Mindful Communication: Bringing Intention, Attention, and Reflection to Clinical Practice

Curriculum Guide

Michael Krasner, MD
Ronald Epstein, MD
University of Rochester School of Medicine and Dentistry

New York Chapter of the American College of Physicians
Physicians Foundation for Health Systems Excellence

Table of Contents

Acknowledgments

The authors of this curriculum would like to acknowledge the following individuals and organizations for their role in this educational program:

- ***The Physicians Foundation for Health Systems Excellence*** for their funding support and concern for the well-being of physicians and the practice of medicine.
- **The *New York Chapter of the American College of Physicians***, and in particular ***Linda Lambert CAE***, its Executive Director and ***Mary Donnelly RN, BSN, MPA***, its quality manager for their commitment and advocacy for this project and for all Internal Medicine specialists in New York State.
- The other members of the project team, in alphabetical order: ***Howard Beckman MD, Ben Chapman PhD, Chris Mooney MS, Timothy Quill MD, Anthony Suchman MD & Melissa Wendland BS*** for their vision, guidance, and hard work.
- The assistance and support of the ***Monroe County Medical Society***, its Executive Director ***Nancy Adams MSM***, and ***Mary Jane Milano MHSA,*** Project Director, for their assistance in recruiting participants and supporting the entire medical community of Greater Rochester.
- ***Jon Kabat-Zinn PhD***, Founding Director, ***Saki Santorelli EdD, MA***, Executive Director, and Co-Directors of Professional Education and Training ***Melissa Blacker MA*** and ***Florence Meleo-Meyer MS, MA***, of the ***Center for Mindfulness in Medicine, Healthcare and Society***, University of Massachusetts School of Medicine for their exemplary teachings and ongoing support.
- The primary care physicians of Rochester, New York for their courage, commitment, and undying concern for the well-being of their patients.
- ***Rita Charon MD, PhD***, ***Michael Baime, MD***, ***Penny Williamson PhD*** and the ***Arnold Gold*** and ***Arthur Vining Davis Foundations*** for their support in the development of a parallel curriculum, *Mindful Practice*, designed for medical students and residency trainees.

Use of this Curriculum

The reader will find in this curriculum the week by week and month by month class outlines with references to some supportive materials used in the program *Mindful Communication: Bringing Intention, Attention and Reflection to Clinical Practice.* The developers of this program and the facilitators teaching have years of training and experience in facilitating communication programs and meditative practices including *Mindfulness-Based Stress Reduction (MBSR).* Additionally, many of the course facilitators have advanced teacher training in MBSR as well as years of experience in classroom and research settings.

In this guide, the reader will find no specific instructions in the guiding of the mindfulness meditation practices. There are a number of ways to develop familiarity and experience with this type of group facilitation; among these are the professional training opportunities at the Center for Mindfulness in Medicine, Healthcare and Society at the University of Massachusetts School of Medicine. The authors also strongly encourage users of this curriculum to have established contemplative practice from which the teaching can naturally arise.

The narrative and appreciative dialogue and interview activities are described in detail where specific exercises are outlined, and the reader may find these descriptions useful as a guide to replicating these activities. Ultimately, the successful use of this curriculum will rely upon the skills, experiences and intentions of its users and the extent to which they fit the intended participants, meet their needs, and are facilitated from a place of authenticity, sincerity, and relationship.

CD recordings of guided formal mindfulness practices of the body scan, sitting meditation and mindful movement are available upon request from the authors.

Background and Goals of the Program

Mindful Communication, Bringing Intention, Attention, and Reflection to Clinical Practice was developed by a team of physicians in Rochester, New York, under the sponsorship of the New York Chapter of the American College of Physicians and through the financial support of the Physicians' Foundation for Health Systems Excellence. It was designed to enhance physicians' satisfaction with their work, improve the physician-patient relationship, and advance the quality of medical care provided by these physicians. This educational intervention was built on a strong biopsychosocial foundation and contains three major components, each integrated with the others into a seamless approach called *Mindful Communication.*

The three components that make up the core experience of *Mindful Communication* are:

Mindfulness- an open, receptive, and non-judgmental orientation to one' present moment-to-moment experience;

Narrative Medicine- the creation and sharing of reflective stories that explore the profound and meaningful experiences one has as a physician; and

Appreciative Inquiry- an approach to individual and organizational change that alters habitual patterns of thinking and behavior by redirecting attention from problems to be solved and deficiencies to be corrected towards strengths and capacities to be enhanced and extended.

The outcome of this intervention, experienced over the course of one year by 70 primary care physicians in Rochester, was reported in the *Journal of the American Medical Association* (Krasner MS, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA.* 2009; 301: 1284-93). These physicians experienced significant improvements in both measures of personal well-being and relationship-centered qualities of care. Specifically, significant improvements in *mindfulness*, *burnout* and *mood states* were demonstrated. *Empathy* was enhanced, and the ability of these physicians to consider the importance of the *psychosocial* dimensions of their patients grew. Additionally, the improvements in mindfulness correlated with the improvements in these other measures of physician well-being and relationship-centered orientation, suggesting a mediating role for mindfulness. Interestingly, most of these changes were evident at the end of the intensive eight-week phase of the program, continued through the maintenance phase, and persisted at 15 months after the program began.

Basic Structure of the Program

The basic structure of this program involves two phases. In the first so called *intensive phase* participants meet 2.5 hours weekly for eight weeks. Between the sixth and seventh weeks, they participate in a day-long retreat. The second so called *continuation* phase consists of monthly 2.5-hour meetings for ten months. Altogether there are 19 meetings, and a total of 52 contact hours. The meetings are co-facilitated by two to four facilitators, each one experienced in guiding mindfulness meditation practices, narrative medicine and appreciative inquiry exercises, and skilled in group facilitation.

Objectives/End-Point Competencies

By the end of the year-long intervention, participants generally report (see *JAMA* 2009):

- Decreased burnout (emotional exhaustion, depersonalization, and low sense of personal accomplishment)
- Enhanced empathic capacity
- Decreased mood disturbance and improved sense of well-being
- Greater attention to patients' personal and psychosocial concerns
- Improved levels of mindfulness which correlate strongly with improvements in burnout, empathy, mood disturbance, and psychosocial orientation towards patients

Objectives of the program also include::

- Keener awareness of the interpersonal dynamics that drive medical interactions with patients
- Improved listening and speaking skills, thus enhancing the medical decision-making process
- Enhanced awareness of the effects of one's emotional reactivity on the physician-patient relationship
- Improved well-being, vitality, and mindfulness
- Greater confidence in handling a variety of challenging medical conditions, in particular chronic conditions, end-of-life care, and conditions with complex psychosocial issues
- Greater degree of comfort in the role of being present to patients' suffering
- An enhanced sense of meaning from the relationships and experiences of clinical medical practice

Components

Although components of the program can be viewed as *techniques*, and the intervention viewed as the acquisition of a set of skills for application in the practice of medicine, the program has a more fundamental aim: transforming one's *way of being* as a physician. Expressed in another way, the practice of *Mindful Communication* is designed to change the way that physicians relate not only to their patients, but also to their colleagues and to themselves. Included in this expanded view is the recognition that through care and attention to oneself the clinician can become a better physician, more attentive and aware of the needs of patients.

The acquisition of medical knowledge, the assimilation of clinical information, and the continued honing of manual skills are vital to medical competence. Likewise, the continual honing of interpersonal skills, the steady development of increased intrapersonal and interpersonal awareness, and the capacity to attend to patients with presence are also central tasks toward the goal of practicing high quality and relationship-centered medical care. A desirable outcome of this program in *Mindful Communication* is for these skills to become integrated into the practitioner's clinical understanding and individual expression as a clinician in much the same way as the understanding of organ systems and their physiology and pathology become integrated into an approach to problem solving in the clinical encounter.

It is with these goals and understandings in mind that the following components are included in an integrated fashion into the *Mindful Communication* curriculum:

Mindfulness Meditation in many ways forms the foundation as well as container for the other two components. It is like the medium through which the Narratives and Appreciative Inquiry dialogues operate. The quality of mindfulness, cultivated through the meditative practices, functions as an ever present lens through which personal stories are contemplated, written, shared, and discussed.

Mindfulness includes the capacity for lowering one's reactivity; the ability to notice and observe sensations, thoughts and feelings even though they might be unpleasant; acting with awareness and intention; and focusing on experience, not the labels and judgments we apply to them. In Mindful Practice for clinicians, four qualities of exemplary practitioners are described: attentive observation, critical curiosity, beginner's mind and presence.

The cultivation of the qualities of mindfulness involves the regular practice of formal meditations. These include:

Body Scan- in which participants practice an awareness of the state of the body just as it is from moment to moment through slow guidance through the body, with attention

directed toward the body sensations experienced as well as thoughts and feelings arising during the exercise.

Mindful Movement- also known as mindful hatha yoga in which participants are guided through a series of gentle movements, postures, and stretching exercises, non-judgmentally attending to feelings, thoughts and sensations that arise.

Sitting Meditation- quietly sitting while observing the flow of thoughts, feelings, and sensations.

Walking Meditation- involves bringing meditative awareness with the same non-judgmental attention to thoughts, feelings and sensations to the experience of walking.

All of these formal practices are designed to enhance the participant's awareness of the stream of thoughts, the flow of feelings, and the presence of sensations that are very often not noticed, yet inform action and behavior from moment to moment. Through the enhancement of the awareness that develops from the regular practice of these mindfulness meditations, it becomes possible at times to step out of the *automatic pilot* mode of living, and instead experience and act with greater awareness.

In order to assist the participant in applying the lessons learned through formal practice to their daily lives, participants are encouraged to bring the same quality of awareness to other activities, both in the classroom- during discussion, while developing and sharing narratives, when engaged in appreciative inquiry exercises - and also outside of the classroom- while engaged in life's activities at work and at home. Because the cultivation of mindfulness is best supported by regular practice and is the foundation underlying the techniques of narrative medicine and appreciative inquiry, participants are encouraged to engage in daily home exercises. Audio recordings of formal mindfulness meditation practices are provided to guide these daily home exercises.

Narrative Medicine provides a way of understanding the personal connections between physicians and patients and the meaning of medical practice and experiences for individual physicians. It also reflects the physicians' values and beliefs, and how these become manifest in the physician-patient relationship, and how that connection relates to the society in which it develops. According to Charon, narrative medicine helps imbue the facts and objects of health and illness with their consequences and meanings for individual patients and physicians. The use of narratives in medicine grants access to knowledge about the patient and about the practitioner him/herself that would have otherwise remained out of reach. Narrative medicine in the Mindful Communication program includes the sharing of stories that arise from the participants' clinical experiences and takes the form of reflection, dialogue and discussion in large and small groups, specific writing exercises, and journaling. Narratives are chosen by the participants about their own personal experiences of caring for patients. Thus, the narratives are grounded in the real lived experiences of the physicians, not in philosophical or rhetorical "what-if's" that impact on cognitive and emotional challenges.

Appreciative inquiry (AI) strives to foster growth and change by focusing participants' attention on their existing capacities and prior successes in relationship building and problem solving (as opposed to an exclusive focus on problems and challenges). Much of medical training focuses on what is wrong rather than what is right. Patients are described in terms of problem lists, but there are no defined places to describe their strengths and resources. Morbidity and mortality rounds focus on analyzing bad outcomes, but there are few opportunities to explore effective teamwork and joint decision-making. The theory behind AI is that reinforcement and analysis of positive experiences with patients and families are more likely to change behavior in desired directions than the exclusive critique of negative experiences or failures. Appreciative inquiry involves the art and practice of asking unconditionally positive questions that strengthen the capacities to apprehend, anticipate, and heighten positive potential. It is an inquiry tool that fosters imagination and innovation. The AI approach makes several assumptions: 1) for every person or group there is something that is working; 2) looking for what works well and doing more of it is more motivating than looking for what doesn't work well and doing less of it; 3) what we focus on becomes our reality and individuals and groups move towards what they focus on; 3) the language we use to describe reality helps to create that reality; 4) people have more confidence to journey to the future if they carry forward parts of the past; 5) we should carry forward the best parts of the past.

Traditionally, the steps of AI involve the following: 1) *definition*-what we wish to see or grow in ourselves and our groups; 2) *discovery*-what gives life; 3) *dream*-what might be; 4) *design*-what should be; and 5) *delivery*-what will be. AI's impact on fostering change includes a strengthening of the confidence and positive dialogue about the future, increased feelings of connection and participation, and an appreciative mindset and culture.

In the Mindful Communication curriculum, the first two steps of AI-*definition* and *discovery* are integrated into the structure of interpersonal dialogues in the sharing of participants' narratives. Participants are guided in using AI techniques when engaged in appreciative dialogues, discussion, and reflection. With the ongoing practice and support of skilled facilitation, this approach becomes second nature and is the predominant technique used for exploring the experiences that arise in the narratives, perceived through the quality of mindfulness.

Guidelines for Appreciative Inquiry Exercises: The following provide suggestions and lines of inquiry that are used to facilitate the conversations that occur between participants during class exercises. The questions are designed for exploring and deepening the narratives selected by the storyteller.

Interviewer guidelines:

As interviewer, think of your role as exploring the mind and experience of your partner, helping to bring forward his or her thoughts, feelings and wisdom.

Listen slowly and deeply: encourage your partner to tell his or her story

Avoid interruptions. It is rare that one gets to tell a story without being cut off, and equally rare that one gets to listen without feeling compelled to analyze, reflect, and interpret. This is an opportunity to do both

Invite elaboration and clarification

You are an explorer whose objective is to learn all you can about your partner's stories and what made them possible.

Take the opportunity to ask questions that you are truly curious about, and in this way assist the storyteller in expanding the narrative

Resist the temptation to interpret the story, or agree or disagree with the storyteller.

Avoid sharing similar experiences that you have had that the story reminded you of.

Use reflective questions and empathy when appropriate.

Storyteller guidelines:

As a storyteller, your role is to authentically share your narrative. Be sure to consider you awareness of thoughts, feelings, and sensations as you re-experience and reflect on the story, sharing not only the content and details of the story but also how you experienced it. You might want to address:

What happened?

What helpful qualities did you bring to that moment?

Who else was involved, and how did they contribute?

What aspects of the context made a difference?

What lessons from this story are useful to you?

Good Appreciative Interview questions are generally:

Stated in the affirmative

Built on the assumption of an individual/organization as full of possibilities

Presented as an invitation

Phrased in rapport talk, not report talk

Evoking essential values, aspirations, and inspiration

Valuing what IS to spark appreciative imagination

Conveying unconditional positive regard

Representative Appreciative Inquiry Questions:

What do you think were the core factors that made this success possible?

What did you do or bring to that event that contributed to its success?

Who else was involved and what did they contribute?

What was it about the setting or situation that made a difference?

What lessons do you take from his experience?

Representative Self-awareness Questions

What were you feeling in your body? What did your breathing feel like? Was there tension in your body? If so, where?

What about the experience was pleasant?

What about the experience was unpleasant?

What emotions were you experiencing?

What kinds of thoughts were you having?

When have you felt this way/found yourself in this situation before?

What aspects of this situation make you feel resourceful/satisfied? In what way?

What aspects of this situation made feel you uncomfortable or afraid? In what way?

What aspects of this person do you feel drawn to? Why?

What aspects of this person make you feel repelled or irritated? Why?

Representative Coaching Questions

How would you describe this situation? What is the story you're telling yourself? What other descriptions/interpretations/stories might be possible?

What worked? What didn't work as well as you might have wished?

What do you think [the other person] was thinking/feeling?

What was her/his goal? What strategy was she/he using? How did you respond? What other options did you have? What guided your choice?

What is your greatest hope [in this situation]? What is your biggest fear?

What were you doing that might have been contributing to the situation?

What has helped you in similar situations in the past?

What other forces may be operating here? Who else has a stake in this?

Where are you feeling stuck? What will help you move forward?

Additional Methods that Help Expand the Narrative

Silence

"Tell me the story"

"Go on/tell me more"

Reflect/Echo

Express empathy

Paraphrase and summarize. For example "Let me see if I have this correct. You said that…"

Themes for reflective questions

Attentive Observation. Help learners note not only what they observe about the patient/presenter, but also their own thought processes and emotions, including the judgments that they make based on those observations. Focus on biases, judgments and heuristics; recognize their consequences ([avoidance of] errors, [lack of] miscommunication, etc.).Using their awareness of their own thoughts and feelings to understand and resolve the clinical issues at hand. Suggested questions:

- "What did you notice that was unusual?"
- "If there were data that you ignored, what might they be?"
- "What interfered with and what facilitated your ability to be attentive and observant?"

Critical Curiosity. Help learners approach two parallel tasks – clinical reasoning and understanding the patient's life situation. The basis for this exercise is that students who are curious and interested in their patients are more likely to express caring, make wise decisions concordant with patients' values, and notice clinical features that others ignore. Suggested questions:

- "What about this situation was surprising or unexpected?"
- "What are you assuming about this patient that might not be true?"
- "How might your previous experience affect how you are approaching this patient?"
- "How did you manage to avoid premature closure?"

Beginner's Mind (Informed flexibility). Learners will examine how taking a fresh look at a situation can alter a diagnostic impression and psychosocial formulation, and, by extension, permit the clinician to better appreciate and care for the patient.

- "What would a trusted peer say about how you are managing this situation?"
- "Is there another way in which you can put (did put) together this patient's story?"

Presence. Learners will discuss situations in which they were either "really present" for the patient and family, or somehow distracted or distant. They will describe their emotional reactions (e.g. what moved them most about the story), and how those reactions affected their relationship with the patient and clinical outcomes.

- "How did you prepare me before seeing a patient (student)?"
- "What moved you most about this situation?"
- "How did this encounter affect your relationship with this patient?"
- "Were there any points at which you were particularly present? Or distracted or uninvolved?"

References

Charon R. The patient-physician relationship. Narrative medicine: a model for empathy, reflection, profession, and trust. *JAMA.* 2001; 286: 1897-1902.

Charon R. Narrative medicine: form, function and ethics. *Ann Intern Med.* 2001; 134: 83-87.

Connelly JE. Narrative possibilities: using mindfulness in clinical practice. *Perspect Biol Med.* 2005; 48: 84-94.

Cooperrider D, Whitney D. *Appreciative Inquiry: A Positive Revolution in Change.* San Francisco, CA: Berrett-Koehler; 2005.

Epstein RM. Mindful Practice. *JAMA.* 1999; 282:833-839.

Kabat-Zinn J. *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness.* New York, NY: Bantam Dell; 1990.

Kabat-Zinn J. *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life.* New York, NY: Hyperion; 1994.

Krasner MS, Epstein RM, Beckman H, Suchman AL, Chapman B, Mooney CJ, Quill TE. Association of an educational program in mindful communication with burnout, empathy and attitudes among primary care physicians. *JAMA.* 2009; 301: 1284-1293.

Langer EJ. *The Power of Mindful Learning.* Reading, MA: Perseus Books; 1997

McCown D, Reibel D, Micozzi MS, Kabat-Zinn J. *Teaching Mindfulness: A Practical Guide for Clinicians and Educators.* New York, NY: Springer; 2010.

Santorelli S. *Heal Thyself: Lessons on Mindfulness in Medicine*. New York, NY: Bell Tower; 1999

Williamson PR. Mindfulness in medicine, mindfulness in life. *Family, Systems & Health.* 2003; 21 (1): 19- 20.

Williamson P. Supporting wellness: Thomas S. Inui, MD, in Schiller M, et.al, (eds). *Appreciative Leaders: In the Eye of the Beholder*. Taos, NM: Taos Institute Press; 2001.

Class Flow

Each class, whether during the intensive or the maintenance phases, has a common flow. Additionally, each class has an overarching theme that is woven into the mindfulness practices, the narrative exercises, and the appreciative dialogues. Classes generally begin with an opening period that may include a brief check-in time or a reading, but then proceeds early in the session to formal mindfulness meditation exercises. In the intensive phase this consists of an introduction through demonstration and actual practice of the formal meditative exercises that will be used throughout the course. By the time participants enter the maintenance phase these practices are a well established part of the participant's repertoire.

Following the mindfulness meditation practice period, there is generally a period of discussion as a way of debriefing and sharing about the mindfulness exercise just practiced. This time also allows for sharing of the home experiences including the home exercises and what other changes participants are noticing about their work specifically, or about their lives in general. This discussion period can occur in large or smaller groups or in paired dyads. During these conversations the facilitators assist participants, not through giving advice but rather through engaging in inquiry, when appropriate, into what the participants are discovering for themselves about their own experience. This helps the participant build a link between the formal mindfulness practices and the "informal" practices of bringing mindful awareness into the everyday occurrences of life. Thus, the facilitator embodies the practices and supports the participants in trusting the power of their own experience, and assists them to realize that the cultivation of attention and awareness skills are not done with the objective of becoming "good" at the practices. Rather, the practices provide a fertile ground where the participants can bring mindful attention and awareness into their way of being.

This reflective period is generally followed by a narrative exercise, related to the theme woven into the class, and supported by the home practice guidance. The narratives that the participants reflect upon are generally drawn from experiences they have had in their clinical practices. The narratives may take a variety of forms including the reading of clinical narratives by facilitators, small group or dyadic verbal sharing of clinical narratives, and writing periods followed by sharing of these narratives. Brief guided contemplative periods are used to focus on the theme for the narratives. During the sharing of these narratives in dyads, small groups, or larger groups, listeners and speakers engage in appreciative inquiry and appreciative dialogues. These are guided by specific instructions, but over time become second nature to the participants.

Appreciative inquiry during these dialogues is intended to explore the storyteller's capacities for meeting the challenges brought up in the narrative, with attention given to noticing how easy it is for the listener to focus on problems and deficiencies, and what may result from a focus on the strengths, capacities, and successes reflected in the narrative, even with challenging themes. For example, upon hearing the particular narrative, the listener might ask:

What is it that worked to help you meet this challenge?

A follow up question may be:

What qualities or skills did you bring to that moment that contributed to success?

What other situations do you see yourself using those skills and qualities?

Reflective questioning is also encouraged. This helps to cultivate curiosity and new ways of seeing the world by inviting doubt, ambiguity, and exploration. Reflective questions can be applied to the emotional impact, difficult dilemmas, or the day-to-day ethical decisions made by clinicians -- how the physician conveys interest in the patient, or how the clinician handles a medical error. The specific answer to the question may not be as important as the process of inquiry - in fact many reflective questions have no answers. Rather, the question should disrupt habitual and rigid patterns of thought and behavior to allow a familiar situation to be seen in a new way and suggest new dimensions of their understanding of their experiences, roles and reactions. Following are some examples (see ***Reflective and Appreciative Inquiry Interview Guidelines*** above for more details):

How might your prior experiences affect your actions with this patient?

What are you assuming about this patient that might not be true?

What surprised you about this patient? How did you respond?

What interfered with your ability to observe, be attentive or be respectful with this patient?

What did you do so that you were more present with and available to this patient?

Were there any points at which you wanted to end the visit prematurely?

If there were relevant data that you ignored, what might they be?

What would a trusted peer say about the way you managed the situation?

Were there any points in which you felt judgmental about the patient – in a positive or negative way?

Why were you so strongly affected by this patient?

What did you do that made the biggest difference?

What would a trusted peer say about the way you managed the situation?

Finally, reflective questions can improve the trainee's ability to listen and observe. Other members of the group might be asked to focus on what was "surprising" about a given narrative, and another might focus on what was most "moving" or " meaningful", or aspects that went well in a problematic narrative, thereby reinforcing the habits of mind and observation we are trying to reinforce. Listening for the unexpected involves the ability to find surprise in the ordinary actions of daily work, and to listen to one-self and others without naming what is heard until it has been understood.

The conclusion of class includes the review of home assignments such as the formal mindfulness practices, the informal practices (ways to bring mindful awareness into everyday activities), readings, and themes to be aware of in the clinical domain that may be fodder for narratives in the subsequent class. The participants are encouraged to reflect upon the connection between the experiences in the class and clinical practice, and suggestions for ways to make those connections stronger are shared by the facilitators. Participants are encouraged to keep a journal and to use it for reflections about the class. A few moments may be taken at the end of class to jot down a few reflections, and to share it with the group. These may be helpful to look at during the opening check-in at subsequent classes. A brief meditative exercise signifies the end of the session.

Home Practice

Home practice plays a very important role in the Mindful Communication curriculum. It assists participants in exercising the muscles of attention and awareness frequently enough for the qualities they promote to spill over into their day-to-day lives with their patients, family, friends, and with themselves. Recognizing that the participants are unquestionably busy and time-stressed, these home exercises take on a variety of forms, each requiring fairly modest time commitments, on the order of 15-30 minutes daily. They are supported by audio recordings of guided formal mindfulness meditation practices, writing exercises, specific things to notice in their daily lives, and readings. Supplemental materials and additional references are made available for those who would like to explore subject matter in greater depth.

The use of a journal is strongly encouraged. It is used by participants to note reflections or questions they have about their experiences during the course. It can also be used for notes taken during the class time. Each week the home practice instructions will suggest specific topics to reflect on in the journal. These reflect the themes focused on in the class, and can be viewed as another kind of contemplative practice.

The materials for the narrative exercises and for many of the discussions in subsequent classes flow directly out of the home practice exercises, especially the mindfulness practice and the journaling. In this way, the classroom time becomes like the lecture hall and seminar in medical school and the home practice becomes more like the clinics and wards- the laboratories where the discoveries, insights, and real-life experiences of the application of mindful practice take place.

Ultimately, the workplace provides the best location for practicing mindful attention and awareness, and through its practice can lead the clinician to a more effective, higher quality, and meaningful professional experience.

Class Outlines

The following is a session by session description of the classes. It includes a discussion of how that the three techniques, mindfulness meditation, narrative medicine, and appreciative inquiry fit together and are integrated. It includes specific class activities. Built into the outlines is an inherent flexibility that allows the facilitators to respond to the unique attributes, needs, and personality of the participants. These outlines also identify thematic elements of each of the sessions. The home practice instructions, suggested readings, and references are also outlined here.

Week 1

Themes: 1) Introduction of the course and of each other; 2) the present moment is the only time to learn, to grow, to change, meditative awareness is fundamental; 3) establishment of a learning contract;

Class Flow*:* As this is the first class, the participants engage in a longer than usual opening period which will contain not only mindfulness meditative elements, but also narrative and appreciative dialogues that involve the participants introducing themselves to one another and to each other.

Exercises: Opening noticing exercise in which the participants are asked to become aware of sitting in the room, their thoughts, body sensations, anxieties if present, anything they notice. This will be relatively brief, lasting only a few minutes. As they are noticing, a brief reading of the *Myth of Chiron* from Santorelli's *Heal Thyself* is read. Then, they are guided in a brief meditation that involves self-inquiry into their reasons for participating in the course.

Participants then share in pairs without further instructions their responses to the self-inquiry just completed. Then in the larger group they are given the opportunity to share something about what they discovered as they reflected on their reasons for being in the class. This may take an hour or more. The judicious and sensitive use of appreciative inquiry by the facilitators enhances this sharing exercise. It is likely that not all will speak in the large group this first class.

They are then be led in the mindful exploration and eating of a raisin, the facilitator eliciting the sharing of their thoughts, feelings, and sensations as participants are guided in noticing and commenting on the objective experience of encountering this familiar object. The facilitator points out the difference between the objective noticing and the subjective comparisons, judgments, and elaborations of thoughts and feelings by participants about the raisin. This is followed by an introduction and guided practice of the first formal mindfulness practice, the body scan, which they will continue daily at home during the week.

After a large group discussion about the body scan exercise, parts of Fitzgerald's *Curiosity* will be read, weaving in the theme of the power of being present and the attitudes of beginner's mind and curiosity.

Class ends with the assignment of the home practice a brief guided sitting period, attending to the breath (will not introduce sitting meditation formally until a later time).

Home practice: Daily body scan, several readings, eating one meal mindfully, noticing mindful moments with patients, especially moments of surprise and misperception. Journal entries about what participants notice in the formal (body scan) or informal (observations of one's everyday experiences with mindful awareness) practices

Class 1 at a glance

0:00-0:10	*Gathering and informal welcoming and greeting participants*
0:10-0:25	*Welcome. Noticing exercise*
0:25-0:30	*Reading: Myth of Chiron*
0:30-0:40	*Guided Inquiry: What brings me here, now?*
0:40-1:00	*Participants in pairs share answers/introduce themselves*
1:00-1:40	*Larger group sharing*
1:40-1:55	*Raisin Exercise*
1:55-2:15	*Guided Body Scan*
2:15-2:25	*Curiosity*
2:25-2:30	*Summary/Home practice assignment*

References and Handout Suggestions

Fitzgerald F. Curiosity. *Ann Int Med.* 1999; 130: 70-72

Fitzgerald F. Wanted: 21st century physician. *Ann Int Med.* 1996; 124 (1 pt 1): 71

Gilner LL. Identity. *JAMA.* 2003; 290 (24): 3172

Hanh TN. *The Miracle of Mindfulness. An Introduction to the Practice of Meditation.* Boston, MA: Beacon Press; 1975

Hergott LJ. Lost in a dark wood. How wisdom sources can light the way. *JAMA.* 2001; 285 (15): 1938-1938

Ludwig DS, Kabat-Zinn J. Mindfulness in medicine. *JAMA.* 2008; 300 (11): 1350-1352

Santorelli S. *Heal Thyself: Lessons on Mindfulness in Medicine.* New York, NY: Bell Tower; 1999

Week 2

Themes*:* The effect of one's perception on shaping responses, including perceptions about one's participation in this course, how one sees one's work and professional and personal challenges, how one views one's level of commitment to this program, with an understanding of how it's not the challenges but how one sees them and responds to them that shapes experiences.

Class Flow*:* After a brief check in, participants are guided in a body scan exercise, and then discuss in small groups the experience of the body scan and the home practice, including the informal practices, sharing what kinds of things they have experienced, learned, have questions about, and feel challenged by. Further reflections are shared in the larger group.

Several perception exercises such as the nine-dot exercise may be used as well and visual illusions, "trompe L'oeil," are used to illustrate how perceptions shape one's experience. Plato's *Allegory of the Cave* can be shared as well to illustrate the problems of framing, perception, and responding, noticing how larger domains of perspectives can change problems into challenges that can be worked with.

Participants then work in groups of three to share narratives from their clinical practice from that involve surprise or misperceptions (see instructions below). Each participant shares his/her narrative with an interviewer, with the third individual acting as an observer. Participants are be given storytelling and interviewing guidelines (see below- these guidelines will be available to participants for future narrative exercises). After a five minute interview, the observer reflects on what he/she noticed during the interview, commenting on both the interviewer and interviewee. This process will be repeated until all three participants have had a chance to share. Then the triads debrief together, and subsequently as a large group

The class ends with the assignment of the home practice, and a more formal introduction to sitting meditation, the second of four formal mindfulness meditation practices. Awareness of breathing is used as the object of meditation followed by a brief guided sitting meditation.

Home practice*:* Participants are instructed to continue with the daily practice of the body scan. They are asked to journal for a few minutes daily about any pleasant events or experiences they have, in particular noting thoughts, feelings, and body sensations as well as the circumstances of the pleasant event. They are asked to pay particular attention to when they feel pleasant during clinical encounters, and to again notice the thoughts, body sensations, and emotional components of that pleasantness.

Class 2 at a glance

0:00-0:10	*Gathering and check-in*
0:10-0:45	*Guided Body Scan*
0:45-0:55	*Small Groups informal discussion of home practice*
0:55-1:10	*Large Group Discussion- Perception*
1:10-2:00	*Triad Narratives: Surprise/Misperception (see Narrative exercise description, themes for reflective questioning, and storyteller/listener suggestions)*
2:00-2:40	*Introduction to sitting meditation*
2:20-2:30	*Home Practice assignment*

Narrative Exercise: Surprises and Misconceptions
Instructions

Written and oral narratives will be used to explore thoughts, feelings, and reactions to situations that clinicians have encountered.

Perhaps find partners with people you don't know quite as well if you feel comfortable doing so.

Take 4 minutes to write a brief story about an experience of something that you found surprising in clinical practice. Perhaps it was an initial misperception, or a turn of events that was completely unanticipated. Perhaps it was something that subsequently seemed obvious. Perhaps it was something delightful, or perhaps it was something more ominous. Preferably this should be an event in a clinical context, but not necessarily so. If you cannot think of a story, don't worry – something will probably come up after listening to one of your colleagues' stories. These exercises are NOT about being a good writer or storyteller. Rather, they are about learning to pay attention to your own thoughts and feelings and observations in everyday life at work, and perhaps also at home.

Once the stories are written, divide into groups of 3 participants. One group member will read (or tell) his or her own narrative, one will be a "reflective listener" and the third will simply observe attentively. Be sure to keep to time: 5 minutes for the story, and 5 minutes for reflective questioning and the observer's final comments; 10-12 minutes all together.

For the listener:

> *Think of your role as exploring the mind and experience of the writer of the narrative, helping to develop and bring forward your partners thoughts, feelings and insights. There are no right or wrong answers. It is not about deciding what to do, or whether the actions taken were correct or incorrect. The role of the listener initially is to clarify and help understand the story-teller's thoughts, feelings and reactions, not necessarily to comment, interpret or educate.*
> *Try to listen without interrupting or responding to quickly – if you need to, count to 5 slowly before making any comments and then see if the comment is necessary.*
>
> - *Invite elaboration and clarification (tell me more about…).*
> - *Try to pay attention to what is attracting your attention, what you might not be hearing, and what you'd rather not hear.*
> - *Feel free to offer empathy if appropriate*
> - *Try not to comment, interpret, agree, disagree, or compare their views with yours or anyone else's; remember that this is not a conversation; the goal is to create a space for your partner's thoughts and not your own.*
> - *If you like, take some notes so that you can relate the major themes of the story.*

- *Try to use some of the **reflective questions** on your handout to explore the storyteller's experience further. The goal of the reflective questions are not to analyze the content of the narrative, but rather for the storyteller to understand his or her own thoughts, feelings and emotions during the time so as to promote self-awareness and self-monitoring in future situations.*

For the observer:

> *While you are observing the story being told and the "listener" is listening, pay attention to what you notice about the process. Perhaps it is a specific observation about eye contact, interruptions, or body language, or) or a more global observation, (i.e., it had a somber tone; conversation appeared forced, elaboration not invited, etc.). After the listener finished a few minutes of reflective questioning, the observer should talk briefly about what he/she noticed about the storyteller, the listener and the story itself. Again, maintain an attitude of respectful attentive inquiry.*

Then, switch roles, so that eventually each of the triad has a chance to tell a story, listen reflectively, and observe.

- **For the storyteller -- Focus on:**
  - What happened
  - Helpful qualities you brought to that moment
  - Who else was involved, and how they contributed
  - Context and setting
- **For the listener:**
  - Be attentive, don't interrupt
  - Ask questions to help your partner clarify and provide details
  - Don't talk about your own ideas or experiences
  - Use reflective questions and empathy when appropriate

Reflective questions

- Attentive Observation
  - "If there were data that you ignored, what might they be?"
  - "What did you notice?" "What were you unable to see?"
- Critical Curiosity
  - "What are you assuming that might not be true?"
  - "What was surprising or unexpected?"
- Beginner's Mind
  - "What would a trusted peer say about how you managed or feel about this situation?"
  - "Can you see the same situation/patient with new eyes?"
- Presence.
  - "What do you notice about yourself when you are at your best?"
  - "What moved you most about this situation?"

References and Handout Suggestions

Damasio A. *The Feeling of What Happens. Body and Emotion in the Making of Consciousness.* New York, NY: Harcourt, Inc.; 1999

Dugdale DC, Epstein RM, Pantilat SZ. Time and the patient-physician relationship. *J Gen Int Med.* 1999; 14 Suppl 1: S34-40

Harrington A. *The Cure Within. A History of Mind-Body Medicine.* New York, NY: Norton; 2008

Krasner MS. Through the lens of attention, attachment, and apprencticehip in health and healing. In: *The Best Buddhist Writing 2007.* Boston & London: Shambhala; 2007

Oliver M. The Summer Day. In: *The House of Light.* Boston, MA; Beacon Press: 1990

Week 3

***Themes**:* Pleasure and power in being present, with connection, belonging, and contact being important elements of pleasant moments. Appreciation for what is already present. The possibility of pleasant experiences even within the most challenging of life circumstances.

***Class Flow**:* After a brief check in, the class is guided in mindful movement. Introduced as a mindfulness practice with emphasis on an exploration of body sensations, thoughts and feeling states, participants explore hatha yoga type postures while maintaining moment to moment awareness, exploring the edges of one's abilities, with attention placed on the dynamic between the somatic experience and the emotional and cognitive components of that experience.

A large group discussion of the movement activities just practiced follows, as well as reflections on the home practices. Participants are asked to notice pleasant experiences as well as more challenging ones, and requested to inquire into what people are learning about themselves in noticing pleasant experiences.

Guided sitting meditation practice follows, with attention to breath awareness and expanding one's focus of attention to include sounds and body sensations as well. The possibility of noticing pleasant experiences is suggested in the sitting practice. At the conclusion of the sitting practice, a fun exercise involving paying attention while tossing objects in a circle follows. In this exercise, groups of between 8-15 people stand in a circle and toss an object around the circle, establishing a pattern. More objects are then added to the tossing in the circle, providing for distraction and forcing the participant to pay attention in a different way.

The participants then write for 5-10 minutes about a pleasant experience they had recently or more distantly, preferably in the clinical practice of medicine. Then, they will meet in dyads and share these narratives. The storyteller and the listener are given specific tasks to notice during the interaction, after reviewing more specifically appreciative inquiry concepts. The listener, after sharing what they noticed during the telling, engages in an inquiry about what made the experience pleasant, exploring questions such as what attitudes/traits/skills were present for the storyteller to have this pleasant experience, as well as what other areas of experience have they noticed using those same skills. After both members of the dyad have had an opportunity to share their narrative, all the participants convene as a larger group and discuss the experience.

The session ends with a brief guided sitting period and home practice is reviewed.

***Home practice**:* Daily mindful movement or body scan practice. Participants are encouraged to practice sitting meditation 5 minutes several times during the week and are given an unpleasant events calendar to fill out.

Class 3 at a Glance

0:00-0:10	*Gathering and check-in*
0:10-0:40	*Mindful Movement*
0:40-1:00	*Large Group discussion of the movement practice*
1:00-1:15	*Guided sitting practice-awareness of pleasant*
1:15-1:35	*Writing period-pleasant clinical experience*
1:35-2:00	*Sharing of narrative*
2:00-2:15	*Large group discussion*
2:15-2:25	*Guided sitting meditation*
2:25-2:30	*Home practice assignment*

References and Handout Suggestions

Kabat-Zinn J. Mindful yoga, movement and meditation. *Yoga International.* 2003

Kearney MK, et al. Self-care of physicians caring for patients at the end of life: "Being connected…a key to my survival." *JAMA.* 2009; 301 (11): 1155-64

Oliver M. The journey. In: *New and Selected Poems: Volume One*. Boston, MA; Beacon Press: 2005

Quill TE et al. Healthy approaches to physician stress. *Arch Int Med.* 1990; 50: 1857-61

Shanafelt TD, et al. Principles to promote physician satisfaction and work-life balance. *Minnesota Medicine.* www.minnesotamedicine.com/PastIssues2008/December2008/ClinicalShanafeltDecember 2008/tabid/2758/Default.asp : accessed October 26, 2010

Shanafelt TD, Sloan JA, Habermann TM. The well-being of physicians. *Am J Med.* 2003; 114: 513-519

Week 4

***Themes**:* The next two classes contain didactic material about stress physiology and its effects on health and illness that are partially brought out in discussion. Additionally some didactic elements about the appreciative inquiry process and narrative medicine are reviewed. The material also focuses on observational skills, on the stressors and the reactivity to stressors, and how that reactivity can lead to behavioral ruts that interfere with greater intelligences (emotional, social, intellectual).

***Class Flow**:* Class begins with a longer sitting period, guiding the participants on expanding the field of awareness to include not only the breath, but also sound, body sensations, and thoughts as objects of attention. Guidance includes an exploration of the awareness of unpleasant experiences.

Then, as a large group, facilitated discussion elicits from the participants the body sensations, thoughts, and feelings that arise in stressful or unpleasant experiences. A "triangle of awareness" diagram illustrates how unattended sensations, feelings, and thoughts can cascade into uncontrolled stress reactions. The physiology of stress is discussed in greater detail in the subsequent class. Facilitators inquire into the relationship between sharing narratives and inquiring about strengths inherent in the individual's handling of challenges, and how these relate to the experience of stress.

The participants then form dyads and after writing narratives about unpleasant experiences, especially from their clinical work, they will share these stories (see below for detailed instructions). The listener is instructed to use reflective questioning and appreciative inquiry to examine more deeply the storyteller's experience, and focus on the skills or attributes used to successfully negotiate the challenge, and where else those skills show up for them in their work and personal lives.

The class concludes, after the home assignment is discussed, with a brief period of sitting practice.

***Home practice**:* Guided sitting practice is assigned for at least three days during the week. On the other days, participants may choose movement, body scan, sitting meditation, or 15 minute writing period about automaticity or about meaningful experiences in clinical practice.

Class 4 at a Glance

0:00-0:15	*Gathering and check-in*
0:15-0:35	*Sitting: Expanding awareness*
0:35-1:30	*Discussion: Triangle of Awareness and Stress Physiology*
1:30-2:15	*Narrative/AI Unpleasant Experiences (see instructions)*
2:15-2:25	*Guided Sitting Practice*
2:25-2:30	*Home Practice Assignment*

Appreciative Inquiry Exercise-Unpleasant Experiences: Mindful Communication

This will be a structured interview exercise about important events at times when we are at our best. To start, find an interview partner, perhaps someone you don't know particularly well.

We want to learn about our capacity to be fully attentive, present, and curious in our work. Our intent is to discover, illuminate, and understand the particular qualities, values, skills and conditions that contribute to our capacity to access and maintain these essential qualities when doctoring or teaching, even under difficult circumstances.

Instructions for the interviewee:

In medicine, we constantly have to deal with experiences that are not necessarily pleasant or comfortable. When we are practicing at our best, we can understand that the situation might not be pleasant, but can still proceed, do our work and make a positive impact on a patient's health and well-being.

As you reflect back over your time as a teacher and physician there have no doubt been highs and lows, peaks and valleys, ups and downs in your experience. For now, focus on a high point— a time in your work with patients or learners when you found you were open, self-aware, curious, mindful and focused – when you brought all of yourself to what was at hand and thereby experienced it fully, resulting in your work at its best. It might have been a moment "against all odds" (e.g., a rushed or stressful time or in the midst of difficult circumstances) or perhaps it occurred in an otherwise ordinary day. It might have been a small moment or a longer event.

In particular, think of a time when you faced an unpleasant task and were able to attend to the patient effectively and meet the patient's needs, while at the same time feeling that you had don't the right thing. This might have been a momentous occasion, or a small event, but it should represent a time when you were practicing at your best. It should be an event that you are willing to share with a colleague. The type of unpleasant situation is up to you -- perhaps the unpleasantness had to do with a strong emotional reaction, a difficult interaction with a patient or staff member, an error, or a situation where you caused someone pain. Perhaps it involved bad news, or a situation in which you did not know the right thing to do. Preferably this should be an event in a clinical context, but not necessarily so. Perhaps address the following issues:

- *What made it a memorable experience?*
- *Who were the others and how did they contribute?*
- *What was it about you—unique qualities or capacities that you have—that made this a high point experience?*
- *What about the circumstances or context contributed (time, venue, relationships, etc.)?*
- *What lessons can you take from this experience?*

Also, reflect on what is the core factor intrinsic to you that makes it possible to live and work with mindfulness and self-awareness in these kinds of situations.

After a few minutes, when you are ready, begin to tell your story to the interviewer. The interviewer's job is to help you focus your story and bring it to life.

For the interviewer:

Think of your role as exploring the mind and experience of the person telling the story, helping to develop and bring forward your partners thoughts, feelings and insights. There are no right or wrong answers. It is not about deciding what to do, or whether the actions taken were correct or incorrect. The role of the interviewer initially is to clarify and help understand the story-teller's thoughts, feelings and reactions, not necessarily to comment, interpret or educate.

- *Listen slowly and deeply; encourage your partner to tell his/her story.*
- *You are an explorer, here to learn all that you can about your partner's stories and what made them possible. (Please resist the temptation to add your own story, reactions or views during this time.)*

Here are some additional guidelines for the listener*:*

- *Try to listen without interrupting or responding to quickly – if you need to, count to 5 slowly before making any comments and then see if the comment is necessary*
- *Invite elaboration and clarification (tell me more about…).*
- *Try to pay attention to what is attracting your attention, what you might not be hearing, and what you'd rather not hear.*
- *Feel free to offer empathy if appropriate*
- *Try not to comment, interpret, agree, disagree, or compare their views with yours or anyone else's; remember that this is not a conversation; the goal is to create a space for your partner's thoughts and not your own.*
- *If you like, take some notes so that you can relate the major themes of the story.*

Then, switch roles, so that eventually each person has a chance to tell a story and be an interviewer.

References and Handout Suggestions

Baer RA. *Mindfulness-Based Treatment Approaches. Clinician's Guide to Evidence Base and Applications.* New York, NY: Academic Press; 2006

Brown KW, Ryan RM, Cheswell JD. Mindfulness: theoretical foundations and evidence for its salutary effects. *Psych Inq.* 2007; 18 (4): 211-37

Emanuel L. The privilege and the pain. *Ann Int Med*. 1995; 122 (10): 797-8

Hergott LJ. Playing the Moonlight Sonata from memory. Celebrating the wonders of our difficult life. *JAMA.* 2002; 288 (20): 2516-7

Rumi J. The guest house. In: *Essential Rumi* by Barks C. San Francisco, CA; Harper Press: 1997

Whyte D. Everything is waiting for you. In: *Everything is Waiting for You. Poems by David Whyte.* Langley, WA; Many Rivers Press: 2003

Week 5

Themes: Reacting and responding to stress. The role emotional reactivity plays in of emotions,

Class Flow: After an extended period of sitting meditation practice where participants are guided in expanded levels of awareness including attention to cognitive activity itself, the group discussion focusing on automaticity and stress reactivity, building a link from this awareness of reactivity to the ways in which it presents itself in the practice of medicine.

Following this discussion is a review of stress physiology, covering historical perspectives on stress as well as current understandings of the neuro-physiologic, cardiovascular, endocrinologic, and immunologic components of the stress response, both acute and chronic. Research findings exploring the growing links between this stress physiology, illness and disease, and their attenuation by contemplative practice activities are discussed.

Participants then develop and share narratives written from experiences in their clinical practice that reflect particularly meaningful experiences. In the paired dialogue and inquiry that follows the sharing of these narratives, participants focus on several of the following questions:

What was it about the experience that made it so meaningful?
What capacities were drawn upon in the experience that may have contributed to it being meaningful?
Where else are these capacities showing up in one's experience?
How can they be used in other areas of your life?

The session ends with a brief sitting period and home practice is reviewed.

Home practice*:* Home practice includes the continued daily guided meditative practices, with at least 50% of the time using the guided sitting practice. Journaling remains an option. Participants may reflect on clinical experiences where there was conflict especially around the idea of "doing the right thing," contemplating which communication styles were found in the conflict. A difficult communications calendar is given for participants to use as a means of noting these events.

Class 5 at a Glance

0:00-0:20	*Gathering/Check in/Noticing*
0:20-0:40	*Sitting: with thoughts as "events"*
0:40-1:00	*Discussion: Automaticity and awareness of reactivity*
1:00-1:25	*Stress Physiology Part 2*
1:25-1:40	*Narrative writing on meaningful experience in medicine*
1:40-2:15	*Dyad interviews/dialogues about narratives*
2:15-2:30	*Sitting and home practice review*

References and Handout Suggestions

Coulehan J, Williams PC. Vanquishing virtue: the impact of medical education. *Academic Medicine.* 2001; 76 (6): 598-605

Epstein RM. Mindful practice in action (II): cultivating habits of mind. *Families, Systems and Health*. 2003; 21: 11-17

Rilke RM. Transforming Dragons. In: *A Year With Rilke. Daily Reading from the Best of Rainer Maria Rilke.* New York, NY; Harper One: 2009

Rumi J. The tent. In: *The Essential Rumi. Translation By Coleman Barks With John Moyne.* San Francisco, CA; Harper: 1995

Week 6

***Themes**:* Stressful communications, assertiveness, effects of stress both acute and chronic on communications. Interpersonal mindfulness: bringing mindful awareness to the activities of conversation and dialogue.

***Class Flow**:* Class begins with an introduction and practice period of mindful walking. Emphasis as always continues to focus on how these practices can be used in every-day activity, as we move, as we sit, as we enter the exam room or engage in review of the paperwork of medicine. The walking concludes with a body sculpting exercise, a series of standing postures embodying aggressive, passive, and assertive communication styles, with attention to how these postures are experienced in terms of sensation, feeling, thought.

\An Aikido-like demonstration introduces discussion of the practice of awareness and attention in communication. Aggressive, passive, passive-aggressive, and assertive communication styles are illustrated through this demonstration, relating them to the experiences of interpersonal relationship and dialogue within interpersonal relationship. The process of bringing mindful attention and awareness right into the midst of interpersonal communication is reviewed.

Drawing on the work of Gregory Kramer and Insight Dialogue, an interpersonal mindfulness practice is introduced as an extension of the formal practices, the informal practices, and how we spend so much of our time in relationship through conversation, exploring the questions about how the same kind of contemplative awareness can be brought into the experience of conversation, whether casual or professional. The basic instructions of this "practice" are reviewed.

Dyads are formed and participants engage in three separate dialogues, each preceded by a meditation on three distinct themes: aging, illness, and end of life. After each dialogue, a brief intra-dyad debriefing takes place, and then after the third dialogue, a larger group debriefing follows. During this discussion, the participants are asked to continue the same instructions for this practice while engaged in the larger group debriefing.

A brief sitting, instructions for the all-day and home practice review mark the end of class.

***Home practice**:* Sitting practice and the writing of a personal narrative that can extend over the next few weeks about self-care. Readings are given about physician self-care.

Class 6 at a Glance

0:00-0:10	*Gathering/Check in/Noticing*
0:10-0:25	*Walking Meditation*
0:25-0:50	*Aikido Demo/Interpersonal Mindfulness Intro*
0:50-2:10	*Interpersonal Dialogues and Discussions*
2:10-2:20	*Sitting Meditation*
2:20-2:30	*All-Day instructions/Home Practice Review*

Insight Dialogue

(Adapted from the work of Greg Kramer, www.metta.org)

What is Insight Dialogue

Insight Dialogue is an interpersonal meditation practice. It is based upon the fundamental fact that we humans are relational beings, and the lucidity of meditation can illuminate suffering and freedom as it arises in contact with others. Just as traditional silent meditation practice has different forms of practice, each benefiting from different instructions, Insight Dialogue also has meditation instructions, or guidelines. These have evolved to support meditators as they migrate from habitual ways of interacting with others to ways that are in alignment with the path of virtue, tranquility, wisdom, and mutuality. Each meditation instruction can be recalled as a simple reminder to calm down, become aware, and notice and release old habits. Interpersonal practices are likely to involve speaking and interacting with others, apparently leaving behind the most obvious feature of traditional meditation, the bastion of silence.

While the practice involves discussion and contemplation about profound subject matter, the content of any Insight Dialogue discussion is not the sole focus of practice. At the heart of this meditation is the intention to settle in and become aware of just how our heart-mind functions. The focus is calming down and paying attention to whatever we find in the emerging moment. The content of the dialogue is simply a part of what is emerging in the moment.

Instructions:

1) Pause-Relax-Open

2) Trust Emergence

3) Listen Deeply/Speak the Truth

Pause-Relax-Open

To pause is to release. The body-mind is astonishingly sensitive and grasps at whatever touches it: sights, sounds, touches, smells, tastes, and thoughts. The first instruction in Insight Dialogue is Pause. Step off the rushing train. Dwell a moment with immediate experience before speaking or while listening. Let the thinking mind take a break. The pause can take place before we speak, while we are speaking, or after we are done speaking. One could become aware of the breath, but often the more effective practice is to become aware of the body as a whole. How is the body now? When we get lost in the fabrications of the mind, carried away by emotions, we can pause, become mindful of the body, and the body will reveal where the moment is. Here is that elusive "now." We may attend to the pleasant and unpleasant qualities of experience, observe the rising and

passing of the thoughts and moods—just passing phenomena. Without the pause, without mindfulness, there is no choice, only habit. The Pause temporarily arrests the torrent of habit.

The second part of the core interpersonal meditation instruction is *relax*. We pause into awareness and relax the body and mind. We bring awareness to those parts of the body where we tend to accumulate tension, and allow the tension to relax. In the Pause, we step out of reaction and into the moment and we meet ongoing thoughts and feelings with acceptance. Accept is to the mind as Relax is to the body. We don't run away from what is uncomfortable, from confusion, fear, unhappiness, or ugliness (even what we perceive to be our own ugliness). When, for example, we notice tightness in the belly or the sinking feeling of sadness, awareness can remain soft and present as the feeling unfolds. The tendency to fly backwards in aversion to the unpleasant sensation is replaced with the conscious note to "relax," to "accept." In this change, the old habit of continuing or amplifying tension is being supplanted with the new habit of ease and acceptance. In this way, Relax heals what the Pause reveals.

Now we come to the third part of the core interpersonal meditation instruction: *Open*. With Open awareness extends to everything around us. While Pause and Relax could be instructions for internal individual meditation, Open invites us to extend this accepting mindfulness to that which is beyond the boundaries of our skin. This extension to encompass the external world opens the door to mutuality and is the basis for interpersonal meditation. If we are meditating in dialogue with one other person, we meet this person with wakeful acceptance. If we are meditating with an entire circle or room full of people, the awareness opens wide to receive the whole. With mindfulness of both the internal and external, we are cognizant of the relational moment, of the whole flux of self and other. Even though some traditional meditation practices encourage a wide open awareness, most do not include awareness of the specific humans we are with and do not open the door to encounter in co-meditation. In Insight Dialogue, we open this door.

Trust Emergence

Trust Emergence is rooted in the wisdom aspect of Insight Dialogue. That is, it supports our seeing things as they are—unstable and far more complex and fluid than the mundane glance can ever know. The very dynamic quality of experience creates the demand for a robust practice and provides the object of that practice: change itself. For example, we see emergence in the way conscious thought arises from a cauldron of sensation, memory and emotions. So to Trust Emergence is to let go into the changing process that we call "now," replete with its uncontrolled sensations, thoughts, emotions, interactions, words, topics, energies, and insights. To Trust Emergence is to enter practice without the bias of a goal. It often happens that as we speak with others, much of our mental activity is taken up with planning what we will say next and, especially in larger groups, where we can find space to insert our contribution. In the Pause of Insight Dialogue we become aware of this micro-planning, relax the tension behind it, open to our partner or the group, and, right in that very moment, let go of even these little plans, and Trust Emergence.

Listen Deeply/Speak the Truth

To listen deeply is to listen with mindfulness, surrendering fully to the unfolding words and presence of our co-meditators. We are a receptive field touched by the words, emotions and energies of our fellow human beings, grounded in clear awareness and sensitive to the speaker's offering. We listen with the generosity of patience, unhurried by a personal agenda. We aspire to the type of generosity Thoreau suggested when he said: "The greatest compliment that was ever paid me was when one asked me what I thought, and attended to my answer." There are active and receptive qualities to Listen Deeply. In active listening, we apply the energy of attention to the many qualities of experience. We seek understanding, absorb detail, and navigate the inlets and bays of the ever-shifting coastline of verbal relating. The receptive quality of Listen Deeply emphasizes the stability and sensitivity of awareness. There is no reaching out, no going anywhere. We are calm and vigilant. Listening deeply includes a delicate inward listening that enables receptive listening to the other.

The simple guideline Speak the Truth invites us to re-examine the process and function of verbal communication. To speak the truth we must know the truth. Because we are referring to the subjective truth, the truth of our experience, we must listen internally in order to discern this truth. Thus, speaking enters meditation practice through the door of mindfulness. Such mindfulness is possible based upon the other Insight Dialogue guidelines. Speak the Truth calls us to live with the paradox set up by the superposition of emergence and mindfulness. We come to recognize meditative speaking as something that has less to do with words than the source from which the words emerge. Delicately present with the moment of experience, we watch speech emerge from the body, thoughts, or the unknowable unconscious.

References and Handout Suggestions

Collins B. On turning ten. In: *Sailing Around the Room; New and Selected Poems.* New York, NY: Random House, Inc.: 2001

Cox V. The cookie thief. In Canfield J & Hansen MV: *Chicken Soup for the Soul.* Deerfield Beach, FL: Health Communication Inc.: 1993

Kramer G. *Insight Dialogue: The Personal Path to Freedom.* Boston & London; Shambhala: 2007.

Krasner MS. The gift of mindfulness. *Families, Systems and Health.* 2004; 22 (2): 213-15

All-Day

***Theme**:* The theme of the all-day session is to deepen meditative awareness through a seamless series of guided and unguided mindfulness practices. The majority of the day is spent in silent participation by the students, guided through a variety of practices by the facilitators. Participants are encouraged to notice any and all aspects of their experience, paying attention to body sensations, thoughts, and emotional states and how they change over time. The intensive nature of this session is intended to assist the participant in firmly and effectively establishing the use of mindfulness skills across multiple situations in their lives while simultaneously preparing them to utilize these methods far beyond the conclusion of the intervention. This all-day session is seven hours long.

***Class Flow**:* Although there is flexibility in how the flow of activities is structured, what follows is a typical schedule for an all-day session beginning at 9:00 AM and ending at 4:00 PM:

9:00-9:05:	*Ring bells, sit 5 minutes in silence, nothing said.*
9:05-9:15:	*Welcome, introduction, review of ground rules.*
9:15-9:50:	*Sitting meditation with focus on awareness of breathing*
9:50-10:50:	*Guided mindful movement, ending with a body scan.*
10:50-11:10:	*Slow walking meditation*
11:10-11:30:	*Sitting meditation, less guidance, more silence.*
11:30-11:40:	*Slow walking meditation.*
11:40-12:00:	*Guided mountain/lake meditation.*
12:00-12:20:	*Talk. The facilitator shares some thoughts relevant to the particular group, incorporating general or specific themes related to practice, the application of the practice in one's life, and in particular with this group, applications as health professionals.*
12:20-12:25:	*Instructions for silent lunch.*
12:25-1:35:	*Lunch, followed by a period of self-directed practice*

1:35-2:00:	*Slow, fast, crazy walking as a group, with slow backwards walking with eyes closed, gathering in the center of the room.*
2:00-2:30:	*Lovingkindness meditation, ending in silence, low on guidance.*
2:30-3:00:	*Short sittings, alternating with short walkings, sitting anywhere one can when change occurs.*
3:00-3:20:	*Sitting in silence.*
3:20-3:40:	*Coming out of silence, talking in pairs about how the day went.*
3:40-3:55:	*Larger group discussion, questions about the day, inviting those who found it challenging to speak out.*
3:55-4:00:	*Final sitting. Instructions for returning home.*

Week 7

***Theme**:* This session continues to focus on interpersonal communications, dialogue, speaking, listening, and how mindful practice influences communications. Additionally, this class also focuses on self-care, and an exploration of what we "take in" including not only what we take in orally, but with all the senses, examining self-destructive as well as health-promoting patterns of behavior. Participants will also prepare for the conclusion of the first phase of the course.

***Class Flow**:* Class begins with a period of guided sitting and mindful movement practices. This is followed by further debriefing of the all-day session, reviewing any concerns, sharing any insights, and discussing reactions to the experience. This is done as a large group, and the facilitators approach this period as an inquiry, questioning participants about what strategies were used during the day that made it work, where they find themselves using these strategies in other areas of their lives, expanding this further to creative approaches to the routines of day-to-day patient care. The discussion may include questions such as:

> *What is the connection between an experience like the all-day and our medical practices?*
> *Can our medical practices be approached in the same way as we ask ourselves to approach the cultivation of a mindfulness practice?*
> *What are those ways explicitly, and how might it look in medical practice?*

After a brief and somewhat didactic discussion on self-care, particularly as it pertains to physicians in the practice of medicine, the participants are grouped into dyads, and after a brief writing period on the topic of self-care, they engage in interpersonal dialogues, using these narratives as a focal point. The narratives that they began at home during the prior week may be shared, or personal stories that arise out of contemplative reflection may be used.

The session concludes with a brief sitting period, followed by home practice assignment and an acknowledgement of the next session being the last one of the first phase of the course.

***Home practice**:* The participants are instructed to engage in home practice with the use of the audio CD's as optional, exploring ways of practicing formally without outside guidance. Narrative writing is encouraged, either continuing along the theme of self-care, or along the theme of discipline and inspiration.

Class 7 at a Glance

0:00-0:10	*Gathering/Check in/Noticing*
0:10-0:25	*Sitting meditation*
0:25-0:55	*Discussion: All-Day*
0:55-1:20	*Physician Self-Care*
1:20-1:35	*Writing exercise: self-care (see Self-Care notes)*
1:35-2:20	*Narrative sharing/dialogues (see Narrative instructions)*
2:20-2:30	*Sitting/Home practice assignment*

Self-Care

Imagine that you are working at your best, and that you are experiencing a general sense of well-being in your daily work as a physician. What would you notice about yourself? What would others notice about you?

Psychological strengths of physicians	***Psychological vulnerabilities of physicians***
Thoroughness	Over-compulsiveness, guilt about not doing enough
Commitment	Exaggerated sense of responsibility, self-blame
Healthy skepticism	Overwhelming doubt and need for certainty
Altruism	Neglecting one's own health
Stoicism	Not recognizing needs of self and family
Hard work	Never home
Engagement with patients	Inability not to think about work
Caring	Compassion fatigue
Rationality	Emotional distance
Calm confidence	Cool detachment
Self-criticism	Self-deprecation

Burnout == depersonalization + emotional exhaustion + sense of low personal accomplishment that affects work life and relatively spares personal life.
Prevalence = 25% - 60% of practicing physicians, 76% of residents

Depression = pervasive sadness and anhedonia affecting all aspects of life

Causes of burnout = personality disposition + overwork + inadequate support + lack of self-awareness/self-monitoring

Consequences of burnout ➔ lower empathy, poorer self-reported patient care, more errors, auto accidents, stress-related health problems, poor relationships, substance abuse, quitting practice

Healthy work = Meaning + relationships + self-efficacy + self-compassion + self-worth ➔ Physician job satisfaction ➔ greater patient satisfaction, adherence, fewer errors, greater retention, greater empathy

Strategies

1. Workplace: good mentoring, setting limits, administrative support
2. Religious/spiritual life
3. Relationships: time with friends and family, supportive partner, support group

4. Self-care, self-awareness and self-monitoring: exercise, nutrition, getting out of toxic relationships, treating depression, avoiding intoxicants, vacation, meditation, support groups, narrative writing, Balint groups.
5. *Healthy philosophical attitude toward life: not taking self too seriously, simplifying, balance, perspective, self-compassion

Narrative Exercise on Self Care

(total time 60 minutes)
(times are approximate, but requires a clear timekeeper)

We know that most of us (physicians) are expert at caring for the needs of others, but not very good at recognizing or caring for our own needs. Yet most of us have experienced some times when we have cared for ourselves in ways that perhaps seem surprising or somewhat out of character. Take about 5 minutes and write a narrative about an experience that you took particularly good care of yourself. It might have been in a small or big way, and it might be in your medical practice or in your personal life, but it should be in a way that might be considered somewhat unusual for you (15 minutes).

Please break into pairs to share your stories. Allow the storyteller to tell the entire story without interruption. After hearing the story, the listener should ask questions that focus on deepening and further exploring the storyteller's narrative. The interviewers should initially keep their own reactions and associations in check unless they serve to further the exploration of the teller's story. There will be some time for debriefing your own reactions and responses in the subsequent time period (10 minutes).

Now take a few minutes to explore your interaction together, both sharing your reactions and responses to the process so far (5 minutes).

Now change roles and allow the previous listener to be the story teller, and vice versa. Remember to allow the story to be told fully without interruption, and to use the subsequent period to explore the story further before debriefing (15 minutes total, as above).

Now let's take some time to respond to and debrief the exercise, and in particular your response to having to tell a story about caring for yourself (10 minutes).

References and Handout Suggestions

Dobie S. Reflections on a well-traveled path: self-awareness, mindful practice and relationship-centered care as foundations for medical education. *Academic Medicine.* 2007; 82 (4): 422-7

Kearney MK, et al. Self-care of physicians caring for patients at the end of life: "Being connected…a key to my survival." *JAMA.* 2009; 301 (11): 1155-64

Oliver M. Wild geese. In: *Dreamwork.* Harcourt Brace & Co: 1992

Shanafelt TD, et al. Burnout and self-reported patient care in an internal medicine residency program. *Ann Int Med.*2002; 136: 391-3

Shapiro SL, Brown KW, Biegel GM. Teaching self-care to caregivers: effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology.* 2007; 1 (2): 105-15

Walcott D. Love after love. In: *Derek Walcott: Collected Poems 1948-1984.* New York, NY; Farrar, Straus & Giroux: 1986

Week 8

***Theme**:* Discipline, keeping up momentum, endings and beginnings are important elements of this session which marks the ending of the first phase of the course, and the beginning of the second phase. Because participants will not be meeting weekly, but will meet for the duration of the project monthly, ways to support continued mindful practice are emphasized.

***Class Flow**:* The class begins with a body scan, one of the first formal practices introduced in week 1. This is followed by mindful movement, walking, and sitting practice.

Participants are given ample opportunity to share narratives they have worked on in the past week or two on self-care or inspiration and discipline. Brief group inquiry, facilitated by the instructors weave in ways to continually bring mindful practice, appreciative inquiry, and narratives into the practice of medicine in the periods between the monthly sessions. Specific resources to support continued development of formal practices are reviewed, and suggestions are made for the participants to create a group list-serve for continued conversation between classes.

The class concludes with a brief sitting period and home practice assignment.

***Home practice**:* The home practice includes sitting meditation, guided or unguided, at least three days weekly. The participants are encouraged to use other formal practices as they desire, and to also consider narrative writing regarding teamwork.

Class at a Glance

0:00-0:10	*Gathering/Check in/Noticing*
0:10-1:10	*Body scan/Sitting/Movement/Walking*
1:10-2:00	*Shared Narratives, large group*
2:00-2:15	*Review of First Phase of Course*
2:15-2:30	*Sitting/Home practice assignment*

References and Handout Suggestions

Horowitz CR, Suchman AL. What do physicians find meaningful about their work? *J Gen Intern Med.* 1995; 138 (9): 772-6

Krasner MS. In pursuit of balance: a paradigm shift. *The Bulletin of the Monroe County Medical Society*. 2008: 14-15.

Shapiro SL, Schwartz GE. Intentional systemic mindfulness: an integrative model for self-regulation and health. *Adv Mind Body Med*. 2000; 16: 128-34

Monthly Class Outlines: Phase 2, Continuation Phase

Monthly Meeting 1

Theme: The theme of this month's session is teamwork. How do the participants find themselves as parts of teams in their clinical work? What does it mean to work with others, and how do the skills of attention and awareness relate to the relationships within a team? The physician finds him or herself working on a variety of levels as part of a larger health care team. These teams include not only colleagues, but also the patients and their families, the office staff, administrators, and numerous other individuals and groups. A deeper exploration into the nature of teams and teamwork may help to contextualize the medical experience for members of the team, and the professional experience for the physician.

Class Flow*:* An opening sitting meditation exercise guides the participant in the month that has passed since finishing the first eight-weeks. Guided meditation includes a reconnection with feelings, thoughts, and sensations in the present moment and an exploration into how this awareness has shown up in the intervening month-at work and at home. Participants are asked to contemplate the barriers they experience to continuing the formal mindfulness practices.

Following this is a checking in period where participants can share some of the results of their inquiry during the sitting period. They are encouraged to discuss successes as well as challenges. Strategies for bringing mindful awareness into the month-long breaks between sessions are reviewed.

Participants are then led in a walking meditation exercise, guided to move around the room, noticing the presence of others and of themselves, noticing what choices they make about where to walk, who to walk toward, who to walk away from, when to stop, when to keep moving. They then return to sitting, guided briefly in a contemplation centered on working in relationship, with their patients, their staff, colleagues. They will are guided in a self-inquiry process about what makes teamwork successful, effective, life-enhancing, and satisfying.

The participants are then grouped into teams of 5-8. They work as a team beginning with a case description, briefly journaling about the case, then engaging in a group discussion using the Interpersonal Mindfulness guidelines, reflecting about the team exercise among the group members, and then in a larger group debriefing (see below facilitator information).The session concludes with a brief sitting period and home practice suggestions.

Home Practice*:* Participants are encouraged to continue or re-establish a daily practice using the guided meditations (sitting, body scan, yoga) or journaling. Attention on experiences of saying no in the participants' clinical practice during the intervening month is suggested.

Class at a Glance Monthly Meeting 1

0:00-0:10	*Guided Sitting Practice*
0:10-0:40	*Gathering/Check In/Noticing*
0:40-1:00	*Walking Exercise/Sitting*
1:00-1:05	*Contemplation-Teamwork*
1:05-2:15	*Teamwork Exercise*
2:15-2:30	*Sitting/Home Practice Review*

Mindful Communication: Teamwork Exercise

(total time about 70 minutes)

Phase 1 (5 minutes): Read the following case, and answer the questions below.

A 38 year old woman presents to your office seeking a new primary care provider. She has been referred to you from a gastroenterologist who is looking for some help addressing her general medical problems while she tries to address her very complex bowel problems. The patient has a long history of bowel dysmotility, and currently weighs 80 pounds. She is receiving central hyperalimentation at night, and is only able to tolerate a small amount of feeding through her jejunostomy tube. She has been seen at the Mayo Clinic for a second opinion where she received an experimental intestinal pacemaker. She has chronic abdominal pain for which she is on a fentanyl patch, and she experiences much more severe abdominal pain if she tries to force eating or drinking.

Her PMH has been dominated by gastrointestinal problems, which began when she was in her mid-teens. She has seen a wide range of specialists, and there is a consensus in her chart that she has a rare disorder of gut motility. She lives with her parents, who are very devoted and concerned about her. She is appropriately frightened by her situation, but otherwise does not seem depressed. All consultant notes that you review refer to her as a lovely person with a very unfortunate medical situation.

Her physical examination shows her to be afebrile, blood pressure 80/60, heart rate 100, respiratory rate of 14, and pain is 4/10 (her baseline.) She appears emaciated and pale and much younger than her stated age. Her lips are cracked, and her tongue is dry and red. She has no lymphadenopathy. Her chest is clear and cardiac exam is without murmurs or rubs. Her abdomen shows multiple surgical scars, and a jejunostomy tube in place. There is no organomegaly, and a pacemaker is palpable in the right lower quadrant. She is very thin. You note some redness around her J-tube, but no fluctuance or pus.

Take a couple of minutes as individuals, and jot some notes about:

What do you notice about sensations you are experiencing in your body?
What do you notice about your emotions?
What do you notice about the thoughts you are having?

Her main problems

What worries you most about this case?

What are the most important elements of your initial approach to this patient?

Phase 2 Instructions (about 20 minutes): Working in Teams

Ask the individuals now to divide up into groups of 4-5, with two goals. First, they should discuss the questions collectively in order to come to a plan of action in a challenging clinical situation. Second, ask them to pay close attention to their own thoughts, feelings and physical sensations, and how the state of their awareness affects the group process as a whole. Also, remind them of the Interpersonal Mindfulness guidelines to use in their conversations. Give them some warning that at five minute intervals, you will stop the groups abruptly, guide them at each interruption through a reminder of the Interpersonal Mindfulness instructions:

1) Pause-relax-open (take a moment to relax, check in with yourself (mind, body, emotion), and open your mind; when you resume discussion, try to:

2) Trust emergence- allowing yourself not to edit your responses, or notice when the editor shows up, and

3) Speak the truth; listen deeply- authentically conveying your emerging thoughts and feelings, while listening without simultaneously focusing or forming your own responses so you can truly hear what is being said.

Then resume discussion for another 5 minutes, and repeat the forced pause as above.

In the third five minute period, ask the group to discuss explicitly where consensus exists in each of the questions, and to note where there are differences.

Phase 3 Instructions (25 minutes): Reflections on Teamwork

Now within each group, ask each individual to speak about their responses to this exercise, and in particular how they experienced it through body sensations, emotions and thoughts. Additionally, reflect on how the interpersonal mindfulness instructions affected the experience of the exercise. After each person has had the opportunity to fully express him or herself, ask questions of clarification if necessary to be sure the person is fully understood. Use the final 5 minutes to discuss how teamwork worked and didn't work within the group. One group member should take notes to summarize the group's experience to share with the larger group.

Phase 4 Instructions (20 minutes): Large Group Debriefing

Ask representatives from each group to summarize the group's experience. Then open to reflections from all the participants, considering the following questions:

What did you notice about your role in the team?

What did you notice about other people's roles?

What did you learn about problem solving?

What did you learn about yourself?

What did you learn about the group process?

In what ways can what you learned inform your work alone and in groups?

References and Handout Suggestions

Fisher R, Patton BM, Ury WL. *Getting to Yes: Negotiating Agreement Without Giving In.* New York, NY; Houghton Mifflin Co.: 1991

Rosenberg MB.*Nonviolent Communication: A Language of Life.* Puddledance Press: 2005

Suchman AL. Control and relation: two foundational values and their consequences. *Journ Interprof Care.* 2006; 20 (1): 3-11

Whyte D. Working together. In *The House of Belonging. Poems by David Whyte*. Langley, WA; Many Rivers Press: 1997

Monthly Meeting 2

Theme: The theme of this session is saying no. A common practice dilemma arises around the issue of having to say no in clinical practice. The circumstances are numerous, but in each circumstance, the physician is challenged to set a boundary, refuse a request, and make a statement of where one stands. This is not always a simple task, and often triggers internal distress which can be experienced as reactivity, indecisiveness, uncertainty, internal conflict, self-criticism, anger and frustration to name a few. It may be experienced by patients in difficult ways as well with anger, fear, rejection, hostility and uncertainty among other feelings that arise. Mindful Communication can help address this challenge by bringing both the physician and patient into clearer relationship while working through these difficulties. It asks the clinician in particular to become intimate with the experience of feelings, thoughts and sensations they experience through mindfulness, while exploring the aspects of these kinds of experiences where in part or in full they have successfully negotiated these challenges.

Class Flow*:* The class begins with a check-in period, sharing anything about the prior month related to the course. This is initiated by asking the participants to turn toward a neighbor and share, and then opened up to the larger group for further discussion.

This is followed by a period of mindful movement, beginning with a walking period, and followed by a standing Yoga session. Guided sitting practice follows, and the practice period concludes with a body-scan meditation.

Participants are then led in a narrative and appreciative dialogue exercise (see handout below annotated for facilitator). This involves the writing and sharing of clinical narratives involving setting boundaries. The storyteller then considers what was discovered or uncovered in the sharing process, and then will rewrite the narrative and share the story again. Particular attention is paid in this second round of storytelling and interviewing to how the story changed, and how deeper reflection may lead to a deeper understanding. This is further explored in the debriefing that follows. The session concludes with a brief sitting period.

Home Practice: Continued daily guided sitting practice alternating with movement or body scan. Journaling about challenging patient encounters is encouraged.

Class at a Glance: Monthly Meeting 2

0:00-0:15	*Gathering/Check-In*
0:15-0:50	*Mindfulness Practice*
0:50-2:10	*Saying No Exercise*
2:10-2:25	*Debriefing*
2:25-2:30	*Sitting/Home Practice Review*

Narrative Exercise: Relational Ways of Saying No

A common practice dilemma arises around the issue of having to say "no." The circumstances are numerous. Some are very obvious, and others go almost unnoticed. For example, the physician may be asked to write a prescription for sleeping pills, or a sedative, or a medication to enhance performance such as an amphetamine derivative used for attention deficit disorder. He or she may be asked to refer for a cosmetic procedure using a diagnosis that may be a stretch in terms of its veracity. Another kind of request may be to accept a friend or relative as a new patient when one does not have the capacity to do so. There are an almost endless number of situations like these often experienced as requests where a boundary or limit setting may help.

These kinds of situations and experiences are among the most challenging for practitioners because they prey upon qualities that many physicians have that can become vulnerabilities, such as the duty to serve, to be kind, to help, to support one's patients, as well as to assist in relieving suffering. These are also challenging for reasons that have to do with the practitioner's own psychological and personality traits reflective, in part, of one's personal and professional formative experiences. These situations often result in distress, and may trigger unnecessary reactivity, further exacerbating the interpersonal and intra-personal effects of this distress.

Mindful Communication involving these kinds of challenges may be one particular way of developing a more balanced way of responding, and because these issues are so challenging, they are worthy of closer attention and certainly a greater dose of one's awareness. So, spend a few moments contemplating a situation in which you held a boundary, even though it was challenging and difficult, but you knew it was the correct thing to do.

Part 1: Narrative Writing

Writing (15 minutes): Ask participants to begin by being mindful of the situation itself and what one recalls about the situation, what one remembers seeing, feeling, touching, tasting, smelling or sensing in any fashion, Recall the thoughts and emotions that arose and anything else that adds depth or richness to the account. Ask participants to let go of having to interpret, make sense, analyze, or "figure it out" at this point and simply describe. They might include any feelings or sensations that are present now in recalling the situation as a means of expressing more clearly what took place then.

***Storytelling and Appreciative Interview (10 minutes each)*:** At this point, participants share with a partner what they wrote about the experience. After sharing this, the listener asks question that are meant to deepen the narrative. As this part of the conversation takes place, the storyteller may want to take a few notes about regarding any insights or thoughts that they discover through this inquiry.

When finished with this part of the exercise, the storyteller and listener reverse roles and repeat the above instructions.

Part 2: Alternative Narrative Writing

Rewriting (20 minutes): This is an opportunity to enrich, expand, and consider the original story in a new way, beginning with reviewing the original draft, using whatever notes or recollections from the initial inquiry. Participants consider any new thoughts or insights that developed and when rewriting, to be sure to include some discussion of what actually took place in the story as well as one's interpretations, impressions, emotional reactions, and associations.

Appreciative Interview (10 minutes each)*:* Dyads share the new narratives and reflect on the experience of rereading. Partners attempt to share (reader) and elicit (listener) thoughts about what capacities exist within the storyteller that supported the right action, and in what other areas of their work and life experience are those capacities present. They are also asked to notice, inquire, and share about how the story developed from the initial narrative to the final narrative, and what was notice d(what were they mindful of) through this exercise.

Monthly Meeting 3

Theme: The theme of this session is the dismissal of patients from practice in the physician-patient relationship. This is one of the most challenging events in clinical practice, and often experienced with a great deal of uncertainty and stress. Awareness of this stress and of its emotional, physical, and cognitive manifestations can assist the practitioner in negotiating this troubling territory. There really is no one "right way" of approaching these situations, but the physician needs to approach each unique experience freshly, with a beginner's mind, attuned to one's inner experience, and sensitive to the experience of the patient and the requirements of the situation.

The narrative exercise involves role playing. This activity allows the participants to consider the experience of the patient as well as the physician in the termination encounter. The participants are guided to pay attention to the foundations of mindfulness, especially body sensations, emotional tone, and thought constructions as they work through the role play.

Class Flow: The class begins with a check-in, followed by a period of guided formal mindfulness practice including periods of walking, sitting meditation, and mindful movement. The intention of this period is not only to assist the participant to enter more deeply the moment to moment experience of the time spent in class but, in regard to the theme, to assist the participant to be able to embody the awareness of not only the self but also of the other. This enriches the role-playing exercise.

After the formal practice period, instructions (see below) for the narrative exercise are reviewed. The participants spend time writing then sharing the narratives in dyads. They then meet in larger groups of 6-8 participants, engaging in a role playing exercise, acting out the narratives they have worked on.

After a period of debriefing this experience they are guided in a period of sitting meditation.

Home practice: Suggestions for the intervening month are made include daily guided practice of any of the formal meditations. Journal writing about the dynamic of attraction and aversion noticed during patient encounters is recommended.

\

Class at a Glance: Monthly Meeting 3

0:00-0:15	*Gathering/Check-In*
0:15-1:00	*Mindfulness Practice*
1:00-1:30	*Narrative Exercise*
1:30-2:10	*Role Playing*
2:10-2:25	*Debriefing*
2:25-2:30	*Sitting Practice/Home Practice Review*

Narrative Exercise: Dismissing Patients from Practice

One of the most challenging tasks in clinical practice arises when a physician has to ask a patient to leave the practice. The reasons for this are varied, and may include a variety of factors including frequent missed appointments, incompatibility, distrust, non-payment, misuse of medications, disruptive behavior, legal infractions or dishonesty. Often the dismissal is done by letter; at other times the warning or actual dismissal involves a conversation or a series of conversations. Physicians often report that conversations with patients about dismissal from the practice are among the most difficult conversations they have.

For today's session, recall a time when you had a conversation with a patient that included either a warning about possible dismissal from your practice or when you notified the patient of your decision to actually dismiss him or her from your practice.

Part I: Narrative writing (10 minutes)

Now, take 5 minutes to write down some notes about the situation, the context, who was present, and how the conversation went. Divide the page in half. On the right half, write notes about your experience of the situation. On the left, write notes about what you imagine that the patient was thinking and feeling. On both sides of the page try to include your thoughts, emotions, and body sensations.

Part II: Storytelling (20 minutes)

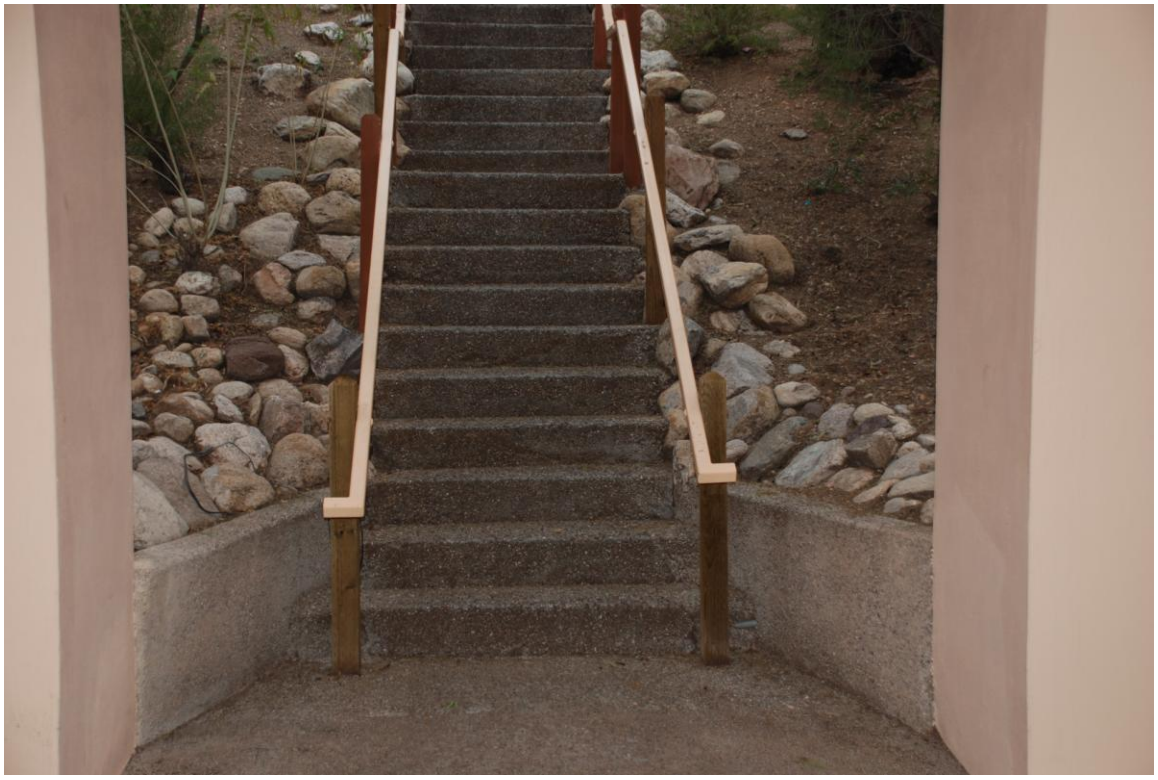
Next, divide into pairs. Share both sides of your story briefly with your partner. Take 7 minutes each. As a listener, listen deeply and attentively, making sure that you understand the story, its contexts, antecedents and outcomes, as well as the emotions that your partner may have felt or is currently feeling. Inquire about the experience in a way that will help you and the storyteller deepen your understanding of the experience. As the listener, your intention is not to help the storyteller feel better or come to terms with the experience. Rather, it should be to simply learn as much as you can about it, without judgment, interpretation, reassurance, or sharing of your own experience. Try to embody the mindful attitudes of acceptance, non-judgment, non-striving, beginner's mind, and trusting emergence. After about 10 minutes, you will be instructed to switch roles.

Part III: Role playing (40 minutes):

Next, join up with two or three other pairs, so that you are now in a group of 6-8.

This will be a role-play exercise. One person should volunteer to tell his/her story briefly, sharing notes from both sides of the experience, the physician's and the patient's, just enough so that the group understands the context. The storyteller then portrays the role of patient. And another group member, not necessarily the teller's partner, should volunteer to be in the role of the physician. The volunteer then begins a conversation to dismiss the patient from the practice.

Allow 2-3 minutes of role play, then stop to debrief, then continue for another 2-3 minutes and debrief again. Debrief the role play with the group, focusing on thoughts, sensations and emotions, and also your tendencies to be attentive or distracted, to be curious, open, or defensive, to be flexible or rigid, and to be present or on "auto-pilot." Each role play should take 15-30 minutes, including debriefing. Each group will have time for only 2 or 3 role plays.



Monthly Meeting 4

Theme: The theme of this session is the dynamic of attraction in the physician-patient relationship. This dynamic, although present in any relationship, can be a challenging one to negotiate as it raises concerns over professionalism and ethics. One of the cognitive pitfalls that practitioners can run into with the dynamic of attraction is the affective error where the clinician's feelings towards a patient may lead to erroneous clinical judgment.

In the exploration of awareness itself, attraction is considered one of the primary forces at work, leading the individual to a moving toward an object of awareness. For example, one may notice a sound, initially as an event experienced in the sense domain of hearing. Layered onto this then is the judgment or feeling tone regarding the sound: *like, dislike, or neutral*. When it is "like" or "pleasant" or "attraction to" the attention moves toward that event or experience, followed by a series cognitive events such as thoughts, pictures and images, stories, memories, fantasies. So attraction itself is worthy of close attention as exploration of it can cultivate a more robust embodiment of the qualities of mindfulness.

Class Flow: The class begins with a check-in and then an extended mindfulness meditation practice session including periods of walking meditation, sitting meditation, and mindful movement. Participants are guided to notice in particular how their attention may be pulled in by thoughts, feelings, and sensations that may be pleasant or enjoyable, noticing the actual dynamic of attachment as it manifests itself in the formal awareness practices.

The participants then engage in a writing period, exploring experiences in which the participants were aware of their attraction to a patient and inquiring how this dynamic affected the clinical relationship. Because of the difficult nature in working with this dynamic, especially as it relates to sexual attraction for example, these stories may be highly charged with self judgment, criticism, shame, and embarrassment. The writing assignment can be as general or as detailed as the participants feel comfortable.

The interview phase of this exercise begins in pairs, and after a period of sharing the dyads then gather together, continuing the conversation with a "fish bowl" approach. In this, several (3-4) participants are placed in the center of a circle and begin the conversation about the stories. At various points during the conversation, members sitting outside in the circle take the place of members in the middle, continuing the conversation. At other points in the exercise, the participants outside of the group are invited to share their thoughts and feelings.

During the fishbowl phase, participants are asked to drop beneath the specifics of the story and consider the effects of this dynamic, bringing the qualities of mindful awareness, with open and nonjudgmental attributes into the discussion. The following are some kinds of questions for participants to consider during their time inside and outside of the fishbowl:

What is it like (as an experience) to talk about attraction?

What thoughts, feelings, and sensations arise when listening? When speaking?

What does it mean to be non-judgmental when listening to or speaking about these experiences?

How does attraction manifest itself in the clinical encounter?

How does it affect the way physicians (you) practice?

How does it get in the way of practice?

How does it help the physician-patient relationship?

How does it interfere with the physician-patient relationship?

What about the opposite experience to attraction, that of aversion?

What are the differences in the experience of these two dynamics?

What are some of the similarities in the experience of these two dynamics?

How can either lead to unskillful behaviors?

What are some of the challenges for the practitioner that are similar in both?

After the fishbowl conversations, a larger group debriefing occurs in which participants are given an opportunity to share the process of writing, storytelling, and being inside and outside of the fishbowl during this exercise. Following this, the group is led in a brief sitting meditation.

Home practice for the coming month includes guided sitting and journaling about encounters with burnout.

Class at a Glance: Monthly Meeting 4

0:00-0:20	*Gathering/Check-In*
0:20-1:10	*Mindfulness Practice*
1:10-1:20	*Narrative Writing*
1:20-1:40	*Paired Sharing of Stories*
1:40-2:10	*Fishbowl*
2:10-2:20	*Debriefing*
2:20-2:30	*Sitting Practice/Home Practice Review*

Monthly Meeting 5

Theme: The theme of this month's meeting is physician burnout. Burnout is characterized by three principal components: emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment and by definition is a distinct work-related syndrome. The components of burnout may be common among practicing physicians, and evidence demonstrates that physicians are highly susceptible to burnout. However, there is very little research exploring the efficacy of interventions addressing burnout.

Mindfulness as a human capacity may be one useful way of exploring the challenge of burnout. It allows the practitioner to accept the present state of one's experience, with an interest in the somatic, cognitive, and emotional components of that experience. Through the suspension of judgment, or at least the recognition of the arising of judgments, the participant may understand more clearly the situation of burnout, and experience less of the clouding of understanding created by the lack of awareness to reactive sensations, thoughts, and feelings. The physician may then, through the recognition of the presence of warning signs of burnout, be able to discern more wisely a plan of action.

Class Flow: The class begins with a checking in of participants, and then an extended mindfulness meditation practice session. This includes periods of walking meditation, sitting meditation, and mindful movement. In this period of formal practice, participants are asked to notice their state of energy, whether they are experiencing exhaustion, physically, cognitively, and emotionally. They are also be guided in an exploration of their sense of self, noticing how they relate to self and others, including an examination of their actual work-life experience, and how it compares with the non-work domains in terms of exhaustion and energy, motivation, enthusiasm, and intra-personal as well as interpersonal relationships.

After this period of practice, and after a relatively brief period of discussion, the group reviews some didactic material about physician burnout. Then participants participate in a period of narrative writing about an experience, preferably a clinical one, in which they felt emotionally exhausted, uncertain of their own abilities and accomplishments, and perhaps felt feelings of depersonalization, treating situations and others as objects. They will include in their narrative something about their recognition and realization of these feelings, and if possible will detail how they manifested in the body, in thoughts, and in emotions.

After the writing period, participants share their narratives in groups of three or four, using techniques of appreciative inquiry, reflective questioning, and interpersonal mindfulness. Then, in a larger group debriefing they explore further their experiences of burnout, its recognition, and the role of mindful awareness in identifying and responding to the components of burnout. A brief sitting period follows.

Home Practice: Continued guided sitting practice along with journal entries about caring for patients with serious and life limiting illness. .

Class at a Glance: Monthly Meeting 5

0:00-0:20	*Gathering/Check-In*
0:20-1:00	*Mindfulness Practice*
1:00-1:15	*Burnout Review*
1:15-2:10	*Narrative Exercise*
2:10-2:25	*Debriefing*
2:25-2:30	*Sitting Practice/Home Practice Review*

Physician Burnout: Highlights

Components: emotional exhaustion- overextended and exhausted by work; depersonalization- negative and cynical attitude, treating patients as objects; and sense of low personal accomplishment-feelings of incompetence, inefficiency and inadequacy. Affects work life and relatively spares personal life, in contrast to depression which affects both personal and work life.

Prevalence: 25-60% practicing physicians; 76% of internal medicine residents; 45% of 3rd year students

Causes: overwork, sleep deprivation, low control/high responsibility, inadequate support, lack of self-awareness, imbalance between personal and professional life

Consequences: lower empathy, poorer patient care, more errors, auto accidents, stress-related health problems, poor relationships, marital/family stress, substance abuse, quitting practice

Responding to stress: Survival, Growth, and Change: Unhealthy reactions include unhelpful behaviors that you feel "you can't keep yourself" from doing, including compulsive and addictive coping mechanisms. "Survival" skills may help you get through a tough time, but may be destructive if habitual, such as foregoing self-care, personal needs, sleep, and nutrition. Growth utilizing healthy coping skills is important in the long-term development as a physician and human being.

Research on physician stress suggests that the following may help alleviate and prevent burnout: adopt a health philosophical attitude toward life, find support in the workplace, engage and find meaning, develop healthy relationships, take care of yourself, cultivate self-awareness

References and Handout Suggestions

Bodenheimer T. Primary care-will it survive? *NEJM.* 2006; 355 (9): 861-4

Dyrbe LN, Thomas MR, Huschka MM. et al. Burnout and suicidal ideation among US medical students. *Ann Int Med.* 2008; 149 (5): 334-41

Krasner MS, Epstein RM, Beckman H, Suchman AL, Chapman B, Mooney CJ, Quill TE. Association of an educational program in mindful communication with burnout, empathy and attitudes among primary care physicians. *JAMA.* 2009; 301: 1284-1293

Machado A. The wind one brilliant day. In: *Times Alone: Selected Poems of Antonio Machado.* Middleton, CT: Wesleyan University Press; 1983

Shanafelt TD, et al. Burnout and medical errors among American surgeons. *Ann Surg.* 2010; 251 (6): 995-1000

Shanafelt TD, Bradley KA, Wipj JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Int Med.* 2002; 136 (5): 358-67

Shihab-Nye N. The Whole Self. In: *Words Under the Words: Selected Poems.* Portland, OR: Eight Mountain Press; 1995

Spickard AJ, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *JAMA.* 2002; 288 (12): 1447-50

Thomas NK. Resident burnout. *JAMA.* 2004; 292 (23): 2880-9

Monthly Meeting 6

Theme: During this session, participants will examine experiences involving end-of-life care. There are few areas in medicine that have as profound an impact on a clinician's experience, sense of self and other, sense of relationship, and mindful awareness as end-of-life experiences. Thus, the sharing of clinical narratives while investigating, with appreciative inquiry, the capacities that the physician summons when working with patients at the end of life, allows the physician to explore these profound experiences in a new way, one that holds the experiences within a container of nonjudgmental, moment to moment awareness.

Another objective in extending this theme over two sessions is to allow the participant to deepen the narrative and the writing experience through writing, sharing, listening to feedback, rewriting, and then sharing again before final revisions. In this process opportunities arise for the storyteller not only to contemplate the theme before the story is initially written, but to also contemplate the written story itself after its initial draft. Likewise, for the listener, there is an opportunity to deepen that experience by not only noting what was elicited by the story, but also by cultivating an awareness of the drifting of one's own consciousness while listening. This drifting, unexamined, may lead to, among other things, disclosures from the listener that have the unintended consequence of invoking a sense of failed communication in the storyteller. During the second of the two sessions participants will be given an opportunity to share with the larger group the narratives they have developed.

Class Flow*:* This class begins with a brief checking in, and then a period of guided mindful practice, concluding with a sitting period. During the guidance for this sitting period, participants are asked to look closely at their relationship to impermanence, including the very transient nature of the thoughts, feelings, and sensations that arise moment to moment. Toward the end of this period, the participants are then encouraged contemplating an end of life experience, preferably one from their work as physicians, but if necessary an experience from their personal lives outside of Medicine may be used if they cannot recall a professional event, or if they would rather work with a more personal experience.

Spending a more substantial period of time writing the narrative, focusing on a profound moment in the care of someone dying, they are guided to record notes not only detailing the experience, but they are also encouraged to write in longer prose, as if this were a rough draft of a story. Using mindful awareness and attention in their reflections, they are guided to include descriptions of the sensory, emotional, and cognitive components of their experience as well. The participants will forms dyads in which the storyteller shares the story through actually reading the draft, elaborating on the story as necessary.

The listener's specific tasks are to listen carefully, noticing any tendency to interpret, analyze, or identify with the story, while inquiring authentically and with curiosity to those aspects of the story that stir interest in the listener. The listener should also try to assist the storyteller in identifying what skills and capacities the storyteller calls upon

when working with the dying patient. Again, this should not be done as an interpretation on the part of the listener, but rather as a form of inquiry, assisting the storyteller in discovering what might be so for him/her. A final equally important task for the listener is mindfulness of the stream of one's own consciousness while listening. This aspect is explored further during the debriefing period.

After this interchange, the participants are guided in a period of contemplation during which they reflect on their stories and the interchange with the listener. Then they spend a briefer period rewriting the narrative. Following this, there is a period of debriefing, initially in pairs and then in the larger group that focuses on the experience of writing, inquiry, contemplation, and rewriting. Additionally, the tendency for the consciousness and attention of the listener to wander and drift and its effects on the ability to maintain a presence with the storyteller are discussed further.

Home Practice: In addition to any of the formal practices, also including the possibility of further rewriting of the narrative from this class as a contemplative exercise.

Class at a glance: Monthly Meeting 6

0:00-0:20	*Gathering/Check-In*
0:20-0:50	*Mindfulness Practice*
0:50-1:15	*Writing Period*
1:15-1:40	*Dyads*
1:40-2:05	*Contemplation/Rewriting*
2:05-2:25	*Debriefing*
2:25-2:30	*Home Practice Review*

References and Handout Suggestions

Chen P. *Final Exam. A Surgeon's Reflections on Mortality.* New York, NY; Vintage: 2007.

Kenyon J. Otherwise. In *Otherwise.* St. Paul, MI; Graywolf Press: 1996

Krasner MS. The gift of mindfulness. *Families, Systems & Health.* 2004; 22 (2): 213-15

Meier DE, Back AL, Morrison RS. The inner life of physicians and the care of seriously ill patients. *JAMA.* 2001; 286: 3007-14

Oliver M. In Blackwater Woods. In: *New and Selected Poems: Volume One*. Boston, MA; Beacon Press: 2005

Rao JK, Koppaka VR. Santi. *Ann Int Med.* 2002; 137 (10): 852-4

Rosenberg L. *Living in the Light of Death: On the Art of Being Truly Alive.* Boston, MA; Shambhala: 2000

Simmons P. *Learning to Fall. The Blessings of an Imperfect Life.* New York, NY; Bantam: 2000

Monthly Meeting 7

Theme: The theme of this meeting is suffering in medicine- one's own and that experienced by patients and families. A personal capacity of particular importance for medical practice is being present – really being there when things are not going well, when patients are suffering, and knowing that your presence really made a difference. So often, time pressures, distractions and emotional intensity conspire to make us want to shut down, accept the observations of others and not notice things that later might seem obvious.

Our intent is to learn more about the particular qualities, values, skills and conditions that contribute to our ability to be fully present, aware, attentive and curious about patients and their families, especially at difficult times – such as when a patient is diagnosed with an incurable or progressive illness and you have to tell the news, when a patient is about to undergo disfiguring surgery, or when your efforts to relieve suffering have been insufficient. Being fully present brings along the compassion and the possibility of healing, returning to a sense of intact wholeness, even when cure is not possible.

Class Flow: This class begins with a brief checking in, and then a period of guided mindful practice, concluding with a sitting period. After this period of sitting, participants will be guided in a period of mindful movement and walking, with particular attention given to the physical capacities present, allowing one to ambulate, move, direct, control, adjust, and respond to oneself and outside conditions. Then, participants sit again and are guided in a contemplation of their relationship to human suffering in their clinical practices. After this, some brief notes on suffering are reviewed (see below). Then participants engage in writing narratives as described below, and then share their stories in dyads. Debriefing occurs then in pairs and then as a larger group followed by home practice instructions.

Home Practice: Daily meditative practice, participant's discretion. Journal entries about one's personal relationship to the suffering dimension of clinical practice.

Class at a glance: Monthly Meeting 7

0:00-0:15	*Gathering/Check-in*
0:15-0:30	*Guided Mindfulness Practices*
0:30-0:45	*Discussion: Suffering*
0:45-1:05	*Narrative Writing*
1:05-1:50	*Dyad Narrative Sharing and Inquiry*
1:50-2:15	*Group Debriefing and Discussion*
2:15-2:30	*Sitting/ Home practice review*

Notes: Suffering

Not explicitly "taught" in medical training

A dimension that has probably the greatest subjective importance for patients

The relief of suffering generally agreed as a primary end-point of health care

Cassell: Persons suffer ("personhood" encompassing many facets, "nondual")

Involves a perceived threat or destruction to a person's intactness

Occurs in relation to any aspect of the person (social, physical, transpersonal)

Why is everyone not suffering?

Frankl:

Pain/Guilt/Death- triad of human existence

How is it possible to say "yes" to life then?

How can life retain meaning in spite of its tragic aspects?

There is a human capacity/drive to creatively turn life's negative aspects into something constructive/positive

Achievement/accomplishment

Out of guilt changing oneself for the better

Out of life's transitory nature, an incentive for responsible action

Meaning leads to happiness which leads to an ability to cope with suffering

By creating a work or doing a deed

By experiencing some thing or encountering someone (which compensates for our one-sided emphasis on the external world of achievement at the expense of the internal world of experience

By rising above oneself, and by doing so, change oneself

Meaning may be found, even when confronted with hopeless situations

When we are no longer able to change a situation, we are challenged to change ourselves

Meaning is possible even in the midst of suffering

Antonovsky: *Sense of coherence*

Meaningfulness: The profound emotive experience of life as making sense and thus coping being desirable.

Manageability: The recognition of the resources required to meet the demands and a willingness to search them out.

Comprehensibility: The conceptual perception of the world being understandable, meaningful, orderly and consistent rather than chaotic, random and unpredictable.

Kobasa: *Stress Hardiness*

Challenge

Commitment

Control

Narrative Exercise: Suffering

Focus on a time when you were present for a patient and/or family in a moment of deep sadness and suffering; perhaps a time when you dealt with a patient/family whose suffering moved you or affected you in some way. Or it may be when you had to cause pain such as giving bad news or doing a painful procedure. Alternatively, it could be when you yourself experienced suffering in having to deal with a very unpleasant task or situation, or when you yourself or someone close to you experienced personal suffering.

Take 10 minutes to write a brief narrative about the experience. When finished, you will be instructed to work in pairs to share the stories.

For the storyteller, address:

What happened?

What helpful qualities did you bring to that moment?

Who else was involved, and how did they contribute?

What aspects of the context made a difference?

What lessons from this story are useful to you?

What sense of meaning, accomplishment, connection, and transcendence were present as you reflect on this experience?

For the listener:

Be attentive
Listen without interrupting or responding too quickly

Ask questions to help your partner elaborate, clarify and provide details

Don’t talk about your own ideas or experiences

Use reflective questions

Pay attention to what is attracting your attention, and what you might not (or rather not) be hearing

Offer empathy if you feel it

Inquiry about the capacities in those involved in the experience to cope with the suffering and find meaning

References and Handout Suggestions

Antonovsky A. *Unraveling the Mystery of Health- How People Manage Stress and Stay Well.* San Francisco, CA: Jossey-Bass Publishers; 1987

Cassell EJ. The nature of suffering and the goals of medicine. *NEJM.* 1982; 306 (11): 639-45

Carver R. What the doctor said. In: *A New Path to the Waterfall.* New York, NY; The Atlantic Monthly Press: 1989

Connelly J. Commentary. *Acad Med.* 2008; 83 (6): 588-89

Frankl V. *Man's Search for Meaning.* Boston, MA: Beacon Press; 2006

Kobasa S. Stressful life events, personality and health: an inquiry into hardiness. *J Pers Soc Psych.*1979; 37 (1): 1-11

Monthly Meeting 8

Theme: The theme for this class is money. This is a domain of medical practice where, although very central to practitioners' concerns, many aspects are unexamined. In fact, many of the issues surrounding money in the practice of medicine never rise to a conscious level. Most medical professionals, although believing that our professional endeavors are important, have a sense that they (themselves) are more than just their work alone. Yet, many work very long hours seemingly on a treadmill to maintain a lifestyle that they do not always have the time to engage in. The conjunction of material prosperity and social recession is referred to by one writer, David Myers, as the "American Paradox." In one survey of physicians, the 3 greatest personal and professional challenges they face were maintaining income and standard of living, balancing personal and professional time, and maintaining professional satisfaction.

In terms of mindful awareness and attention, there are a number of questions that arise when examining the issue of money including:

What is the relationship between happiness and money?

How hard should I work?

What are my needs?

For whose needs am I choosing to work in the manner that I am working?

How do I handle the issue of money with patients?

What is my relationship between money and my own personal values?

How "open" or "transparent" should I be with my staff, colleagues, and family members about money?

How does my attachment to money affect my choices and behavior?

Class Flow: The class begins with a check-in of participants and then an extended mindfulness meditation practice session. This includes periods of walking meditation, sitting meditation, and mindful movement. In this period of formal practice, meditative guidance asks participants to consider a typical work day or work week and bring into the field of awareness the amount of time and energy devoted to work pursuits. They are guided to consider their time at home or off of work. How do they spend it? What choices do they make and how satisfied are they with the balance of work and professional life, with the rewards of each, and how do they actually spend their energies on each domains?

After this period of practice, and a brief period of discussion, the participants participate in a period of narrative writing about ways in which they have made choices relating to the issue of money and the practice of medicine. In particular, they may consider writing about their own recognition of the tendency, if present, to approach work in a way that is not completely congruent with their personal values (for some more it may be a more common experience than for others, or it may occur at some times more than other times), and how they have made or are considering making changes in that approach to more accurately reflect their values. This may be an example of deciding to "get off the treadmill" in a creative way. The intention here is to bring to awareness, reflection, and then a narrative expression to an experience that reflects their consciousness of the dynamic that money plays in their lives, bringing light to unconscious assumptions that may be present in relationship to money.

One way for participants to inquire about money during the narrative exercise is to reflect and then write about a time when they did something important that reflected their relationship to money. In order to get at this question it may be helpful to think of a time when the pursuit of money led to a sense of ease or happiness, or alternatively to consider a time when the pursuit of money led to an experience of dissatisfaction or unhappiness.

After the writing period, participants share their narratives in groups of two or three, reviewing the narratives, exploring them using reflective questioning and appreciative dialogue. Then, a larger group debriefing will further explore the experiences of money and our professional and personal relationship to money.

Home Practice: Includes daily sitting practice, with or without recording guidance. Participants may want to journal about their relationship to money reflected in their medical practice. They may also consider having one mindful dialogue with a colleague or a family member about their inquiry into this topic.

Reference:

Dunn PM, Rossen CL. Medicine and money. How much is enough? *West J Med.* 2007; 174: 10-11

Class at a glance: Monthly Meeting 8

0:00-0:15	*Gathering/Check-in*
0:15-1:15	*Guided Mindfulness Practices*
1:15-1:35	*Narrative Writing*
1:35-2:05	*Dyad Narrative Sharing and Inquiry*
2:05-2:20	*Debriefing and Discussion*
2:20-2:30	*Sitting/Home Practice*

Monthly Meeting 9

Theme: The theme for this session is an exploration of uncertainties encountered in the day-to-day practice of medicine. Although a challenging topic, every practitioner has regular encounters with uncertainties, unknowns, and it may be that one of the hallmarks of a skilled and effective practitioner is the degree to which he or she is comfortable with that unknown. Better stated, knowing that one does not know can create a position of great wisdom in the medical relationship. Out of this acceptance arises the curiosity or the beginner's mind, the non-judgment, and the initiation into relationship that must take place for the care to proceed in a thorough and effective manner.

Therefore, it is worth reflecting upon medical encounters in which the unknown, as recognized through the presence of the clinician's fears and insecurities, are present. Reflecting on these kinds of encounters may result in a heightened sense of the practitioner's inadequacies and self-doubts about his or her skills. However, the intention here is to illuminate not the inadequacies, but rather the qualities of mindful attention and awareness that are naturally inherent in such an alive encounter, and that can be called upon to assist one in the challenges of uncertainty in medicine.

Drawing upon earlier work with the structured meditative discussion of Insight Dialogue, the participants will consider the improvisational qualities of the medical interview and encounter. The work of Haidet with his exploration of Jazz music as a metaphor for the dynamics inherent within the medical encounter is helpful by highlighting the improvisational dynamic in a physician-patient encounter, which he refers to as *Creating Space, Creating Trait, and Creating Ensemble*. His framework correlates with the lessons from Kramer's *Insight Dialogue*, providing practitioners with a useful way of practicing mindful communication- as understood through the instructions of *Pause-Relax-Open, Trust Emergence, and Speak the Truth-Listen Deeply*.

Class Flow: Class begins with a check-in period followed by guided mindfulness meditation practice. Emphasis is made in the contemplative practices to include awareness of the random nature of our encounters with experiences of sensation, feelings, and thought domains. A more prolonged period of sitting with *choiceless awareness,* where the guidance of meditative practice becomes whatever phenomena- thought, feeling sensation, is found to be central in one's field of awareness, form moment to moment. This may attune the practitioner to a different kind of relationship to the unknown.

After this period, a presentation and discussion of Haidet's use of the improvisational nature of jazz music and its relationship to the medical encounter and how it can be used along side of *Insight Dialogue* primes the participant for the narrative exercise. The use of jazz musical excerpts help to illustrate the process of *creating space, developing voice, and creating ensemble.* Participants will write narratives about clinical experiences in which they experienced great uncertainty, and share in dialogues (see instructions below). Class ends with a brief sitting meditation period and home practice review.

Home Practice: Continued daily practice involving any or all of the formal meditative practices used in the course. Contemplation recommended about the end of this year-long course, with the next class being the last. Journaling about uncertainties and about insights and experiences that have occurred related to *Mindful Communication* is recommended. Participants may consider bringing something *nourishing* to share at the last class. Finally, participants may want to contemplate what it is they commit to as medical practitioners. This will be part of the writing exercise at the final class.

Class at a glance: Monthly Meeting 9

0:00-0:15	*Gathering/Check-in*
0:15-1:00	*Guided Mindfulness Practices*
1:00-1:25	*Discussion/Demonstration: Jazz and the Art of Medicine*
1:25-1:45	*Narrative Writing*
1:45-2:00	*Dyad Narrative Sharing and Inquiry*
2:00-2:20	*Group Debriefing and Discussion*
2:20-2:30	*Sitting/ Home Practice Review*

Insight Dialogue and Improvisation in the Medical Encounter

(from Greg Kramer, www.metta.org; and Paul Haidet, MD, MPH)

Pause/Relax/Open: ❖ Dwell a moment with immediate experience before speaking or while listening. Let the thinking mind take a break. ❖ The **Pause** temporarily arrests the torrent of habit ❖ **Relax** brings awareness to those parts of the body where we tend to accumulate tension, and allow the tension to relax. ❖ Accept is to the mind as relax is to the body ❖ **Open**: awareness extends to everything around us. While **Pause** and **Relax** could be instructions for internal individual meditation, **Open** invites us to extend this accepting mindfulness to that which is beyond the boundaries of our skin. ❖ Creates personal and interpersonal space	**A Communicative Act/Creating Space:** ❖ A powerful but underused skill ❖ Not what is said, but what is not said ❖ Giving patients space to say what they want to say ❖ Allowing a telling of the illness narrative from a patient's perspective rather than forcing the narrative to tell the biomedical perspective ❖ Difficult because the culture is uncomfortable with pauses or quiet ❖ Does not come naturally; takes practice and discipline ❖ Creates personal and interpersonal space
Trust Emergence: ❖ **Trust emergence** supports our seeing things as they are—unstable and far more complex and fluid than the mundane glance can ever know ❖ To let go into the changing process that we call "now," replete with its uncontrolled sensations, thoughts, emotions, interactions, words, topics, energies, and insights. ❖ To **Trust Emergence** is to enter practice without the bias of a goal. ❖ To be oneself	**A Communicative Trait/Developing Voice:** ❖ Basic communication skills are but the building blocks ❖ Personal style ❖ Creatively applied in each encounter in a way that meets the context and communication of the patient ❖ Requires one to "show up" rather than adopting a third-party stance ❖ To be oneself
Speak the Truth/Listen Deeply: ❖ We listen with the generosity of patience, unhurried by a personal agenda. ❖ In active listening, we apply the energy of attention to the many qualities of experience. ❖ The receptive quality of **Listen Deeply** emphasizes the stability and sensitivity of awareness. ❖ In **Speak the Truth** we come to recognize meditative speaking as something that has less to do with words than the source from which the words emerge ❖ To be present	**A Communicative Event/Creating Ensemble:** ❖ One's statements are viewed in the context of the partner's ❖ Converging vs. diverging statements ❖ The voices in the interaction exist in harmony rather than one striving to dominate the other ❖ Ensemble improvisation allows all voices to find common ground ❖ It takes listening aligned toward *understanding* and raising one's awareness to nonverbal signals, fleeting glimpses of emotions, and key words, and follow-up on these clues ❖ To be present

Narrative Exercise: Uncertainty in the Practice of Medicine

The practice of medicine involves the regular meeting of skill and experience with uncertainties and unknowns. This meeting is part of the source of satisfaction and exhibition of competence and professionalism but it may also be the source of stress, anxiety, and self-doubt.

One hallmark, therefore, of an exemplary physician, may be the comfort and skill that practitioner has in meeting the unknowns. One place to look for these unknowns is in the clinical experiences in which the practitioner has had fears and insecurities. Reflecting on these encounters may bring up thoughts of self-doubts and inadequacies. However, the intention here is to illuminate the qualities of mindful attention and awareness that are alive in these kinds of encounters. These qualities can be called upon to assist the physician in facing the challenges of the unknowns.

Begin by focusing on an experience in which you noticed fear or insecurity. If possible, try to recall a particular clinical encounter where there was great uncertainty, and you found yourself facing many unknowns. Perhaps the stakes were large such as a significant diagnosis, a potentially grave prognosis, or where you felt alone in terms of assistance from colleagues with greater experience. It may have been a situation unlike any other, where there was no roadmap to guide your diagnostic and treatment process. If you have difficulty with a clinical encounter, consider something from your personal life. Take 10 minutes to write a brief narrative about this experience, in particular, considering the qualities of awareness and attention that you experienced related to the thoughts, feelings, and even physical sensations of the experience.

After the writing of the narrative, you will be instructed to engage in a dialogue with your partner about the narrative. Try to share the story by either reading or using what you wrote as notes, giving the listener a full, multidimensional and textured picture of your experience. Use the scaffolding of Insight Dialogue to bring a contemplative quality to the storytelling, and to the listening. Notice the quality of improvisation within the dialogue, creating space (pause-relax-open), developing a voice (trust emergence), and creating ensemble (speaking the truth/listening deeply). Allow for both members of the dyad to engage in telling and inquiring, noticing the interplay between the two.

References and Handout Suggestions

Espin S, et al. Error or an "act of God"? A study of patients' and operating room team members' perceptions of error definition, reporting, and disclosure. *Surgery.* 2006; 139 (1): 6-14

Graber M, et al. Diagnostic error in internal medicine. *Arch Int Med.*2005; 165: 1493-99

Haidet P. Jazz and the 'art' of medicine: improvisation in the medical encounter. *Ann Fam Med.* 2007; 5 (2): 164-9

Hilfiker D. Facing our mistakes. *NEJM.* 1984; 310 (2): 118-22

Kramer G. *Insight Dialogue: The Personal Path to Freedom.* Boston & London; Shambhala: 2007.

Groopman J. *How Doctors Think.* Boston & New York: Houghton Mifflin Company: 2007

Redelmeier DA. The cognitive psychology of missed diagnoses. *Ann Int Med.* 2005; 142: 115-20

Schon DA. From technical rationality to reflection-in-action. In Elstein A & Dowie J Ed: *Professional Judgment: A Reader in Clinical Decision Making.* Cambridge, UK: Cambridge University Press; 1988

Monthly Meeting 10: Final Session

Theme: This is the last of meeting. The theme for this class is the highest aspirations of the participants. Through the guided mindfulness meditation period, the narrative writing, and the use of appreciative inquiry, the participants are better prepared to practice an integrated approach that is befitting of this last class. Enough space is built into the schedule to allow for appropriate sharing and goodbyes. Additionally, participants are given time to share anything nourishing they may have brought to class, and also encouraged to share their interests in creating some kind of ongoing connections to share experiences similar to those shared in this course for the future.

Class Flow: During a period of guided mindfulness practices participants are asked to contemplate and inquire about not only the fact that this is the final class, but also about the experiences they had in the course that have related to their sense of professionalism, collegiality, and meaning. Following this, the participants read and reflect in the large group on both the classical version and the modern version of the *Hippocratic Oath*.

After this discussion, they are guided again in a short period of contemplation, followed by a narrative writing exercise that captures their highest aspiration in medicine. The story drawn from their clinical experiences should reflect the professional at his or her best. They are asked to consider why this story in particular moved them. They then share these narratives in pairs, and then in the larger group discussion, opening to the experiences of hearing and telling these narratives. Discussion continues about the course in general with opportunities to share what participants may have brought in to class as well as anything that comes up in the moment.

At the conclusion of the group discussion, a period of guided sitting meditation practice concludes the session.

Class at a glance: Monthly Meeting 10

0:00-0:10	*Gathering/Check-in*
0:10-0:30	*Guided Mindfulness Practices*
0:30-0:50	*Reading and Discussion: Hippocratic Oath*
0:50-1:10	*Narrative Writing*
1:10-1:30	*Dyad Narrative Sharing and Inquiry*
1:30-2:25	*Group Discussion and Sharing*
2:25-2:30	*Sitting*

Hippocratic Oath: Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.

Hippocratic Oath: Classical Version

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Translation from the Greek by Ludwig Edelstein. From The Hippocratic Oath: Text, Translation, and Interpretation, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.

For further information and additional training opportunities please contact:

Mick Krasner MD
Associate Professor of Clinical Medicine, University of Rochester Medical Center
Olsan Medical Group
2400 South Clinton Ave, #H230
Rochester, NY 14618
585-341-7230
Michael_Krasner@urmc.rochester.edu

Ron Epstein, MD
Professor of Family Medicine, Psychiatry, and Oncology and Nursing
Director, Center for Communication and Disparities Research
University of Rochester Medical Center
777 Clinton Ave
Rochester, NY 14620
585-279-4800
Ronald_Epstein@urmc.rochester.edu

For ordering additional copies of this curriculum, please contact:
Dawn Case
585-506-948
Dawn_Case@urmc.rochester.edu