

**Personal Reflection:
A Prescription for Medical Education**

A Thesis submitted to The University of Arizona College of Medicine-
Phoenix in partial fulfillment of the requirements for the
Degree of Doctor of Medicine

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2011

Dedication

For my wife Sara. Her strength and courage throughout the fight for her life has inspired me to strive to be the best person I know how to be. Her constant support and belief in me encourages my spirit and gives me the confidence to pursue my goals.

For my parents. They have always supported the endeavors that fulfill me and my passions. They have loved, guided, and befriended me every step of the way. I am who I am today because of them.

For my cat Sophie. She stayed by my side, and watched this project evolve throughout its entirety, perched right on top of my computer keyboard.

Acknowledgements

This project is only a success because of the insightful mentoring and guidance of Jason Scott Robert, Ph.D. He gave me the inspiration to embark on this journey of reflection and self-discovery. He defended the scholarly nature of research in the area of medical humanities and recognized its critical significance in the pursuit of humanistic medicine. His patience in support of me and my efforts to make this project a success allowed me to support my family in its greatest time of need and uncertainty.

I would also like to thank Jane Maienschein, Ph.D., Lynn Hankinson Nelson, Ph.D., and Richard Creath, Ph.D. for their guidance during the initial inception of this project. They gave me the confidence to explore scholarly research in a subject domain that lies beyond my realm of expertise.

Abstract

Since the time of the Second World War, patients have taken a more active role in their medical decision-making processes (Thomasma 1983). This has led to an increased expectation of professionalism, empathy, and respect from their physicians. The act of personal reflection by physicians is proposed as a means to help physicians meet these growing expectations from patients. The study of literature throughout the process of medical education has been established as a means to promote this type of personal reflection (Charon 2006). An exploration of the historical elements of this process provides a framework for the role that personal reflection plays in the practice of medicine and in the process of medical education. An analysis of key components of educating future physicians is provided, with an emphasis placed on methodologies that have been previously implemented. A review of personal reflection seminars that have been available in various medical education settings provides an understanding of factors that lead to the success and failure of such curricula, and provides the framework for a set of recommendations, a prescription, which may assist additional medical educators as they produce similar programs. Examples of personal reflection by the author are provided in order to emphasize the salient themes identified by the literature.

Table of Contents

Dedication ii

Acknowledgements iii

Abstract iv

Introduction	1
Research Materials and Methods	3
Discussion	4
Personal Reflection	4
Personal Reflection in Medicine	9
Personal Reflection in Medical Education	21
Future Directions and Conclusions	40
References	44
Appendix	48
Poster	51

PERSONAL REFLECTION:
A PRESCRIPTION FOR MEDICAL EDUCATION

Introduction

Since the Second World War, there has been significant evolution of the physician-patient relationship, with a growing emphasis placed upon the autonomy of the patient (Thomasma 1983). The traditional paternalistic model of physician-patient interaction, which provided the physician with the authority to provide the medical care that he or she believed would be most beneficial for the health of the patient, regardless of the wishes of the patient, has been replaced by models that incorporate the ideals, beliefs, and choices of the patient into the medical decision-making process (Emanuel and Emanuel 1992). As the evolution of the role that patients play in the management of their own healthcare has continued, the expectations that patients have for their physicians has also been modified. In 1968, Korsch, Gozzi and Francis (1968) acknowledged that patient expectations exceeded medical competence and included such characteristics as compassion, friendliness, and approachability for the questions and concerns of the patient. As patient expectations for their physicians evolved, medical educators began to assess the process of medical education in an

attempt to prepare medical students for the growing expectations they will face as physicians.

In 1984, The Association of American Medical Colleges (AAMC) produced a report titled “Physicians of the Twenty-First Century: Report of the Project Panel on the General Professional Education of the Physician and College Preparation for Medicine,” which identified traits of medical students that enable them to meet the growing emotional needs of their patients. The report suggested that an increased emphasis should be placed on promoting communication skills in medical students, arguing that physicians must recognize their values, attitudes, and emotions in order to build successful relationships with their patients (AAMC 1984). Further, the report stated, “ethical sensitivity and moral integrity, combined with equanimity, humility, and self-knowledge, are quintessential qualities of all physicians” (AAMC 1984, 1). This report was widely distributed throughout the medical education community and an effort was made to “recapture the human spirit in medicine” (AAMC 1984, 177). Since the time of the report, medical schools have sought methods of fostering the development of these humanistic skills in medical students (Reifler 1996). Various methods of encouraging the

development of these interpersonal skills have been utilized by medical educators; however, a large emphasis has been placed on promoting personal reflection through the processes of reflective reading, reflective writing, and storytelling.

An evaluation of the historic and current uses of personal reflection within the medical community will provide an understanding of what role it can play in the promotion of positive interactions between physicians and patients. Further, evaluating the outcomes of studies that have incorporated personal reflection into medical curricula will provide the foundation to make recommendations for the most effective implementation of personal reflection in training physicians. Ultimately, a prescription for personal reflection in medical education can be produced.

Research Materials and Methods

In order to obtain an understanding of the background and current discussion about personal reflection, articles and other publications were reviewed. These findings led to the examination of personal reflection within the practice of medicine through additional review of the literature. Evaluation of the literature culminated with a

detailed review of current uses of personal reflection in medical education with focus placed upon the established outcomes and the potential benefits of its implementation. This information was then synthesized into a manuscript with suggestions regarding future implementation of personal reflection in medical education. Personal reflective writing samples have been incorporated into the manuscript to provide examples and illustrate points that were emphasized in the literature.

Discussion

Personal Reflection

Background

Personal reflection is a process by which a person takes the time to critically analyze his or her personal attitudes, beliefs, and assumptions (Mamede and Schmidt 2004, 1304). This process allows the individual to gain an understanding of his or her identity, and may provide the ability to transform his or her approach to life, thought processes, and behavior patterns. Charon (2001) stated that the process of personal reflection allows the individual to assign meaning to his or her experiences and fosters a deeper understanding of the

affective and symbolic undertones expressed through interaction with others. Charon (2001) suggested that by reflecting on the personal and professional stories of our lives, we become better able to comprehend, interpret, and be moved by the experiences in which we engage (Charon 2006). Kenyon and Randall (1997) argue that our lives are composed of a series of stories, which include stories about our past, our present, and our future. By taking the time to reflect upon these stories, we enrich our lives.

There have been various approaches to performing personal reflection, which include activities such as reflective reading, reflective writing, and group discussions including storytelling, art, film, and dance. A further analysis of the areas of reflective reading, reflective writing, and storytelling will provide a better understanding of how these activities promote personal reflection.

Reflective Reading

Reflective reading is a process by which an individual uses the written accounts of others to promote personal reflection. Hunter, Charon, and Coulehan (1995) suggested that reading is valuable to the process of personal reflection because it allows the reader to perceive

the world from the perspective of a person who has endured potentially vastly different life experiences than the reader. Charon (2006) argued that the process of reading narratives and literature provides the reader with a deeper understanding of the components of narrative including plot, setting, and conflict. This allows the reader to critically appraise the story that has been told, as well as left untold, for the purpose of broadening the reader's understanding of the cognitive and affective condition of the writer. Through the process of reflective reading, the reader challenges his or her perception of the story of his or her own life and that of the greater human condition.

Reflective Writing

While reflective reading is essential to gaining an understanding of how others perceive the world, reflective writing adds to this experience by forcing the writer to describe and communicate how the world appears either from the perspective of the reader himself, or from the foreign perspective of another being. DasGupta and Charon (2004) stated that educational programs have incorporated writing exercises into curricula in a multitude of ways including alternative perspectives writing and activities to explore descriptive and affective

components of stories. Hunter, Charon, and Coulehan (1995) stated that the process of writing requires the writer to articulate concepts and perceptions that would have been inaccessible to the individual without having undergone the process of writing. Reflective writing can also help an individual to process his or her affective response to life events. Pennebaker (2000) found that volunteers who were asked to write about their most traumatic life experiences often cried during the process; however, 98% of the participants described the experience as positive and meaningful after the process was complete. For these purposes, the act of reflective writing proves itself valuable to the process of education and emotional development at nearly every age (Ashbury 1993).

Storytelling

Kenyon and Randall (1997) stated, “To be a person is to have a story. More than that it is to *be* a story” (1). While the process of reflective writing allows the writer to access the world as it is perceived from various points of view, the act of storytelling requires the active engagement between individuals. Pennebaker (2000) argues that the process of telling a story helps people to understand

themselves and to make sense of their experiences. These types of interpersonal interactions allow for a very intimate connection between the storyteller and the audience where both parties evolve in their understanding of one another. In a similar process to reflective writing, storytelling illuminates unique characteristics of both the speaker and the listener that would have remained hidden without having undergone the process of storytelling (Charon 2001).

Personal Reflection from the Author

As a first-year medical student I was sent on a field trip to the county medical examiner's office in order to view autopsies and broaden my understanding of human anatomy. This experience proved rather traumatic to me, so I spent some time performing a reflective writing exercise in the form of a journal entry:

The sterile white room with empty, stainless steel beds felt like another world, like I was on a space station. The smell. The smell of death. I thought I knew what death smelled like, but today, it overwhelmed me. I couldn't overcome it. No matter where I looked, no matter what I thought about, I couldn't escape death. The bodies. They were so real, so raw. I could still see the expressions on their faces. This was nothing like the anatomy lab. In the anatomy lab there is a sense of awe. There I feel like our education is the end that justifies the means; that the donors have given their last sacrifice for the greater good. But here, there was just death. And though I

was covered from head to toe with gowns and masks and scrubs I felt naked. Exposed.

The team began its work. “This lady was hit by a car crossing a street.” I’ve done that. Why her? Why not me? Her nails were painted perfectly. Today is her birthday. Of course her nails were done, she had a birthday party to attend. Was this what she imagined when she painted her nails? They analyzed her uterus and cervix “she’s delivered at least one child.” Where are they? How are they grieving the loss of their mother?

Maybe I’m not so sure that medicine is right for me. Maybe I want to be an accountant. They don’t deal with death, do they? But can I ever forget today? No. I can’t go back. Ignorance *was* bliss.

The process of writing and reflecting helped me to gather my thoughts that day. I learned about my expectations and fears through the process of writing about the events of my emotional trauma. I defined my values and changed my perception of my own life by exploring my inner thoughts as well as by processing the effect that these events had on others.

Personal Reflection in Medicine

Medical Communication

In order to gain an understanding of the role that personal

reflection plays in the practice of medicine, one must explore the nature of medical communication. Hunter, Charon, and Coulehan (1995) describe the process of medical communication to include the story that the patient tells, which is then translated and reorganized by the physician until it no longer resembles the story of the patient, but rather takes the form of a medical case. Once the physician has transformed the story of the patient into a medical case, he or she can begin to interpret the data, generate differential diagnoses, and generate a diagnostic and treatment plan. Hunter (1991) described this form of communication and processing between physician and patient to represent “parallel stories.” The patient relates the narrative story of the condition of facing real or perceived disease, while the physician listens for the diagnostic clues from the case his or her patient is presenting. Furthermore, in order for the physician to effectively express his or her thoughts to the patient, the case must be carefully translated back into a form that is meaningful to the patient (Hunter 1993). This rapid translation of information between the language of the patient and the language of medicine is not ideal and may lead to critical information being lost in the process.

Dwamena, Fortin, and Smith (2005) described the biomedical

model of obtaining the patient history whereby the physician asks questions of the patient that are primarily intended to gather specific pieces of information regarding details of symptoms and illness. These questions are rather specific and often do not take into account the emotional experience of the patient. This style of communication is quite beneficial to the language of the physician; however, it may leave the patient feeling unfulfilled. There are two outcomes of this communication barrier that are commonly emphasized by patients: that physicians do not listen and that they do not care (Fitzgerald 2005). Charon (2001) emphasizes that patients often require more significant interpersonal interaction from their physicians such as, “tenderness in the face of pain, courage in the face of danger, and comfort in the face of death.” By understanding the emotional needs of the patient, it becomes evident that physicians must learn to honor the stories of their patients and allow the intimate process of storytelling to move the physician to act in the best interest of the patient (Charon 2001).

Personal Reflection About Medical Communication

During my third year of medical school, I was asked during a

didactic session to role-play with an instructor and act as a physician talking to a patient in the clinic. I was told that the patient had some specific concerns and I was to address them appropriately. The following is a reflection written after the encounter:

I knew my task. I was supposed to address the concerns of a worried parent in a pediatric clinic. I listened carefully as the father told me of his son's fever. I listened to when it started, how high the temperature had gone, whether the child had still been eating, and all of the other symptoms that the child had. I formulated my differential diagnosis. I reassured the father that we would perform some diagnostic tests to generate a final diagnosis. I even gathered information about the mother's pregnancy and delivery of the child. But when the encounter was finished, I learned that I never paid attention to the sound of fear and uncertainty in the father's voice when he talked about how high the child's fever had been running.

After a period of personal reflection and a discussion with my instructor, I learned that the patient had never asked for a diagnosis, he never asked what diagnostic tests needed to be performed, he never asked me to *do* anything. He shared his concerns about how high his son's fever had gone, and had indirectly asked me to reassure him that fevers aren't dangerous, and that they can be treated. There were other medical students in the room who were an audience to my interaction. They all told me that it was obvious to them what the father wanted, I just hadn't heard it. I was so focused on the medical decision-making process that I forgot to listen to what my patient really needed, reassurance.

Through the process of reflectively writing about my experience simulating the physician-patient interaction in the pediatric clinic, I

exposed my natural tendency to assume that I know what my patients require of me. I came to understand that in order to improve my interactions with patients, I must slow down, listen beyond what they are saying, and focus on how they are expressing themselves to me.

The Communication Divide Between Physician and Patient

As the parallel stories of the patient and physician unfold, it becomes evident that there is a divide that has developed between the physician and the patient (Charon 2006). Charon (2001) acknowledges that patients need a physician who is not only competent at employing the latest technological and pharmaceutical advances to improve health, but also a physician who can understand their fears and anxieties and can join the patient in the struggle against disease. The communication divide may not only contribute to decreased patient satisfaction, but also contribute to a detriment in health outcomes for patients. Charon (2001) stated that the communication barrier between physician and patient may cause incomplete information transfer, which may lead to inefficient diagnostic testing and inadequate treatment of disease.

Narrative Competence

In order to close the divide between physician and patient, physicians must discover a method of combining the scientific and humanistic goals of the physician-patient encounter. Charon (2001) has proposed the concept of narrative competence, which is the ability to “acknowledge, absorb, interpret, and act on the stories of others.” In order to introduce the concept of narrative competence to the community of physicians, Hunter, Charon, and Coulehan (1995) suggested that the field of medicine turn to literature for guidance. Physicians have long relied on literature to help make sense of the difficult failures and triumphant successes of medicine, so the concept of using the literature to nurture narrative competence is not unexpected (Hunter, Charon, and Coulehan 1995). Reichert et al. (2009) suggested that medicine, when practiced appropriately, employs both the science of medicine and the art of interpersonal interactions, the latter of which may be guided by personal reflection through the study of literature.

Brady, Corbie-Smith and Branch (2002) suggested that as a physician practices medicine, he or she reacts to experiences based upon the values, attitudes, and behaviors of his or her personal and

professional identities. Dickinson (1997) stated that physicians have, in the past, employed detached concern in their interactions with patients, which is a process by which physicians care for their patients in a professional capacity, but do not allow themselves to be personally affected by the perils faced by their patients. Charon (2001) suggested that personal reflection enables physicians to employ empathy, trustworthiness, and professionalism simultaneously, which allows engaged concern to replace detached concern.

Charon (2001) claimed that personal reflection in medicine can impact four major interactions in medicine: physician to patient, physician to self, physician to colleagues, and physician to society. Each of these interactions is best supported when the physician seeks to combine his or her personal and professional identities (DasGupta and Charon 2004).

Benefits of Personal Reflection in Medicine

Physician to Patient Interaction

Personal reflection by physicians allows for a deeper interaction between physician and patient. Charon (2001) recognized that this engagement is beneficial for both the physician and the patient.

Reflection and self-examination allow both physicians and patients to more fully explore the condition of facing disease and allows patients to cope with the disease process that they face in a more meaningful manner (Charon 2001). Yamada (2003) emphasized that reflective writing enhances empathy by the physician that may lead to a deeper sense of trust between the physician and the patient. Patients must be able to place trust in those who serve to heal them (Charon 2001). Novack (1997) stated that when a physician is engaged, compassionate, and reflective, his or her very presence can serve as a powerful therapeutic tool.

Physician-Self

Physicians have chosen a profession that exposes them to significant emotional experiences. Charon (2001) stated that physicians are immersed in a world filled with tragedy, pain, suffering, courage, and faith. Because of this climate, physicians are subject to significant stress and are at-risk to experience burnout. Bolton (1999) stated that enhancing personal reflection will reduce the risk of burnout, and will enhance the satisfaction that physicians express toward their careers. DasGupta and Charon (2004) added that

reflective practitioners are better equipped to interpret their emotional responses to the positive and negative emotions they experience through their careers, which renders them more available to their patients. An additional factor that may lead to a dysfunctional relationship between the physician and the self is the feeling that the self is not allowed much time to speak. Physicians feel pressure to arrive at the appropriate diagnostic evaluation and treatment plan, so the physician spends much time speaking medicine with patients and with other medical professionals. This has led to what Verghese (2001) described as the silencing of the voice of the physician. Personal reflection, with the help of narrative competence, has begun to reintroduce the voice of the physician into a profession that has traditionally kept this voice silent (Verghese 2001).

**An Example of a Personal Reflection by the author
illustrating the importance of the relationships physicians
encounter**

One night during my 3rd year of medical school, my family and I were sitting playing cards at my parents' house. My girlfriend of three-and-a-half years was especially stumped by

one of the hands that was dealt to her, and while rubbing her neck considering her options, she felt a large mass. She pointed it out to me, and I had a miniature panic attack. As a medical student, it is easy to take even the smallest signs and symptoms and turn them into catastrophic diseases in my mind. Luckily for me, my dad is a physician, and he usually grounds my thoughts when I am catastrophizing in this way. I had him feel her neck so that he could tell me to stop worrying about it. When he felt the location and quality of the mass, his face turned pale, and he got very quiet. He and I quietly excused ourselves from the table, and walked into the laundry room to talk. The mass was in her right supraclavicular fossa, a place where I've only felt masses on patients with metastatic cancer. My dad and I decided not to get too ahead of ourselves, so we scheduled her for a chest x-ray the next morning. The next day I awoke at my usual time of 4:00am, was in the hospital by 4:45am, and had seen my cancer patient by 6:00am. All I could think about while I was treating her was my girlfriend, and how scared I was that she may be just as sick as this patient. At noon, she and my parents were in the x-ray facility, and by 12:20pm I had a text message from my dad that said "Call me now." I did, and he told me that my girlfriend had a mass the size of a grown man's fist in her chest, and that it looked like it was pressing on her lungs, heart, and major blood vessels. He said that it looked like it was lymphoma (cancer of the lymph nodes). He told me that I should probably get home to be with her, because she was pretty upset. My mind went blank. I couldn't remember what lymphoma was, what it meant, what the different types were, or what the survival rate was. All of the medical training, all of the books that I'd read meant nothing to me anymore.

During this one day, I went from the student doctor walking a patient through her battle with cancer, to a kid feeling as helpless as my patients. Talk about an identity crisis. Everybody told me last year that you can't understand a disease by reading it from a book, they said that you have to see a patient with the disease to truly understand it. I

thought that I understood cancer because of my patients, I was wrong. I didn't know the first thing about cancer until it struck my family. And I am not naïve; I know that I don't understand cancer like she does. This is all on a continuum.

Physician and Colleagues

Physicians have used literature as a means to express their successes and frustrations with the treatment of patients. Through review of literature, physicians can join their colleagues, and share in these experiences with one another (Charon 2001). Furthermore, physicians who are personally reflective may be more comfortable sharing these experiences with their colleagues directly, which could increase the camaraderie between physicians and their colleagues. Charon (2001) stated that medicine is considered to be a profession partially because of the strength of the interactions between physicians, and that the introduction of personal reflection into medicine can serve to increase these bonds.

Physician and Society

Physicians serve many different roles in society. They may act as medical care providers, researchers, and teachers. One responsibility that accompanies the professionalism of medicine is that of self-

regulation. Charon (2001) stated that in order to recognize the professional ideals of the field of medicine, one must possess personal reflective capabilities. Only under these conditions does the profession of medicine have the capacity to uphold those ideals and hold each other responsible when the expectations that society places upon them are not met.

Personal Reflection in Medical Education

Purpose

As the benefits of personal reflection have become better recognized within the field of medicine, medical educators have strived to develop curricula for medical education that foster these principles. One goal of introducing personal reflection into medical education is to prevent the void between physicians and patients from ever developing. Aukes (2008) stated, “reflection is at the heart of educational transformation” (1). This implies that personal reflection is not only important to medical education because it prepares future physicians to meet the expectations of patients, colleagues, the self, and society, but also because it aids in the process of transforming student to physician.

An Example of Personal Reflection by the Author

The first few months of 3rd year scared the daylights out of me. I didn't really know how to write effective notes, I had no idea how to present cases on rounds, and I felt like I *never* understood what the residents and attendings were talking about. They all talked about drugs I'd never heard of, diseases I couldn't pronounce (my favorite was “tracheobronchopathia osteochondroplastica”), and they rattled off management

principles that I couldn't follow. I felt like I had an almost empty toolbox, and was being taught how to work on the fly. I will never forget that during my first rotation, Internal Medicine, I attended a lecture that focused on all of the steps involved in properly reading and EKG. One week later, I was on my inpatient rounds, and my attending (who had no idea that I had just sat through this lecture) slid an EKG in front of me and asked me to read it for him. I followed the steps that I had just learned, and when I was done he smiled at me and said "wow, your medical school must really know how to teach EKGs, that was very impressive!" I smiled, took a big sigh of relief, and began to understand the process of medical education. I learned that I needed to trust the system to teach me the material that I needed to know, and trust that I had the ability to retain it.

Background

In the years following the Second World War, patients began to emphasize the need for personal autonomy in the promotion of their own health (Thomasma 1983). As patient autonomy increased, the expectations that patients had for their physicians transformed, as well. Patients began to expect their physicians to express friendly, approachable personalities (Korsch, Gozzi and Francis 1968). As these physician expectations evolved and scholars began to turn to literature and personal reflection to help physicians meet these goals, medical schools began to formally employ faculty from the field of literature. In 1972, Pennsylvania State University College of Medicine created the

first faculty appointment for Professor Joanne Trautmann Banks, who was a founder of the journal *Literature and Medicine* (Hunter, Charon and Coulehan 1995). Since that time, the field of literature and medicine has been developed and has grown to include faculty at many medical schools across the United States.

In 1984, the Association of American Medical Colleges (AAMC) released a report titled “Physicians for the Twenty-First Century: Report of the Project Panel on the General Professional Education of the Physician and College Preparation for Medicine,” which served to delineate the growing expectations of patients. The report outlined characteristics expected of physicians to include compassionate, caring, sensitive, and able to effectively interact with patients (AAMC 1984). The report suggested that a focus be placed on integrity and humility in physicians. Because the field of literature and medicine was relatively new at that time, there was a large effort by many medical schools in the United States to place an emphasis on the development of humanism in medical students. This emphasis on humanistic medicine has continued in various forms into modern medical school curricula. One such example is The University of Arizona College of Medicine – Phoenix, which has incorporated journaling assignments

into the pre-clinical and clinical curriculum (See Appendix).

Current Expectations of Medical Education

Today, 27 years after the report of the AAMC, the Liaison Committee on Medical Education (LCME) continues to push for medical schools to encourage personal reflection and humanistic teaching. The “Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree” outlined many requirements that medical schools must meet in the education of future physicians. Among the expectations that the LCME has identified include an emphasis on behavioral and socioeconomic subjects, communication skills, ethics and human values, recognition of wellness and determinants of health, understanding of diverse cultures and their responses to health and disease, and the ability to reflect upon personal gender and cultural biases (LCME 2010). Because the LCME requires that future physicians be educated on these subjects, medical curricula continue to include activities that are intended to encourage personal reflection as a means to achieve these goals.

How Medical Education can work against Humanism

As medical schools have worked to increase personal reflection and humanistic values in medical students, some have tried to identify factors that may lead medical students to become detached from themselves and their patients.

Desensitization

Reifler (1996) recognized that patients often criticize physicians for being emotionally detached from them and states that the process of desensitization may begin as early as the gross anatomy course in medical school. Students learn in their gross anatomy course how to handle human remains in an unemotional, scientific manner (Reifler 1996). Reifler (1996) suggested that such experiences may desensitize physicians to their patients, and may contribute to a lack of engagement between the physician and his or her patients upon entering medical practice. Common distancing mechanisms employed by medical students in the setting of the gross anatomy lab include treating body parts as if they are inanimate objects, the use of highly scientific descriptive language to identify human organs, and the use of graphic humor to break the tension caused by handling such graphic material (Reifler 1996). While the process of desensitizing medical

students to their patients carries many disadvantages, there are some places in the practice of medicine where detachment from patients may be beneficial. Reifler (1996) suggests that during surgery and during cardiopulmonary resuscitation, it would be inappropriate for a physician to be overwhelmed by emotion, so these defense mechanisms of desensitization may be beneficial in some regards. Regardless of the potential benefits of detachment, patients demand that physicians engage with them on a deep and meaningful level, so an effort to decrease this process is underway within the field of medical education.

Reflection on desensitization

On the first day of my gross anatomy course, I surprised myself by my reaction to meeting my cadaver and the beginning of the journey through the dissection process. This is a personal reflection that I produced following that experience:

When I first unzipped the bag to reveal my cadaver, I was excited to meet my “first patient.” As I removed the plastic to reveal his face, I froze in my tracks when I revealed the face of my Grandpa Jack. Silence. How could this be? Grandpa passed away years ago... As I regained my bearings, I realized that the cadaver I was staring in the eyes was not, in fact, my grandpa. Relieved by this understanding, I reflected on how

quickly I had been shaken to my core by my first patient. Will this happen with all of my patients? Am I going to be an emotional wreck throughout my entire career? I hope not.

We began our dissection. The chest wall had already been removed, so our task was simple: remove the heart and lungs. Inside the chest, nothing looked real, this may as well have been a plastic model in the shape of a heart, ribs, and lungs. At last, our job was done! I stood holding a human heart in my left hand, and a human lung in my right hand. How cool is this? I *never* thought this would ever happen in my life. Oh wow! Look at all of the arteries wrapping their way around the heart! They look just like the textbooks described. How exciting!

We finished our work, and began to wrap our patient up to return him to storage. As we did, I caught a glimpse of his face. This time, he did not look like my grandpa, but he did look like a real person. I began to contemplate how “cool” it was to hold his heart in my hand. I began to imagine him years ago: exercising, leaving the saltshaker alone, eating his Cheerios, taking his blood pressure medication. Each of these in an attempt to protect the very same heart I was holding in my left hand. This isn’t just a heart, this is *someone’s* heart. This is the heart that fluttered when he had his first kiss, the same heart that he gave to his first love, the life-force that he desperately needed to function to keep him alive. And there I was ooh-ing and aaah-ing at how cool it was. No, this isn’t cool, this is powerful.

Through the process of reflecting on my first experience, I learned that I am not as invincible as I had previously believed. I could, and likely would, be uncomfortable with some of my patients. I understood that the excitement of being accepted to medical school was quickly being replaced by the power of the

responsibility that would soon be mine. I also learned how easily one can lose his sensitivity to this awesome responsibility. As quickly as I had been rattled by the sight of my grandpa, I had completely lost my sensitivity to the very realness of my first patient.

Separation of Mind and Body

Another potential cause of the emotional detachment between physicians and patients lies in the way that medical students are taught to regard their patients. DasGupta and Charon (2004) suggested that medical students are taught to place an emphasis on the bodies of their patients, while simultaneously placing an emphasis on the minds of themselves. This creates a mental distance between the medical student and his or her patient. Because of the difference in how medical students are taught to regard their patients and themselves, it is easier for medical students to disengage themselves emotionally from their patients (DasGupta and Charon 2004).

Resurrecting Humanism in Medical Students

Many applicants to medical school state that they want to be

physicians because of an internal humanistic drive (Hojat et al. 2004). As a result of some of the factors that promote emotional detachment of medical students from their patients including desensitization and separation of mind and body, medical educators struggle to reintroduce humanism into medical students. DasGupta and Charon (2004) indicated teaching medical students empathy and methods of promoting effective relationships with patients is among the most difficult tasks they face. Hunter, Charon, and Coulehan (1995) stated that teaching literature in medical schools is one of the principle methods of promoting these positive, empathetic relationships with patients. The focus of literature and medicine courses for medical students should be placed on experiencing the life of the author, this serves to increase the students' ability to appreciate the value of the lives of their patients (Hunter, Charon, and Coulehan 1995). Additionally, teaching literature to medical students provides them with the framework to approach patients with empathy and understanding (Hunter, Charon, and Coulehan 1995).

Activities that Promote Personal Reflection

Reflective Reading

Reflective reading was initially employed by medical educators in an attempt to encourage medical students to experience aspects of life not commonly encountered by young students including death, aging and disability (Hunter, Charon, and Coulehan 1995). Similarly, the writings of culturally diverse authors help medical students to consider the gender and cultural factors that are faced by patients and colleagues (Hunter, Charon, and Coulehan 1995). These benefits are a result of the principle that it is difficult for a person to understand a concept that he or she has not personally experienced. By introducing students to the writings of individuals with diverse life experiences, students may be more likely to understand these experiences when they face patients who share a diversity of experience. This principle applies to illness as well. Charon (2001) stated that physicians use their knowledge of diseases to imagine the experiences of their patients, and thus gain a stronger understanding of the struggles of their patients as they face disease.

Reflective Writing

Narrative writing has become widely utilized in the area of

medical education as an attempt to strengthen reflection and self-awareness (1986). Hunter, Charon, and Coulehan (1995) stated that by writing about experiences, students gain an understanding of their feelings and attitudes that would have been inaccessible to them without employing the process of reflective writing. Various forms of reflective writing have been employed by medical educators in an attempt to teach students empathy and the principles of humanistic care. Some of these methods of reflective writing include critical incident reports, clinical journal writing, clinically based reflection, letters written to patients, and autobiographical sketches (Branch 1993). Hunter, Charon, and Coulehan (1995) stated that exercises that allow students to write in normal language as opposed to using medical jargon allows medical students to explore their emotions and attitudes effectively. A number of writing exercises require students to discuss their work as a method to further promote personal reflection (Hunter, Charon, and Coulehan 1995). These exercises draw upon the concept of storytelling and the effects that it has on promoting the personal processing of feelings and behaviors.

Conceptual Approaches to Personal Reflection

While there are various activities that can promote personal reflection such as reflective reading and reflective writing, there are also various conceptual approaches to personal reflection that have been described in the literature. Three conceptual approaches will be discussed: the Ethical Approach, the Aesthetic Approach, and the Empathetic Approach. Hunter, Charon, and Coulehan (1995) stated that the majority of the programs that are designed to teach personal reflection to medical students occur in the preclinical years of medical education, however, some schools do offer courses during the clinical years.

Ethical Approach

The ethical approach to teaching literature in medical school is one of the more common approaches, focusing on moral reflection by attempting to engage students in issues relating to moral or ethical principles (Hunter, Charon, and Coulehan 1995). The methods commonly employed by programs that embrace this approach include reading texts, small-group discussion, role-playing activities, and writing assignments (Hunter, Charon, and Coulehan 1995). These

activities generally focus on emotionally charged topics such as death and dying, AIDS, and substance abuse (Hunter, Charon, and Coulehan 1995).

Aesthetic Approach

The aesthetic approach to teaching literature to medical students generally focuses on reading, writing, and the interpretation specific literary works (Hunter, Charon, and Coulehan 1995). These courses generally focus on literary work that is unrelated to medicine in an attempt to convince the medical student to search for meaning in the literature being analyzed (Hunter, Charon, and Coulehan 1995). The purpose of analyzing the literary works in the aesthetic approach extends beyond simply understanding the meaning that the author is attempting to convey; it includes gaining an understanding of how the story is told. Students are taught to analyze of the structure of the literature including the point of view and metaphorical structure employed by the author. Once the medical student is taught to understand the structure of literature is then encouraged to utilize this understanding in analysis of his or her own life experiences.

Empathic Approach

The empathetic approach to teaching literature in medicine attempts to teach the medical student to understand the values and feelings of others (Charon 1993). Courses that employ the empathetic approach focus attention on analysis of literature from a diverse group of individuals, thereby increasing the exposure that the student has to the unique challenges and perspectives that patients may possess (Hunter, Charon, and Coulehan 1995).

Previous Research Studies Related to Personal Reflection in Medical Education

An analysis of the research that has been published regarding courses that promote personal reflection in medical education allows for a greater understanding of the characteristics that are beneficial and detrimental to this process. Three studies will be addressed and the lessons-learned from each study will be outlined as recommendations for the future implementation of similar programs within the field of medical education.

The Study of Reichert et al.

A study asked students finishing the first year of medical school to self-select to participate in a community-based preceptorship in a medically underserved area in a rural community (Reichert et al. 2009). This experience was the first sustained clinical experience in which these students were to participate (Reichert et al. 2009). The students performed weekly write-ups about patient encounters, which were reviewed by their preceptor and by faculty members from their home institution (Reichert et al. 2009). The students provided overwhelmingly positive feedback at the culmination of this experience; one student stated that he or she felt as if the experience had transformed his or her behavior and “the lens through which I saw my patients at every subsequent encounter” (Reichert et al. 2009, 259).

Lessons learned from this study are numerous. Reichert et al. (2009) suggested that the feedback from the students indicated that sharing the reflective writing samples with and receiving feedback from mentors and preceptors was helpful because it made the students aware that their feelings and thoughts were being heard (Reichert et al. 2009). Reichert (2009) identified three key elements to the success of the program: choice, privacy, and power. Students were given the

freedom to choose the topics of their write-ups, which allowed them to focus their attention on topics that were important to them (Reichert et al. 2009). The students were assured that their reflections would remain private and that their mentors would not be grading their reflections; this allowed students to express their feelings without the fear of repercussions (Reichert et al. 2009). Power was afforded to the students in that the students were able to choose which of their writings they would like to share with the other students in the program allowing the students to make the experience as private or public as they chose (Reichert et al. 2009).

The Study of DasGupta and Charon

This study was performed with a group of self-selected predominantly second year students who engaged in a six-week seminar (DasGupta and Charon 2004). During this seminar, the students simultaneously read patient narratives while writing personal reflections about their experience with disease through a family member, a friend, or themselves (DasGupta and Charon 2004). After their experience with the seminar, students provided feedback to the instructors. When asked about emotional states that were

experienced by the students during the act of producing the personal reflections, the students reported such emotions as pride, enlightenment, healing, accomplishment, relief, clarification, a wish to have more time to reflect, growing confidence, vulnerability, embarrassment, detachment, exposure, confusion, resentment, fear, and difficulty (DasGupta and Charon 2004). Many of the students who reported the negative emotional states reported that they overcame those emotions as the seminar progressed (DasGupta and Charon 2004). When prompted to provide feedback regarding the process of sharing their personal reflections with the other students participating in the seminar, students initially experienced fear and nervousness, however students stated that they became more comfortable sharing these experiences once they learned that the group environment was very supportive (DasGupta and Charon 2004). When asked to provide feedback regarding their response to listening to their classmates share their personal narratives, students provided only positive feedback, stating that they felt as if they came to know their classmates better through the process (DasGupta and Charon 2004). Students reported that, through the process of personally reflecting on their experience with disease, they gained a better understanding of

their emotional response to disease, which was a very positive experience for the students (DasGupta and Charon 2004). Additionally, most students reported that the process of producing personal reflective writing about disease positively influenced their ability to care for patients (DasGupta and Charon 2004). Finally, all of the participants stated that they would recommend that other students participate in this seminar (DasGupta and Charon 2004). Components that were identified to be key to the success of the exercise were a supportive environment, a small class-size, and confidentiality (DasGupta and Charon 2004). One student suggested that this seminar should be available to students who have advanced into their clinical training, offering that the experience may be more beneficial for students who are actively engaging with patients on a regular basis.

The Study of Reifler

This study included data from an activity that included both reading and writing to promote personal reflection (Reifler 1996). The students participated in this activity in the period of time during which they were engaged in their gross anatomy course in medical school

(Reifler 1996). The students produced three personal reflective writing samples, each guided by prompts from the instructor (Reifler 1996). The first writing sample was to be written from the perspective of the student and was intended to be related to the experience of first interacting with his or her cadaver in the gross anatomy lab (Reifler 1996). Students commonly described the process by which they dehumanized their cadaver through various means; one student explained “We dehumanized the cadaver by turning it inside out and making it look like no other living being we had ever seen before (Reifler 1996, 188-189). The second reflective writing sample was to be written from the perspective of the cadaver; students shared their writings with each other, and stated that it was a positive experience to learn that they were not alone in their discomfort with thinking about their actions from the perspective of the cadaver (Reifler 1996). The final writing sample encouraged the students to reflect upon their own attitudes and feelings related to death and dying (Reifler 1996). The lessons learned from this study were focused on the benefit of learning that students are not alone in the uncomfortable feelings they experience in the anatomy lab.

Future Directions and Conclusions

The purpose of this project was to evaluate the reasons why personal reflection has been incorporated into medicine and medical education, evaluate the methods by which personal reflection has been implemented in various medical curricula, identify lessons-learned from these curricula, and propose a recommendation, or a prescription, for how future medical educators may successfully integrate personal reflection into their programs of study.

Based upon analysis of the available literature, recommendations for the promotion of personal reflection in medical education include the incorporation of reflective reading, reflective writing, and storytelling into voluntary seminar activities. Reflective reading assignments may include a combination of medical and non-medical literature. These reading assignments could be utilized to teach medical students how to perceive the world through the eyes of another human being, how to analyze the narrative stories of others, and how to tune the student's focus beyond what is being said in order to perceive how the author is presenting the information (Hunter, Charon, and Coulehan 1995). Mentors should read reflective writing assignments, however, feedback by the mentors should not incorporate

a grade. Rather, feedback should positively reinforce the honesty and personal reflection of the student (Reichert et al. 2009). Writing assignments may include rather free-form samples such as personal journal entries, but may also include structured assignments that are designed to encourage the student to reflect upon a difficult moral, ethical, or emotional subject (Hunter, Charon, and Coulehan 1995). Writing samples may be shared with other students, however, students should be given the choice of which samples to share and should be given the freedom to edit these samples prior to this process (Reichert et al. 2009).

Key factors that have been identified in the successful implementation of such seminars have been identified. DasGupta and Charon (2004) stated that small class-size and strict confidentiality of reflective writing samples and class discussion were identified as being very important to students who participated in personal reflection seminars. While many of the studies analyzed included students in their preclinical training, there may be benefit to incorporating such seminars into the clinical training of medical students and residents (DasGupta and Charon 2004). The clinical contact that students and residents who are participating in clinical training encounter may

allow students a stronger affective and experiential base for personal reflection. No clear recommendations for the frequency of personal reflection activities in medical education can be provided. Challenges include preventing students from being overloaded by personal reflection seminars as well as preventing students from feeling as if they do not have access to enough reflective outlets. DasGupta and Charon (2004) report that some students provided feedback asking for more opportunities for personal reflection. Therefore, recommendations include providing a multitude of optional personal reflection seminars that allow students to choose their own level of participation.

Continued evaluation of outlets for personal reflection in medical education is necessary. As more educators evaluate and report the lessons-learned from their implementation of individual personal reflective seminars, additional medical curricula may incorporate these findings into the successful implementation of similar seminars. As future studies focus on how to successfully implement personal reflection curricula in medical education, it remains well accepted that these activities are worthwhile. As studies continue to suggest that medical students express declining levels of empathy as they progress

through their journey of medical education, it will remain imperative that attempts to decrease this trend persist (Hojat 2004). This effort is worthwhile for the benefit of both physicians thier patients, who now have a strong voice imploring respect and empathy from their physicians (Charon 2006).

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Appendix

Journaling Resource Guide and Governance Policy, MS3
The University of Arizona College of Medicine - Phoenix

Journaling Resource Guide and Governance Policy, MS3

Jason Scott Robert, PhD, Jacqueline Chadwick, MD, and Michele Lundy, MD
The College of Medicine – Phoenix | July 2009

*When they ask me . . . how I have for so many years continued an equal interest in
medicine and the poem, I reply that they amount for me to nearly the same thing.*
William Carlos Williams

Journaling is a critical component of the curriculum at The College of Medicine – Phoenix. Journaling exercises focus on core clinical elements of the curriculum: during years 1 and 2, the focus is on the Block Capstones and Longitudinal Clinical Experience; during year 3, the focus is on clerkship rotations. In order to avoid the need for many different kinds of journals, medical school journaling activities will be based in the Medicine and Society Theme and assessed within the Intersessions.

What is a journal?

A journal is a running commentary on medicine as a calling, the profession of medicine, the practice of medicine, medicine as an art and as a science, medicine in/and society, and a student's personal and professional development in relation to these theme. A journal is *not* meant to be merely descriptive, or to be a daily log of activities. But neither is it meant to be something to complete at the last minute before it is due. Instead, a journal is meant as a site of introspection, humanistic reflection, and critical analysis.

One excellent strategy is to purchase a small notebook in which to jot down details of interesting events, emotions, patients, observations, quotations, insights, diagnoses, experiences, run-ins, etcetera, as they happen, and then to make a little time at least once a week to write a bit more about those items that stand out. Be selective: you do not have time to write about everything! Choose for elaboration only those topics about which you feel you have something to say, or about which you need or feel compelled to say something. Occasionally, and depending on your constitution, you may prefer to include a poem, or a drawing, in your journal. Your journaling efforts will persist throughout your medical education; many students will want to continue journaling in their residency and beyond. This *Journaling Resource Guide* includes some questions to catalyze your journaling process, but you may always contact the Medicine and Society Theme Director for advice or strategies to facilitate your efforts.

What is journaling for?

The aim of journaling activities is to foster introspection, reflection, analysis, and dialogue. *Introspection* refers to a focus on your own values, beliefs, attitudes, assumptions, and biases; probe your experiences as a source for further reflection. *Reflection* begins with the results of your introspection, and sets them in the context of your clinical experiences, basic medical knowledge, and knowledge and experiences of medicine in society; reflection requires re-description, representation, and critical insight. *Analysis* refers to the critical interrogation of your reflections in context – for instance, by querying the relationship between your new experiences and your prior beliefs, or generating hypothetical thought-experiments about what you might or should do in particular situations; critical analysis contributes to an ongoing dialogue as you proceed through your medical education. *Dialogue* is thus deeply important, and

your journal should constitute an ongoing conversation – actually, two conversations: one within yourself as you mature as a medical student, and one with your core faculty at The College of Medicine – Phoenix.

When is my journal due?

In an ideal world, you would journal on a weekly basis, which would allow you to be selective as to which journaling exercises you submit for assessment. But we recognize that the 3rd Year schedule is hectic, and so have adopted the following schedule for journal submission. Please note that this is a required component of the Year 3 curriculum. **Hard copies of journals, consisting of 2-3 pages double-spaced, will be submitted by 1:00 pm on the first day of each Intersession, as follows:**

Monday, 28 September 2009
Monday, 14 December 2009

Monday, 22 March 2010
Tuesday, 6 July, 2010

Note: Since journaling is part of the Pediatrics clerkship, a separate journal submission for the Intersessions following the block in which you take Pediatrics is not required but is encouraged.

Recommended topics for journal submissions include:

First Intersession (28 September 2009) – What was the most challenging patient care experience you had during your last clerkship(s)? OR Discuss any changes in your self-perception along your journey from medical student to physician.

Second Intersession (14 December 2009) – What are you most worried about in terms of your own behavior or that of your peers? OR Discuss any changes in your self-perception along your journey from medical student to physician.

Third Intersession (22 March 2010) – Discuss an ethical challenge you have either experienced first-hand or observed in your clinical setting(s) OR Discuss any changes in your self-perception along your journey from medical student to physician.

Fourth Intersession (6 July 2010) – Where are you leaning for specialty selection, and why? OR Discuss any changes in your self-perception along your journey from medical student to physician.

What if I am having trouble journaling?

Don't freak out! Journaling is not meant as a burden, or simply to make more work for you in your already busy schedule. Journaling is meant to be liberating, an outlet for exploring experiences, tensions, emotions, and concerns, and also a catalyst for reflective thinking about your development from medical student to practicing physician. But if you are having difficulties with any aspect of journaling, please speak with the Medicine and Society Theme Director or the Intersessions Director as soon as possible, so that we may provide additional resources.

How should I get started with journaling?

The easiest thing to do is to just start writing. Write about whatever you find interesting or exciting or worrisome or problematic, or use these questions to help catalyze your journaling:

How will my journal be assessed?

Your feelings and opinions are NOT being evaluated. Instead, all journal submissions will be formally assessed for quality of introspection, insight, and integration.

Introspection: How deeply and broadly have you plumbed your own experiences, beliefs, values, attitudes, and prejudices? How much of yourself have you brought to the task?

Insight: Beyond mere description, how carefully and thoughtfully have you reflected upon and critically analyzed your knowledge, experiences, and values in context?

Integration: How successfully have you tied together perspectives, elements, and/or themes from across the medical school curriculum? How successfully have you tied together your own journal from the beginning of Year 1 onward?

Who will have access to my journal?

The *Journaling Governance Policy* (reproduced here) sets out access conditions for journal submissions, and stipulates the bounds of confidentiality of journal entries.

(1) It is critical that students feel free to journal in an open and honest manner, rather than feeling constrained by concerns about who will have access to individual entries. Accordingly, **only four individuals will have access to your journals, and your responses will be treated as confidential material:**

- Medicine and Society Theme Director (Dr Jason Robert), Vice Dean for Academic Affairs (Dr Jacqueline Chadwick), Intersessions Block Director (Dr Michele Lundy), and Dr David Beyda, pediatric intensivist and ethicist at Phoenix Children's Hospital. These faculty members will thus have exclusive access to the journals, except as indicated in (2), below.

(2) There are some occasions on which entries submitted specifically and exclusively to these faculty members may be shared with other medical school personnel. Obvious examples include evidence of the potential for a student to be a danger to her/himself or another, and evidence of potentially illegal or otherwise significantly inappropriate activities. Wherever possible, faculty members will first consult with the student.



Personal Reflection: A Prescription for Medical Education

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PURPOSE

Since the time of the Second World War, patients have taken a more active role in their medical decision-making processes (Thomsma 1983). This has led to an increased expectation of professionalism, empathy, and respect from their physicians. The act of personal reflection by physicians is proposed as a means to help physicians meet these growing expectations from patients. The study of literature throughout the process of medical education has been established as a means to promote this type of personal reflection (Charon 2006). An exploration of the historical elements of this process provides a framework for the role that personal reflection plays in the practice of medicine and in the process of medical education.

PROCEDURE

1. Explore literature regarding societal expectations of physicians and the historical evolution of the physician-patient relationship.
2. Analyze the literature regarding the concept of personal reflection, the role that personal reflection plays within the field of medicine, and how personal reflection has been incorporated into the process of medical education.
3. Review the literature regarding lessons learned from previous attempts to incorporate personal reflection into the process of medical education and identify key components of the success and failure of these trials.
4. Provide examples of reflective writing samples that support the identified themes.
5. Develop a recommendation, a prescription, for the future successful inclusion of personal reflection into the process of medical education.

PERSONAL REFLECTION

DEFINITION

- Analysis of personal attitudes, beliefs and assumptions
- Gain understanding of identity thought process, and behavior patterns
- Assign meaning to life experiences
- Foster deeper understanding of interactions

TYPES OF PERSONAL REFLECTION

Analysis of literature suggests the following are platforms for personal reflection. Exploring these activities provides a better understanding of how they promote personal reflection.

- **Reflective Reading** – allows reader to perceive the world from the perspective of another
- **Reflective Writing** – forces writer to describe and communicate own perspective
- **Storytelling** – active engagement between individuals

REFLECTION IN MEDICINE

Communication within the medical field occurs between:

- Physician and Self
- Physician and Patient
- Physician and Colleagues
- Physician and Society

The literature has identified a void that has formed between physicians and their patients, which causes miscommunication and a lack of understanding. Personal reflection allows for deeper interaction, empathy, personal strength, and trust between physicians and patients, which can help to close this communication void (Charon 2001).

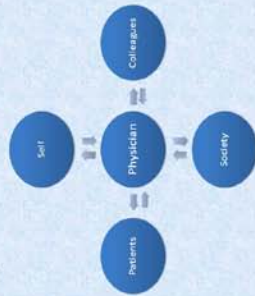


Figure 1. Physician Interactions

REFLECTION IN MEDICAL EDUCATION

The incorporation of personal reflection into medical education may proactively prepare students to prevent a communication void between physicians, patients, colleagues, and society.

The AACM and LCME have published recommendations and standards for humanistic qualities which may be fostered through the promotion of personal reflection in medical school curricula.

AACM	Physicians of the Twenty-First Century: Report of the Physician and College Preparation for Medicine <ul style="list-style-type: none"> • ethical sensitivity and moral integrity, combined with equanimity, humility, and self-knowledge, are quintessential qualities of all physicians" (AACM 2004, 3). • "The humanistic qualities that are the hallmark of medicine" (AACM 1984, 3-72).
LCME	Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree <ul style="list-style-type: none"> • Emphasize behavioral and socioeconomic subjects • Promote communication of ethics and human values • Recognize cultural responses to health and disease • Reflect on personal, gender, and cultural biases

Figure 2. Medical Education Standards

REFLECTIVE WRITING REFLECTION EXERPT

The sterile white room with empty, stainless steel beds felt like another world, like I was in a space station. The smell, the sound, the light, it all felt so different. I didn't know what I was doing, but today, it overwhelmed me. I couldn't overcome it. No matter where I looked, no matter what I thought about, I couldn't escape death. The bodies. They were so real, so raw. I could still see the expressions on their faces. This was the last time I would see them. I had just finished the sense of awe. There I feel like our education is the end that justifies the means: that the donors have given their last sacrifice for the greater good. But here, there was just death. And though I was covered from head to toe with gowns and masks and scrubs I felt naked. So exposed.

The team began its work. "This lady was hit by a car crossing a street." I've done that. Why her? Why not me? Her nails were painted perfectly. Today is her birthday. Or maybe it was her anniversary. I don't know. I don't know. I don't know. Was this what she imagined when she painted her nails? They analyzed her uterus and cervix. "She's delivered at least one child." Where are they? How are they grieving the loss of their mother?

Maybe I'm not so sure that medicine is right for me. Maybe I want to be an accountant. They don't deal with death do they? But can I ever forget today? No. I can't go back. Ignorance was bliss.

Figure 3. Example demonstrates Reflection in Medical Education

SUCCESSFUL IMPLEMENTATION

The available literature suggests that successful incorporation of personal reflection into medical education incorporates the following characteristics into voluntary seminar activities:

- Reflective reading assignments based in medical and non-medical literature to teach multiple perspectives of different experiences (Hunter, Charon, and Coulehan 1995)
- Structured and unstructured reflective assignments with mentors who provide non-judgmental feedback to promote honest reflection (Reichert et al. 2009).
- Students given a choice regarding whether or not to share personal reflections (Reichert et al. 2009).
- Small class size, strict confidentiality of seminars which may take place in pre-clinical and clinical years of training (DasGupta and Charon 2004).

PRESCRIPTION

Recommendations for future incorporation of personal reflection into medical education include:

- small groups
- strict confidentiality
- voluntary participation
- non-judgmental feedback
- supportive environment
- choice regarding sharing
- incorporation of reading, writing, and storytelling

ACKNOWLEDGEMENTS

This project is only a success because of the insightful mentoring and guidance of Jason Scott Robert, Ph.D. I would also like to thank Jane Malerschein, Ph.D., Lynn Hankinson Nelson, Ph.D., and Richard Creath, Ph.D. for their guidance during the initial inception of this project.

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DISPENSE AS WRITTEN SIGNATURE DATE