a family practice resident who did the delivery, noted in the chart that in order to speed the labor, he had

artificially ruptured Foua's amniotic sac by poking it with a foot-long plastic "amni-hook"; that no anesthesia was used; that no episiotomy, an incision to enlarge the vaginal opening, was necessary; and that after the birth, Foua received a standard intravenous dose of Pitocin to constrict her uterus. Dr. Thueson also noted that Lia was a "healthy infant" whose weight, 8 pounds 7 ounces, and condition were "appropriate for gestational age" (an estimate he based on observation alone, since Foua had received no prenatal care, was not certain how long she had been pregnant, and could not have told Dr. Thueson even if she had known). Foua thinks that Lia was her largest baby, although she isn't sure, since none of her thirteen elder children were weighed at birth. Lia's Apgar scores, an assessment of a newborn infant's heart rate, respiration, muscle tone, color, and reflexes, were good: one minute after her birth she scored 7 on a scale of 10, and four n1inutes later she scored 9. \Vhen she was six minutes old, her color was described as "pink" and her activity as "crying." Lia was shown briefly to her mother. Then she was placed in a steel and Plexiglas warmer, where a nurse fastened a plastic identification band around her wrist and recorded her footprints by inking the soles of her feet with a stamp pad and pressing them against a Newborn Identification form. After that, Lia was removed to the central nursery, where she received an injection of Vitamin K in one of her thighs to prevent hemorrhagic disease; was treated with two drops of silver nitrate solution in each eye, to prevent an infection from gonococcal bacteria; and was bathed with Safeguard soap.

Foua's own date of birth was recorded on Lia's Delivery Room record as October 6, 1944. In fact, she has no idea when she was born, and on various od1.er occasions during the next several years she would inform MCMC personnel, through English-speaking relatives such as the nephew's wife who had helped her check into the hospital for Lia's delivery, that her date of birth was October 6, 1942, or, more frequently, October 6, 1926. Not a single admitting clerk ever appears to have questioned the latter date, tl1ougb it would imply that Foua gave

birth to Lia at the age of 55. Foua is quite sure, however, that October is correct, since she was told by her parents that she was born during the season in which the opium fields are weeded for the second time and the harvested rice stalks are stacked. She invented the precise day of the month, like the year, in order to satisfy the many Americans who have evinced an abhorrence of unfilled blanks on the innumerable forms the Lees have encountered since their admission to the United States in 1980. Most Hmong refugees are familiar with this American trait and have accommodated it in the same way. Nao Kao Lee has a first cousin who told the immigration officials that all nine of his children were born on July I5, in nine consecutive years, and this information was duly recorded on their resident alien documents.

When Lia Lee was released from MCMC, at the age of three days, her mother was asked to sign a piece of paper that read:

> **I CERTIFY that during the discharge procedure I received my baby, examined it and determined that it was mine. I checked the Idem-A-Band® parts sealed on the baby and on me and found that they were identically numbered 5043 and contained correct identifying information.**

Since Foua cannot read and has never learned to recognize Arabic numerals, it is unlikely that she followed these instructions. However, she had been asked for her signature so often in the United States that she had mastered the capital forms of the seven different letters contained in her name, Foua Yang. (The Yangs and the Lees are among the largest of the Hmong clans; the other major ones are the Chas, the Chengs, the Hangs, the Hers, the Kues, the Los, the Mouas, the Thaos, the Vues, the Xiongs, and the Vangs. In Laos, the clan name came first, hut most Hmong refugees in the United States use it as a surname. Children be- long to their father's clan; women traditionally retain their clan name after marriage. Marrying a member of one's own clan is strictly taboo.) Foua's signature is no less legible than the signatures of

most of MCMC's resident physicians-in-training, which, particularly if they are written toward the end of a twenty-four-hour shift, tend to resemble EEGs. However, it has the unique distinction of looking different each time it appears on a hospital document. On this occasion, FOUAYANG was written as a single word. One A is canted to the left and one to the right, the Y looks like an X, and the legs of tl1e N undulate gracefully, like a child's drawing of a wave.

It is a credit to Foua's general equanimity, as well as her characteristic desire not to think ill of anyone, that although she found Lia's birth a peculiar experience, she has few criticisms of the way the hospital handled it. Her doubts about MCMC in particular, and American medicine in general, would not begin to gather force until Lia had visited the hospital many times. On this occasion, she thought the doctor was gentle and kind, she was impressed that so many people were there to help her, and although she felt that the nurses who bathed Lia with Safeguard did not get her quite as clean as she had gotten her newborns with Laotian stream water, her only major complaint concerned the hospital food. She was surprised to be offered ice water after the birth, since many Hmong believe that cold foods during the postpartum period make the blood congeal in the womb instead of cleansing it by flowing freely, and that a woman who does not observe the taboo against them will develop itchy skin or diarrhea in her old age. Foua did accept several cups of what she remembers as hot black water. This was probably either tea or beef broth; Foua is sure it wasn't coffee, which she had seen before and would have recognized. The black water was the only MCMC-provided food that passed her lips during her stay in the maternity ward. Each day, Nao Kao cooked and brought her the diet that is strictly prescribed for Hmong women during the thirty days following childbirth: steamed rice, and chicken boiled in water with five special postpartum herbs (which the Lees had grown for this purpose on the edge of the parking lot behind their apartment building). This diet was familiar to the doctors on the Labor and Delivery floor at MCMC, whose assessments of it were fairly accurate gauges of their general opinion of the Hmong. One obstetrician, Raquel Arias recalled "The Hmong men carried these nice

little silver cans to the hospital that always had some kind of chicken soup in them and always smelled great." Another obstetrician, Hobert Small, said, "They always brought some horrible stinking concoction that smelled like the chicken had been dead for a week." Foua never shared her meals with anyone, because there is a postpartum taboo against spilling grains of rice accidentally into the chicken pot. If that occurs, the newborn is likely to break out across the nose and cheeks with little white pimples whose name in the Hmong language is the same as the word for ''rice."

Some Hmong parents in Merced have given their children American names. In addition to many standard ones, these have included Kennedy, Nixon, Pajama, Guitar, Main (after Merced'sMain Street), and, until a nurse counseled otherwise, Baby Boy, which one 111other, seeing it written on her son's hospital papers, assumed was the name the doctor had already chosen for him. The Lees chose to give their daughter a Hmong name, Lia. Her name was officially conferred in a ceremony called a *bu plig,* or soul-calling, which in Laos always took place on the third day after birth. Until this ceremony was performed, a baby was not considered to be fully a member of the human n1ce, and if it died during its first three days it was not accorded the customary funerary rites. (This may have been a cultural adaptation to the fifty-percent infant mortality rate, a way of steeling Hmong mothers against the frequent loss of their babies during or shortly after childbirth by encouraging them to postpone their attachment.) In the United States, the naming is usually celebrated at a later time, since on its third day a baby may still be hospitalized, especially if the birth was complicated. It took the Lee family about a month to save enough money from their welfare checks, and from gifts from their relatives' welfare checks, to finance a soul-calling party for Lia.

Although the Hmoug believe that illness can be caused by a variety of sources-including eating the wrong food, drinking contaminated water, being affected by a change in the weather, failing to ejaculate completely during sexual intercourse, neglecting to make offerings to one's ancestors, being punished for one's ancestors' transgressions, be-ing cursed, being hit by a whirlwind, having a stone implanted in

one's body by an evil spirit master, having one's blood sucked by a *dab,* bumping into a *dab* who lives in a tree or a stream, digging a well in a *dab's* living place, catching sight of a dwarf female *dab* who eats earthworms, having a *dab* sit on one's chest while one is sleeping, doing one's laundry in a lake inhabited by a dragon, pointing one's finger at the full moon, touching a newborn mouse, killing a large snake, urinating on a rock that looks like a tiger, urinating on or kicking a benevolent house spirit, or having bird droppings fall on one's head-by far the most common cause of illness is soul loss. Although the Hmong do not agree on just how many souls people have (estimates range from one to thirty-two; the Lees believe there is just one), there is a general consensus that whatever the number, it is the life-soul, whose presence is necessary for healtl1 and happiness, that rends to get lost. A life-soul can become separated from its body through anger, grief, fear, curiosity, or wanderlust. The life-souls of newborn babies are especially prone to disappearance, since they are so small, so vulnerable, and so precariously poised between the realm of the unseen, from which they have just traveled, and the realm of tl1e living. Babies' souls may wander away, drawn by bright colors, sweet sounds, or fragrant smells; they may leave if a baby is sad, lonely, or insufficiently loved by its parents; they may be frightened away by a sudden loud noise; or they may be stolen by a *dab.* Some Hmong are careful never to say aloud that a baby is pretty, lest a *dab* be listening. Hmong babies are often dressed in intricately embroidered hats (Foua made several for Lia) which, when seen from a heavenly perspective, might fool a predatory *dab* into thinking the child was a flower. They spend much of their time swaddled against their mothers' backs in cloth carriers called *nyias* (Foua made Lia several of these too) that have been embroidered with soul-retaining motifs, such as the pigpen, which syrr1bolizes enclosure. They may wear silver necklaces fastened with soul-shackling locks. When babies or small children go on an outing, their parents may call loudly to their souls before the family returns home, to make sure that none remain behind. H mong families in Merced can sometimes be heard doing this when they 'leave local parks after a picnic None of these ploys can work, however, unless

the soul-calling ritual has already been properly observed.

Lia's *hu plig* took place in the living room of her family's apartment. There were so many guests, all of them Hmong and most of them members of the Lee and Yang- clans, that it was nearly impossible to turn around. Foua and Nao Kao were proud that so many people had co1ne to celebrate their good fortun in being favored with such a healthy and beautiful daughter. That morning Nao Kao had sacrificed a pig in order to invite the soul of one of Lia's ancestors, which was probably hungry and would appreciate an offering of food, to be reborn in her body. After the guests arrived, an elder of the Yang clan stood at the apartment's open front door, being East 12th Street, with two live chicken in a bag on the floor next to h i m, and chanted a greeting to Lia's soul. The two chickens were then killed, plucked, eviscerated, partially boiled, retrieved from the cooking pot, and examined to see if their skulls were translucent and their tongues curled upward, both signs that Lia's new soul was pleased to take up residence in her body and that her name was a good one. (If the signs had been inauspicious, the soul-caller would have recommended that another name be chosen.) After the reading of the augurics, the chickens were put back in the cooking pot. The guests would later eat them and the pig for dinner. Before the meal, the soul-caller brushed Lia's hands with a bundle of short white strings and said "I am sweeping away the ways of sickness." Then Lia's parents and all of the elders present in the room each tied a string around one of Lia's wrists in order to bind her soul securely to her body. Foua and Nao Kao promised to love her; the elders blessed her and prayed that she would have a long life and that she would never become sick.

Appendix 2

Guide to close reading exercise

BIRTH

by Anne Fadiman

Plot - This first chapter of Fadiman's book focuses on the character Lia's birth in America and contrasts the birth to what would have happened if she was born in Laos. It vividly describes the Hmong customs that go along with the birth and then describes in detail Lia's American birth. In Laos, the custom is for the mother to squat on the floor and pull the baby out of her womb with her own hands. She would also have labored in silence and the father would have cut the umbilical cord and tie it with string. After the baby was born, the father would bury the placenta in the dirt floor of their house under the parents' bed for a girl and near the base of the central wooden pillar of the house for a boy.

In contrast to this, Foua, Lia's mother, gave birth to her on a metal table with sterile drapes, painted with betadine solution to keep everything sterile. Lia was Foua's fourteenth child and the first to be born in America.

The final paragraphs of the chapter describe Lia's naming ceremony called *hu plig* or soul calling, three days after her birth. The Hmong believe that the most common cause of illness is soul loss and that life souls of babies were especially prone to disappearance. As a result, their mothers dress them in intricately embroidered hats which when viewed by an evil spirit seeking their souls from above will appear to be flowers and protect them.

For this ceremony a pig and chickens are sacrificed. Before the meal, the soul-caller performs a ceremony and Foua and her husband promise to love Lia. The ceremony ends with the elders blessing her.

Form – This is a book chapter and written in the form of an essay or short story. The story is told in the third person. The narrator is an unknown observer of all that happens in the story.

Time – This story is written from the present and looks back at past events.

Frame – This chapter demonstrates to the reader the cultural clash between the Hmong people and the American health care system and doctors who work within that system. It begins Lia's story by describing her unorthodox birth, setting up the remainder of the book which focuses on Lia's health.

Desire – The reader will learn much about the Hmong people and health care in the United States. The will be sensitized to the issue of cultural competence and the lack thereof. It is the hope is that this reading exercise will help students realize the need for cultural competence in health care.

Unit 15

Final OSCE

This OSCE will be the final OSCE for the course. As noted in Unit 6, many medical schools utilize this type of exam and have staff members who can help you to set it up. Detailed directions for setting up an OSCE are included in that Unit.

As a reminder, the standardized patient (actor) should be given the script ahead of time (appendix 1). He/she should also be given an evaluation sheet for each student (appendix 2). When possible, these activities/examinations should be recorded (by camera/video) so that the instructor and student can review the student's performance.

At least 24 hours before the OSCE the students should receive the instructions included in Appendix 3. Once at the exam site, the students will get instructions on the door of the exam room (Appendix 4). The faculty member will observe the student/patient interaction and record on the check list all of the components of the history asked appropriately by the student (Appendix 5). In addition, comments should be made on the student's interpersonal skills.

At some point in the week or two that follow the exam, faculty should meet with each student individually to provide feedback. When appropriate (if applicable) the faculty member should review the recording with student and provide him/her with a copy for viewing.

The following five appendices include everything needed for the OSCE.

Appendix 1
OSCE Script for Standardized Patient
Shortness of Breath

Middle aged adult with shortness of breath

Response to: What brings you here today or first open-ended question? I am having difficulty breathing

Response to second open-ended question: "I feel like I cannot get enough air in."

You are an executive on a very busy schedule who has noticed difficulty breathing over the past 24 hours. You were trying to ignore it and meet a deadline for your advertising company but you are now feeling very anxious. The breathing sensation is very uncomfortable. (You may have episodes of breathing shallowly. When examined, you can wince and point to the right side when you take a deep breath).

When did it start yesterday
Quality/What is it like "like I can't fill my lungs enough"
Severity really uncomfortable, present at rest
What brings it on? nothing really brings it on
What makes it better? nothing makes it better
Positional it is the same if I sit down or lie down
How many blocks can you walk before the pain starts? I can usually jog but I can't really do anything today
Progression I think it may be getting worse
Cough no
Coughing up blood no
Wheezing no

Chest pain today it started hurting slightly when I try to breathe deeply - point to right chest

Severity of Chest Pain mild, 2 on a scale of 1-10

Last CXR l ong ago, don't remember exactly when

Exposure to TB, Last PPD n o known exposure - don't know last TB test

Fever feeling warm, did not take my temperature

Palpitations none

Cyanosis (blueness of skin or lips) none

Ankle Swelling no

Leg swelling now that you mention it, maybe my calf on the left is a little bigger-could you check that out

Recent Chest Trauma none

History of Pulmonary disease no

History of cardiac disease/risk factors no cardiac disease smoked in early 20's, no high blood pressure, no diabetes, no recent cholesterol check

History of panic disorders/anxiety none

Immobilization what do you mean?

Have you been sitting for a long time? yes

Recent Travel—I flew back from England a week ago

Cancer no history of cancer

Recent Surgery no

Hormone replacement therapy (for female model) – No

Birth Control (for female model): Husband had vasectomy

Blood Clotting abnormalities I don't think so

Smoking in early 20's quit

Current Medications vitamins only

Allergies – none

(UMDNJ "Shortness of Breath Osce")

Appendix 2

Student Name_____

Standard Patient Feedback checklist

Strongly agree	Agree	Disagree	Professional and Communication Skills
			Student introduced her/himself appropriately (first and last name, PA student)
			Student addressed patient as Mr or Ms
			Student clarified purpose of visit
			Interview was conducted in an organized manner
			Open ended (more than one) and focused questions were used
			No jargon and when medical terms used, defined immediately
			Student used encouraging and supportive gestures, body language, remarks and made good eye contact
			Student provided positive verbal feedback and reinforcement
			Student used deliberate techniques to check patient's understanding
			Student allowed the patient to express his emotions
			Student encouraged patient to ask questions
			Student ends interview telling patient it is time for PE (closure of interview)
			Student asked for the patient's explanation of disease/symptoms
			Student asked the impact of the disease/symptoms on patient's life

Comments:

Appendix 3

OSCE Instructions for Students

As with the previous OSCE, this exam will be videotaped as a method for students to observe their actual behavior with patients. It can be an invaluable tool to discuss both interviewing techniques as well as nonverbal communication. There is much to be learned by hearing and seeing oneself react with a patient.

As you may remember, Objective Simulated Clinical Exercise (OSCEs) are a specialized technique to assess the skills mentioned above. OSCEs are very similar to the role plays previously done with advisors except that the patient will be a professional actor and each student will do the questioning alone. The patient/PA student interaction will be videotaped so that student and advisor can review at a later time.

How it will work:

1. A detailed schedule of when each student is interviewing will be distributed prior to the OSCE day.
2. Students should arrive for the exam dressed in professional attire including white coat. At this time, last minute questions and announcements will be made. The OSCE coordinator will review the procedures of the patient experience.
3. At your scheduled time, you will go to the exam room and read the instructions/description on the door. When you walk into the exam room, it should be as if you walked into a real patient's room. You should introduce yourself, wash your hands, and ask the patient why he/she is at the office.
4. **You will be responsible for taking the medical history necessary to complete the patient's HPI along with a directed physical exam.**
5. he patient's chief complaint may be anything and you have 20 minutes to complete the interview and physical exam. Keep in mind, the point of the exercise is to have you effectively ask the proper questions and perform a

directed physical exam, it is not for you to come up with the diagnosis or treatment plan.

6. Just as in the hospital, you may bring in a few small cards with the ROS questions to help jog your memory. Remember though, the more you have memorized, the smoother the interview will go. Fumbling through multiple cards is ***not*** good technique.

Appendix 4

INSTRUCTIONS for STUDENTS

(To be placed on door of examining room)

First name last name, a 55 year old male (female) has come to the office today because of difficulty breathing

Vital signs:

Pulse: 90

Temp: 98.

BP: 140/90

Resp: 20

Obtain a history pertinent to this patient's problem and perform a directed physical exam.

You have 20 minutes.

Appendix 5

Student Evaluation Sheet

Student Name_____

Faculty Name_____

Instructions to Examiner: Please give the students one check mark in the column when s/he elicits the historical data indicated or demonstrates the appropriate behavior

SOB OSCE

Data Gathering Checklist			
	1		What brings you in today?
	2		When did shortness of breath begin?
	3		What is quality of shortness of breath? Tightness? Gasping?
	4		What is severity of SOB ? At rest? With activity?
	5		How far patient can walk before shortness of breath occurs?
	6		What makes it worse?
	7		What makes it better?
	8		Does it change lying down or sitting up?
	9		In general is SOB getting better, worse, the same?
	10		Cough
	11		Coughing up blood
	12		Wheezing

	13		Chest pain
	14		Severity of Chest Pain
	15		Exposure to TB, Last PPD
	16		Last CXR
	17		Fever
	18		Palpitations
	19		Cyanosis
	20		Leg or ankle swelling
	21		Recent chest trauma
	22		History of pulmonary disease (work exposure risk?)
	23		History of cardiac disease
	24		History of anxiety disorder or panic attacks?
	25		Immobilization / long travel
	26		Must ask at least 2 of these risk factors (hormone replacement therapy, cancer, recent surgery)
	27		Blood clotting abnormalities
	28		Smoking
	29		Current Meds
	30		Allergies
Professional and Communication Skills			
	31		Student introduced her/himself appropriately (first and last name, PA student)
	32		Student addressed patient as Ms.

	33		Student clarified purpose of visit
	34		Interview was conducted in an organized manner
	35		Open ended (more than one) and focused questions were used
	36		No jargon and when medical terms used, defined immediately
	37		Student used encouraging and supportive gestures, body language, remarks and made good eye contact
	38		Student used deliberate techniques to check patient's understanding
	39		Student allowed the patient to express her emotions
	40		Student asked patient to ask questions
	41		Student clearly specifies future plans at end of interview (closure of interview)
	42		Student asked for the patient's explanation of disease/symptoms
	43		Student asked for impact of the disease/symptoms on patient's life
Physical Exam Skills			
	44		Inspect the neck for JVD and measure (attempt/explain okay)
	45		Inspect the chest: ant., lat, post
	46		Auscultates the lungs: ant., lat., post. (at least 4 places)
	47		Percusses the lungs: ant., lat., post. (at least 4 places)
	48		Palpate the chest for thrills with fingertip or ball of hand (4 places)
	49		Palpate the chest for the PMI (roll if needed)
	50		Auscultates the chest in at least 4 cardiac regions (with diaphragm)
	51		Auscultates the chest in at least 2 cardiac regions (with bell)
	52		Inspect the lower extremities b/l

	53		Palpate the lower extremities b/l
	54		Perform the Homan’s test b/l
	55		Palpate for PT and DP pulses b/l
	56		Student conducted exam systematically
	57		Student washed hands correctly
	58		Student provided for patient comfort
	59		Student provided for patient privacy
	60		Student prefaced exam maneuvers with simple explanations

Work Cited

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VITA

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Educational Institutions:

School	Place	Degree	Date
Secondary	John Dewey HS Brooklyn, NY	Diploma	1973
Collegiate	SUNY Stony Brook Stony Brook, NY	BS Biology	1978
Graduate	Rutgers University Robert Wood Johnson Medical School Piscataway, NJ	MPH	1988
Graduate	Drew University	DMH	2014