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Presence: A Mechanism for Developing Rapport in Physician Interprofessional Engagement

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Keywords

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Preface

A neurosurgeon came to me with the idea that if elite athletes can have coaches, maybe he, too, should have one to help with his performance. More precisely, he wanted to find ways to manage his emotions during challenging surgical events. Upon arrival at my office, he told me he was getting angry with some nurses in the middle of surgery. He described the circumstances in some detail. During more lengthy procedures, a nurse may participate mid-surgery to relieve the lead surgical nurse; when they arrive, nothing is said, and the surgery continues. Then when the nurse made an error or wasn't fast enough, the surgeon would not only get angry, but he would express his anger by ignoring or berating him. The physician's inner narrative was, "*You are disinterested and don't care. I can't trust you*." He would then become distracted by these thoughts and feel he would lose focus, which is a critical aspect of surgical success. "*I lose sight of the operation. I go from being in flow to not breathing, and I react* with *anger. I want the nurse to feel bad about what had happened. I want to punish him*." My client was no longer feeling a sense of trust. As he said this out loud to me, he immediately had some insight - he had assumed the nurse was disinterested and didn't care. He also realized that the nurse was certainly very aware of his error, and the last thing he and the rest of the team needed was an absence of harmony and collaboration.

I asked him how he opens his surgery, and he told me that he welcomes the team, and they stand quietly together as he invites each healthcare team member to set an intention. Through sharing this with me, he recognized the 'new' nurse was not part of this ritual - they were walking into a very complex surgery without a shared intention or a sense of mattering. The patient herself was seen as only the part of the body that was exposed for surgery — no face…no name.

With new insight, and when possible, this surgeon now creates a moment to welcome the new nurse and 'introduce' him to the patient to humanize the procedure and connect to the greater goal. He invites the new team member to set an intention, how, why, and where they want to focus their attention. The surgeon can positively impact the team's performance and well-being, focusing the surgical team's attention by setting an intention that aligns the energy in the surgery. Discord is minimized, and rapport increases. Now when the nurse comes in to relieve another nurse, he looks directly at him and says, "Thank you for helping. I am happy you are here."

Introduction

I am not a physician; I am a coach. This capstone is inspired by my work with medical school faculty, physicians, resident physicians, and other healthcare providers at an academic medical center in Boston. *For the privacy and confidentiality of my clients and the hospital, I have not named the medical center and have altered details about gender and medical specialty in any personal stories.* Some physicians are enterprising and choose to be coached to improve their well-being and develop their leadership skills; others are encouraged by faculty or supervisors to seek coaching to address an issue — perhaps impatience, a fixed mindset that inhibits curiosity, ineffective communication skills, or overall stress management. These individuals are empathic and have the ability to develop and experience rapport with patients, yet often don't engage in the same communication and relationship skills with colleagues, their students, or fellow faculty. This story exemplifies increasing individual and team well-being and shifting outcomes by actively engaging in mindfulness and presence to increase rapport, moments of mutual trust and understanding. These are the moments that inspire me.

Much of my work supports my clients' well-being by encouraging effective communication, curiosity, and respectful relationships with their colleagues. I work with individuals to mitigate negative affective behaviors, promote mindfulness and curiosity, and guide them toward a more positive outlook by increasing engagement with their strengths and positive emotions. In addition, I have a personal interest in the topic of rapport and mindfulness as daily I witness and support physicians experiencing high levels of stress and anxiety; their tempers are short, and, as in the story of the neurosurgeon, communication easily breaks down, and attention and collaboration falter.

The pressures and expectations for perfection are overwhelming for physicians and students in a world-renowned academic medical center. From faculty (physicians of the medical school) who oversee residents in training to the faculty themselves in their roles as physicians, these high-achieving individuals often experience their work similarly to elite athletes – high expectations, performance under pressure, collaboration, and a need for focused attention. Indeed, academic medicine has a culture in which physicians are considered high achieving, focused, and scholarly while exemplifying achievement, innovation, and connection (Kirch, 2007; Plews-Ogan et al., 2007). It is often an unforgiving culture of perfectionism, hierarchy, and competition (Haidet & Stein, 2006; Kirch, 2007; Pololi et al., 2009).

The culture of academic medicine can have a profound negative impact on physician engagement and rapport as it creates and supports basic assumptions about what is acceptable behavior in a way that almost goes unnoticed, as a kind of "white noise" (Haidet & Stein, 2006, p.17) in the background — *doctors must be perfect, uncertainty and complexity should be avoided, the outcome is more important than process, and hierarchy is necessary* (Hafferty, 1998; Haidet & Stein, 2006). The resulting behavior, this *white noise* is indicative of humans'

engagement with self-protection from threats in times of stress as human beings are more influenced and aware of negative characteristics of their environment than positive (Haizlip et al., 2012). More specifically, Haizlip et al. (2012) suggest this influence culminates in negativity bias, the instinct to react based on negative emotions and negative past experiences, anticipating the worst. Under stressful conditions, this can permeate and create friction within interprofessional relationships (Haizlip et al., 2012).

To be clear, my experience with my clients informs my view that hierarchy is necessary for medical practice; physicians working amid trauma or emergency may not have the time to introduce themselves or be invitational in welcoming colleagues. My clients share with me there are times when complexity and ambiguity are their reality. And yes, in a medical setting, the outcome most often takes precedence over the process. Yet, the actual practice of medicine is not all that is happening in the hospital that impacts patient outcomes and physician well-being. I am speaking about all physician encounters, those with colleagues, leadership, medical students, and direct reports. In my coaching work with physicians, we explore the positive outcomes of treating our interprofessional colleagues with presence and full attention, and not in a habitual, often rushed way that fosters discord. We explore approaches such as communicating and connecting while walking the hospital hallways and in meetings where informal opportunities exist to connect and build rapport. In other words, invitational approaches that support the teaching and learning by faculty and residents promote rapport. My point of view is that of a coach who strives to shift individuals toward agility and to become aware of when the *white noise* is necessary and when it is simply that— noise — a habitual distraction away from the moment. My coaching engagements with physicians focus on shifting their awareness to

conscious choice with intention. It is not about how they practice medicine but how they practice presence and rapport toward developing healthy interprofessional relationships.

Medical education is predicated upon mastery of facts and skills focused on providing answers and away from inquiry and curiosity (Dyche & Epstein, 2011). Medical schools and teaching hospitals are expected to develop knowledgeable and skillful physicians; they are not tasked with increasing anxiety, fostering cynicism, nor hindering curiosity. Yet, these are the behaviors I witness and learn about from the voices of the residents and physicians I coach. I champion these individuals to mitigate negative affective behaviors, encourage mindfulness and curiosity, and guide them toward a more positive outlook by increasing engagement with their strengths and positive emotions. I meet with these individuals amid tremendous stressors in their work and personal lives; they have moved through a competitive education system that promotes peer pressure and anxiety rather than collaboration (Dyrbye et al., 2005).

My clients are brilliant clinicians, yet many don't have the inner tools, the awareness, to navigate interpersonal skills, anxiety, and overwhelm. What would the effect be on physician well-being if medical education and continued learning also focused on preparing them to be present and curious in the face of the tumult and uncertainty in interprofessional relationships? Many of my clients will eventually move into hospital leadership roles such as Attending, Chief Resident, and Chief Medical Officer; I collaborate with the practitioners to develop better communication skills and provide them with the tools to be pro-active in their physical, emotional, and intellectual well-being. Through my practice, I have seen that positive psychology precepts can provide a foundation upon which residents and physicians manage their stress, collaborate more effectively, and better serve their patients.

I engage my clients with tenets of Positive Psychology, the theories of presence, mindfulness, and their impact on cultivating and fostering rapport, collaboration, and healthy relationships. Together we create a trusting relationship where exploration is encouraged to recognize and value their entire range of emotions while embracing positive emotions, which can be fleeting and less frequently accessed in high-stress environments. Through our mutual rapport, we reinforce a mindset of receptivity, creativity, building, and connecting.

I will begin with an introduction to positive psychology. Then, I'll discuss the importance of relationships and how positive psychology plays a noteworthy role in defining their significance. Later, I will examine key constructs of mindfulness, and presence germane to developing rapport in physician interprofessional engagement.

Introduction to Positive Psychology

From Aristotle to James Pawelski, William James to Martin Seligman and Mihaly Csikszentmihalyi, philosophers and scientists have posed questions with a desire to understand, "what is happiness and what does it take to achieve it?"

Aristotle believed happiness was defined as eudaimonia or, in current terminology, flourishing (Melchert, 1999) and suggested a virtuous life aspires to excellence and engagement. He suggested happiness is in the pursuit of character, and in addition to our rational, intellectual endeavors, there are virtuous actions in the physical and social elements of our lives (Melchert, 1999). Although the good life does not simply happen to us, it does result from the pursuit of and commitment to virtue, and according to Aristotle, it is not possible to experience happiness without a virtuous life which is attained through the intention and action of virtuous experiential learning (Melchert, 1999). Many theories of well-being are in consensus with Aristotle's belief

there is an important difference between a meaningful life, *eudaimonia,* and a state of pleasure, *hedonia* (Peterson, 2006).

Historically, in research, positive emotions have become marginalized in favor of negative emotions (Fredrickson, 1998). Dr. Martin Seligman (1999) brought this to light when he gave an address in 1998 where, as the president of the American Psychological Association, he announced the scientific study of positive psychology would be one of his initiatives. Psychology had become a science focused almost solely on pathology and mental illness and Seligman (1999) proposed the formal study of positive psychology 'to utilize quality scientific research and scholarship to reorient [psychological] science and practice toward human strength' (p. 561).

This initiative of positive psychology would focus on strengths as much as weaknesses, as much interest in raising what is best in life as in restoring the worst, and as much attention to encouraging what is good in the lives of people as healing the troubled (Seligman, 2011; Seligman & Csikszentmihalyi, 2000). At the core of positive psychology is the proposition that human goodness and excellence are as genuine to the human condition as disease and suffering (Peterson, 2006). Instead of correcting what is wrong or seen as a weakness, positive psychology builds upon strengths and nurtures what is best in humankind (Seligman & Csikszentmihalyi, 2000). At an individual level, positive psychology values well-being, satisfaction, and contentment with the past; flow and happiness in the present; and hope and optimism for the future. At a group level, positive psychology celebrates the virtues of civility, altruism, work ethic, and tolerance (Seligman & Csikszentmihalyi, 2000), all of which, from my vantage point as a coach, are critical to the success of my clients and the healthcare industry.

Emotions are complex involving subjective feelings and habitual patterns of physiological activation, thoughts, and behaviors (Peterson, 2006). Peterson (2006) further

suggests the meaning of the word emotion comes from the root word, *motion,* which conveys emotions move through us, and as they are more fleeting than sensations, they perhaps drive our behavior. The positive emotions of *joy, gratitude, awe, interest, serenity, hope, pride, amusement, love*, and *inspiration* are examples of positivity that are foundational to Barbara Frederickson's (1998) *broaden-and-build* theory. In this model, Fredrickson (1998) explores how positive emotions served us evolutionarily and how they encourage flourishing while supporting us in our ability to be resilient in difficult times. This model posits negative emotions narrow people's thought-action responses, such as fight or flight, while positive emotions *broaden* people's thought-action responses, encouraging them toward creative and innovative action; joy creates the urge to play while interest creates the urge to explore (Fredrickson & Joiner, 2002). Positive emotions accrue, creating an opportunity to broaden one's mindset, build physical, social, and intellectual resources, and experience enhanced future accomplishment (Cohn & Fredrickson, 2009; Fredrickson, 1998). In a positive emotional state, people are more agile and innovative (Peterson, 2006). In addition, positive emotions often serve as an antidote to negative emotions' effects therefore, positive emotions do more than reflect success—they are essential components that produce success (Fredrickson, 1998). As one might expect, living our best life is not a simple comparison of positive emotion versus negative emotion. Living our best life requires reflection, awareness, and, perhaps most importantly, an understanding that there are times when we must embrace both the positive and the negative for optimal flourishing (Pawelski, 2005; Seligman, 2002).

Dr. Martin Seligman posits well-being theory is understanding, first and foremost, that well-being, not happiness, is the subject of positive psychology (Seligman, 2011). Seligman (2011) further suggests that well-being is a construct of five intrinsically rewarding and

measurable elements, which he identifies by the acronym PERMA: positive emotions, engagement, relationships, meaning, and accomplishment. Martin Seligman (2011) believes that these five elements of PERMA include both hedonic and eudaimonic aspects of well-being research. They are critical individually and collectively for building and enhancing well-being and are important elements for individuals to pursue for their own sake (Seligman, 2011).

The first element of Seligman's (2011) PERMA model that gives rise to flourishing is *Positive emotion* which, as mentioned earlier, is the foundation on which Barbara Fredrickson's broaden-and-build theory was constructed. Positive emotions are pleasurable subjective elements that are felt in the moment. *Engagement* is the second element that, like Positive emotion, is subjective, yet the experience of pleasure is retrospectively assessed. Engagement refers to a psychological state in which individuals report having been absorbed by and focused on what they were doing. Seligman (2011) suggests that other people are the best interventions to life's challenges and therefore has included *Relationships* as one of the elements of his PERMA model. *Meaning* suggests belonging to and serving something more significant than oneself. And the last element in the acronym of PERMA is *Accomplishment*, or achievement, which is pursued for its own sake even when it results in no positive emotion, meaning, or positive relationships (Seligman, 2011).

Relationships

In this section I have chosen to focus on relationships, the 'R' in PERMA, which are central to the interdependence of humanity — how we are in connection to and dependent on others. The ability to love and be loved, belong, and matter – these words express what it means to be human. Supported by empirical data, shared experience as well as forming and maintaining

positive close relationships is crucial for health and well-being (Gable & Gosnell, 2011). Yet, not just any relationships, but relationships of rapport built on connection and mattering. Mattering is a core human motivator consisting of two complementary and highly interdependent psychological needs—*feeling valued*, the awareness that one is appreciated and recognized, and *adding value*, believing one has the ability to contribute and make a difference (Prilleltensky, 2020). Social psychologist, Gregory Elliot (2009), suggests that perceiving oneself as a significant part of the world around us is one way to experience mattering; being a part of the world, and even a part of a team, allows us to embody belonging, a key pillar to mattering (Prilleltensky, 2020).

Positive emotions play a key role in broadening an individual's mode of thinking and momentary experience: contentment urges the desire to savor, and love sparks a recurring cycle of these desires within close and safe relationships (Fredrickson, 2004). The resulting broadened mindset promotes innovation and creative actions, ideas, and social bonds, which build an individual's physical, intellectual, social, and psychological resources. By engaging in and eliciting positive emotions, organizations and their leadership can be transformed and reap the benefits of the broaden-and-build theory; they become more agile when their workforce is more flexible, empathic, and creative and, over time, as with individual impact, broadening builds more significant social connections and increases innovation (Fredrickson, 2000). The broaden-and-build model shows that a wide range of positive emotions, from pride and joy to gratitude and contentment, create and sustain the relationships and processes that keep individuals and organizations thriving (Fredrickson, 2000).

In discussing better communication and developing healthy interprofessional relationships, my clients will often say that the risk of vulnerability within interpersonal

relationships is too great and, in addition, they don't have time to build relationships in the workplace. I will encourage them to open their minds about what defines a relationship and why there is the perception it will take too much time and energy. I invite them to learn about and engage with High Quality Connections (HQC) (Dutton & Heaphy, 2003). As is helpful to introduce a new idea to scientists and physicians, I share the supporting empirical evidence of the benefits of HQCs to champion such an initiative. People who have more HQCs over the course of a day experience more significant well-being, which is exhibited through increased positive emotions and an increase in vitality (Reis et al., 2018). As for the benefits to an individual and the organization, HQCs amplify the capacity to work within and across teams (Dutton, 2003). My clients will set a goal of a certain number of HQCs they will commit to engaging each day. A surgical resident shared with me that she committed to having five HQCs a day with her surgical team and all the care team who keep the surgery clean and functioning. She reported back after two weeks that the number of engagements easily increased to 10 or more, and she felt more engaged and present with the staff. Rapport is created by HQCs, through the positivity that is felt by the participants as they experience a feeling of inspiration when engaging with another who expresses genuine interest and concern in how they are doing (Stephens et al., 2012). As I coach, the goal is to shift my clients from automatic responses to what Parker et al. (2015) identify as internal attunement and self-regulation to support healthy interpersonal relationships.

Positive Organizational Scholarship note three experiences that make up an HQC: invitational moments of vitality, experiences of positive regard, feeling known or respected, and mutuality where status and hierarchy disappear, allowing for collaboration and a sense of belonging (Stephens et al., 2012). Embracing the theory of High Quality Connections (HQCs) creates many opportunities for short-term, often dyadic, relationships that are subjectively

positive experiences associated with greater levels of trust and psychological safety (Stephens et al., 2012). For clarity, Dr. William Kahn (1990), a professor of Organizational Behavior at Boston University, describes psychological safety as, “feeling able to show and employ one’s self without fear of negative consequences to self-image, status, or career” (p. 708).

Deep personal knowledge and long engagements are not requisite for a High Quality Connection; an email can be an HQC, and everyday actions that may be fleeting can be HQCs as an impromptu moment of connection in a meeting or while walking in the hallway that can create energy and vitality for both participants (Dutton, 2003). On the contrary, Dutton (2003) indicates that a lack of High Quality Connections may erode innovation, loyalty, and commitment, undermine dignity and respect and impact one’s ability to perform at their best. She further states in many institutions, an underlying current of Low Quality Connections (LQCs) seems to permeate, creating a fearful and toxic toll on energy and well-being, which can be expressed by distrust and disregard for others' worth, negatively impacting one's ability to learn, show initiative and take risks ultimately impacting the well-being of all relationships (Dutton, 2003).

In the spirit of relational well-being, Isaac Prilleltensky (2020) proposes a shift from a ‘Me Culture’ to a ‘We Culture,’ suggesting that many people exist in the narrative of the *Me Culture* that states, “I have the right to feel valued by others so that I may experience wellness” (p. 11). Prilleltensky (2020) reframed this statement to be far more relational and celebrate interdependence: “We all have the right *and* responsibility to feel valued *and* add value, to self *and* others, so that we may all experience wellness *and* fairness” (p. 11). The difference in these two assertions is, in the latter, Prilleltesnky suggests balancing rights *with* responsibilities,

feeling valued *with* adding value, and bettering the self *while* bettering others; the *We Culture* proposed is focused on relational well-being (Prilleltensky, 2020).

Rapport

In my coaching sessions with physicians and medical students, I recommend engaging in emotional and intellectual intimacy to support a feeling of belonging and mattering as essential to rapport, a way of 'being' in relationship. Perceptions of greater interpersonal trust can increase mutual trustworthiness and cooperation, suggesting the development of mutual trust and cooperation is like a dance fundamentally affected by each individual's contribution (Ferrin et al., 2008), resulting in rapport.

As defined in the Merriam-Webster dictionary (n.d.), rapport is "a friendly, harmonious relationship; especially: a relationship characterized by agreement, mutual understanding, or empathy that makes communication possible or easy." In the medical setting, the definition of rapport focuses on the physician-patient relationship and is defined as, "a harmonious accord or relation that fosters cooperation, communication, or trust" (Merriam-Webster, n.d.).

In much of the current model in medical education, physicians don't receive the same type of guidance in relating to their patients as they do in developing clinical expertise (Suchman & Matthews, 1988). In my experience, the same disengagement in relationships is exhibited in their interprofessional connections. Suchman and Matthews (1988) suggest that a feeling of connection with others, going beyond the boundaries of self, is a basic human need, and this need can be satisfied through connexional experience. Suchman and Matthews (1988) champion the word connexional as it comes from the words *co* (meaning together) and *nexus* (a binding together of parts to form a whole) suggesting the *mutual* experience of joining results in a

sensation of wholeness. For instance, when a patient senses they are deeply listened to, a feeling of connectedness with the healthcare provider can ease distress and reduce feelings of isolation. Feeling connected is at the heart of healing, so in addition to whatever biomedical treatments are offered, transpersonal physician-patient rapport matters (Suchman & Matthews, 1988).

I call attention to Suchman and Matthews' (1988) distinction between interpersonal and transpersonal experiences. Interpersonal experiences are encounters between two separate people that coexist, either cooperatively or competitively but do not necessarily join or connect. *Transpersonal* experiences foster a connectedness that exhibits losing oneself in another person or group of people and permeates an awareness of deep harmony and resonance, allowing a feeling of great understanding of others and one of feeling profoundly understood (Suchman & Matthews, 1988)

Presence and Mindfulness

Medical practice is complex and ambiguous, and practitioners must engage with curious reflection, have the patience to pause and critically examine one's assumptions and foster deep listening, moving from automatic and reflexive responses to deliberate and reflective approaches. In addition, *adaptive expertise*, the ability to manage the unexpected, involves emotional awareness and discovery and is as critical to physicians' education as is clinical expertise (Arnone, 2003; Bereiter & Scardamalia, 1993; Dyche & Epstein, 2011; Epstein, 1999).

In this section, I do not focus on meditation as a path to mindfulness and presence, nor will I discuss in-depth relaxation or mood management through the act of mindful meditation or mindfulness training. I will speak of mindfulness as a state, a way of being, not as a formal mindful or meditation practice which Jon Kabat-Zinn (2005) suggests is the "scaffolding" to develop the skill and subsequent state of mindfulness. In the same spirit, Shapiro et al., (2006)

propose mindfulness is more than meditation. I will bring to light the mechanisms of the actions of mindfulness itself.

The concept of mindfulness can be a bit confusing as Shapiro and Carlson (2017) recognize that mindfulness is both a *process* and an *outcome*, an intentional attendance while utilizing an open and accepting attitude. The *process* part of mindfulness is a mindful and intentional practice in an open and caring way that involves attending to, knowing, and forming the mind. The *outcome* is *mindful awareness*, an enduring presence, and a deep knowing that creates freedom from reflexive responses (Shapiro & Carlson, 2017). These mechanisms result in what I suggest is mindful awareness with intention and can facilitate presence and rapport.

To further elucidate mindfulness and its methods, *formal mindful practice* is a structured meditation practice that may include sitting or walking meditation, may be brief and integrated into one's day, or practiced as part of an intensive retreat spanning hours, days, or longer. *Informal mindful practice* involves experiencing mindfulness in everyday activities such as mindful cooking, mindful eating, mindful walking, and mindful reading (Shapiro & Carlson, 2017). Psychiatrist and Zen teacher Dr. Barry Magid (2013) clearly states what it means to embody presence away from formal and informal mindful practice:

> When we speak of just sitting, we are not limiting ourselves to describing a particular posture or practice. We are describing a way of being in the world in which everything we encounter is fully and completely itself. Nothing is merely a means to an end, nothing is merely a step on the path to somewhere else. Every moment, everything, is absolutely foundational in its own right. (Magid, 2013)

Many times a day, something grabs our attention, and we experience brief *focal attention* before cognitive judgments, assessments, and emotional reactions take over. Very quickly, a conceptual

mode of processing occurs, and subjective perceptions create a response that is often biased in nature, based on the self and an assessment is made: ‘good,’ ‘bad,’ or ‘neutral’ (Brown et al., 2007). As noted earlier in relation to negativity bias, similar past experiences can immediately evoke a memory or bias, and existing cognitive schemas, the ordering of events and experiences as relevant to the self, may further define one’s reaction and experience (Brown et al., 2007).

The opportunity for developing presence and rapport lies in engaging with a mindful mode of processing which requires a receptive state of mind (Brown et al., 2007) to attend to and employ cognitive control (Tang & Posner, 2009). A core principle of *grounded cognition* indicates that cognition shares mechanisms with perception, action, and the receptive state of mind —introspection (Barsalou, 2008). Barsalou (2008) further suggests grounded cognition emerges from interactions between *classic cognitive processes* (e.g., attention, knowledge, thought, etc.), the *modalities* (e.g., internal and external perception), *the body* (e.g., heart, breath, limbs, etc.), the *physical environment* (e.g., indoor, outdoor, artifacts, etc.), and the *social environment* (e.g., self, group, mirroring, culture, etc.). Cognition is not a module in the brain that can be effectively studied in isolation but must be studied in the context of these five domains (Barsalou, 2020).

Dr. Dan Siegel, M.D. (2009) developed the concept of interpersonal neurobiology, which focuses on another person's mind, allowing us to harness neural circuitry that enables two people to experience *mindsight*, to "feel felt" by each other. *Mindsight* suggests the brain can actually map out one’s own mind and the mind of others by seeing into our own mind with insight, experiencing an attuned relationship with oneself and focusing on one's inner world. Then to complete the circuit, employing this with empathy and an attuned relationship while seeing the mind of another, allowing resonance with the inner world of someone else (Siegel, 2009).

One of the most profound elements in helping others heal is presence - being open and receptive toward others (Siegel, 2010). In times of uncertainty and vulnerability, what Harper (2006) calls *boundary situations* the role of presence is particularly important. Philosopher, theologian, and professor Ralph Harper (2006) appraises presence as a *bonded resonance*, which he suggests is a way of being in which two individuals are attuned to one another. The American Heritage Dictionary of the English Language (n.d.) defines resonance as a, "richness or significance, especially in evoking an association or strong emotion." In my practice, I recognize and articulate this as rapport.

In my coaching engagements, I share that just as a physician 'practices' medicine throughout their career, mindfulness and presence are practices one can engage with every moment of every day throughout one's life. Presence can become a way of being that, with practice, does not require conscious attention (Parker et al., 2015). I encourage my clients to engage in a practice of mindful awareness; we take this approach not to add any more tasks to their day. But, just as one engages in the practice of medicine, one can engage in the practice of presence. Dr. Barry Magid (2020) eloquently states that his practice of Zen and his profession of psychoanalysis are *ritualized disciplines of attention* to his moment-to-moment experiences. Similarly, Brown and Ryan (2003) state that deliberately attending to one's moment-to-moment experience creates a state of consciousness and a way of being aware in an open and receptive way.

Through the experiences of my clients, I have witnessed the phenomenon of presence and how it can shift an interaction from transactional to the genuine possibility of being transformational. This is evident in the story of the neurosurgeon: to maintain the attunement, the harmony my client had created for his team at the opening of surgery, he needed to come back to

the present moment in his mind and body; he needed to engage in mindful awareness and experience presence.

Presence necessitates a respite from a habitual reaction in favor of receptive attention. This *receptivity* requires a conscious intention and a commitment to engage with openness and acceptance, allowing access to all the experiences that arise (Brown & Cordon, 2009; Geller & Greenberg, 2002). The literature uses many words to define presence —resonance, attunement, mindful awareness—words that involve internal and external experiences that orient toward energy flow. How one senses you. How your energy feels for others. Dr. Dan Siegel (2009) states it has been shown mindful awareness contributes to well-being by altering brain function and interpersonal relationships. He further suggests there are nine functions related to mindful awareness. I have chosen to illustrate six that relate directly to presence: *body regulation*—balancing the sympathetic with the parasympathetic nervous system; *attuned communication*—when two people tune in to each other to the point of feeling resonance; *response flexibility*—the ability to create space between stimulus and response; *insight*—the conscious knowing of one's own existence; *empathy*—the capacity to imagine another's mental and emotional perspective; and *intuition*—the nonverbal areas of our experience that come into our awareness (Siegel, 2009).

Presence is critical to harmony within interpersonal relationships and represents the ability to attend to the most genuine and least automatic experience (Parker et al., 2015). Sōtō Zen priest, Josho Pat Phelan (2010) examines the ethos of presence by offering that when we allow ourselves to 'step away' to evaluate or examine an experience, the original experience comes to an end, and we begin to reflect on the past, which is a new experience; we are no longer in a state of presence. Stated another way, attending to each moment without thoughts of the past

or contemplating the future exemplifies presence (Baldini et al., 2014). This illustrates how fleeting presence can be and how important focused attention is to the process.

"Presence has an echo, but only to one who is interested…It may be the onset of what we call intimacy…" (Harper, 2006, p.58). As a poet may pause and repeat a particularly poignant phrase, please allow me the grace to do the same: *"Presence has an echo, but only to one who is interested…"* (Harper, 2006, p.58). This is one of the most powerful portrayals of presence I have come across, as it beautifully illustrates the resonance and attention within oneself and in relation to others which are essential components of rapport.

Emotional states such as anxiety and depression can manifest in physiological conditions such as increased muscle tension and blood pressure. These psychosomatic responses are physiological feedback telling us that the body is out of balance. Our thoughts, emotions, and behaviors impact how our bodies function, and the opposite is also true — the body can influence what we think and feel, creating a state of mind which can deem itself more confident and able (Seligman, 2002, as cited in Faulkner et al., 2015). A healthy mind existing in a healthy body, or the effects of the body on the mind, is what Dorothy Virginia Harris proposes is the *somatopsychic principle* (Faulkner et al., 2015). For example, when we gain physical strength, we often feel more confident in our abilities and gain positive self-perception.

Although presence does not need to be physical, it does result in a somatic experience as Barsalou (2020) notes, the body is one of the cognitive domains. The body and the mind are deeply intertwined, and Robert Shusterman (2006) suggests all emotion must be experienced somatically to be experienced at all. Parker et al. (2015) suggest that in addition to the interpersonal and the mental aspects, the somatic experience influences presence by interoception, the awareness of one's body and its response to another.

Emotional and psychological constitution relies on the somatic experience; being aware of where our body is in space, how it feels as it moves, and listening to our bodies for feedback is as critical as paying attention to our minds (Shusterman, 2006). Shusterman (2006) further suggests we cannot act without bodily means, and therefore our bodies may be considered the prime expression of our ideas about agency and freedom.

Other aspects of presence, such as curiosity and interest, broaden an individual's mind to explore with an intrinsic desire to increase knowledge (Fredrickson, 1998). Learning and interpersonal communication, intrinsically motivated by curiosity, is far more effective than learning motivated by extrinsic reward. Yet, it is challenging to have intrinsic motivation when distress and anxiety are high, as is the case in medical schools and teaching hospitals. In fact, studies suggest in the current state of medical education, standard practices may unintentionally hinder curiosity, which is sensitive to and can be dampened by negative emotions (Dyche & Epstein, 2011). As medical students are motivated to express a façade of certainty and competency due to social norms and the culture of medicine, the resulting expression of overconfidence can be a barrier to curiosity and may discourage lifelong learning and asking for and accepting feedback (Duffy & Holmboe, 2006; Rudolph & Morrison, 2008). Yet interest, or curiosity, is fundamental to understanding a patient's experience, building respectful relationships, deepening self-awareness, supporting clinical reasoning, and encouraging life-long learning (Dyche & Epstein, 2011). Curiosity is a positive emotional state of exploration supporting intrinsic motivation; acting on curiosity cultivates personal growth, creativity, and intelligence development (Fredrickson, 1998; Kashdan & Silvia, 2009). According to Dyche and Epstein (2011), the ability to engage with mindfulness and reflection represents a bridge between curiosity and problem solving, critical thinking, and self-assessment. Dyche and Epstein (2011)

further suggest that self-reflection, collaboration, and critical thinking falter in the absence of curiosity. Mindfulness is opening one's attention nonjudgmentally to the present; reflection is the process of 'stepping back' after an event to evaluate it with curiosity (Dyche & Epstein, 2011). In my experience, mindfulness and reflection are crucial components of developing presence and rapport in physician-patient and physician-interprofessional relationships.

Mindfulness Models

Although there is no single definition, theory, or construct of mindfulness, I found common themes that emerge across the research literature— self-awareness, open awareness, presence, attention, intention, and curiosity are just a few. Well-established in Buddhist psychology, mindfulness bares witness to ideologies with several philosophical and psychological traditions from ancient Greek philosophy to contemporary American Humanism (Brown et al., 2007). Brown and Ryan (2003) define mindfulness as a self-regulatory capacity, of receptive attention and awareness of present events. By all accounts, mindfulness involves a central axiom of attention as we pivot attention away from the past or the future and toward the direct experience of the present moment (Tang & Posner, 2009). It is critical, as stated by Brown et al. (2007) that mindfulness is not considered contrary to thought but instead creates a different relationship with it. Bishop et al. (2004) propose a model of mindfulness incorporating two components. The first is attentional self-regulation devoted to immediate experience allowing the ability to acknowledge mental events in the present moment. The second component involves shifting one's perspective of the current moment experiences toward curiosity, openness, and acceptance (Bishop et al., 2004).

IAA

Seeking to understand the complex and mystifying process of mindfulness, Shapiro et al., (2006) propose a model of mindfulness illustrated by prospective mechanisms that likely explain how mindfulness affects positive change. They introduce a model of three components: *intention, attention,* and *attitude* (IAA), which lead to a meta-mechanism of action called *reperceiving;* more simply stated, a shift in perspective. In a cyclical and simultaneously occurring process, the interplay of *intention (the why or the purpose of what we do), attention (offering attention or being in attendance with another),* and *attitude (how one attends to others)* result in a reperceiving, enabling people to increase objectivity toward their internal experience and gain clarity

Intention. In the traditions of mindfulness, intention is simply knowing why one is practicing, what is the aspiration and motivation (Shapiro & Carlson, 2017). Echoed by scientist, writer, and mediation teacher Jon Kabat-Zinn (1990), "Your intentions set the stage for what is possible. They remind you from moment to moment of why you are practicing in the first place" (p. 32). The question may arise, how can someone have an intention for formal or informal mindful practice while at the same time not being goal-oriented or striving for something in the future? (Shapiro & Carlson, 2017). It's important that intentions be separated from the concept of goal attainment or striving as an intention is not a finite destination but rather a direction (Shapiro & Carlson, 2017).

Attention. In the context of mindfulness Shapiro et al. (2006) suggest that offering attention is being in attendance with another while experiencing receptive awareness. Mindfulness takes root in bringing awareness of current experiences while regulating one's focus

of attention — observing one's thoughts, emotions, and physical sensations (Bishop et al., 2004). Although often used interchangeably, there is a subtle yet distinct difference between attention and awareness, an interplay paramount to mindfulness and its flexibility that bears noting. Flexibility empowers one to move in and out of awareness and attention based on circumstances allowing attention to move from a narrow focus to a wider perspective without distraction; for instance, engaging with awareness to access a larger perspective of events or homing in with focused attention when prudent (Brown et al., 2007).

Self-regulation of attention fosters receptivity, non-elaborative awareness, toward thoughts and emotions rather than reactivity, which is expressed in rumination, thoughts *about* one's experience versus the event itself experienced within mind and body (Bishop et al., 2004; Teasdale et al., 1995). According to Jha et al. (2007), receptive attention is *objectless* as the goal is to have one's attention in the present moment, in a state of readiness, receptive to a whole field of awareness while remaining open to experience thoughts and emotions without judgment.

Attitude. Attitude, how one attends, or the qualities one brings to the act of paying attention and engaging with awareness is crucial and deeply associated with mindfulness, yet the *quality* of attention is often not categorically defined (Shapiro et al., 2006). When intentionally cultivating the attitudes of patience, compassion, and acceptance toward the practice of attention, one can develop the ability to allow pleasant and unpleasant experiences to exist without appraisal or judgment (Shapiro et al., 2006). Bishop et al. (2004) suggest one embody the quality of simple awareness of a present moment experience while relating to the experience with an attitude of curiosity, openness, and acceptance.

Quite similarly, Dr. Dan Siegel (2010) describes a mindful awareness attitudinal process that allows space for nonjudgmental observation. The elements in this process are identified using the acronym COAL: the state of being *curious* (inquiring without judgment) *open*, (the freedom to experience what is occurring without judgment), *accepting* (the need to be exactly where and how one is), and *loving* (*being compassionate and empathic toward others and oneself)*. COAL is a state of mindfulness, an attitude that is open and receptive to whatever arises in one's awareness; being mindful of what is, of one's judgments, and noticing these feelings and thoughts as they come and go (Siegel, 2010). By engaging with a reflective COAL mindset, a fundamental process of discernment, or disidentification, from the activity of your own mind, Siegel (2010) suggests it becomes possible to be aware that the activities of your mind are not the entirety of who you are. The perspective of self-understanding within this COAL frame of mind can directly create ways of knowing that can be transformative (Siegel, 2010).

Reperceiving. Through the act of mindfulness, one can become less reactive to internal and external factors and remain in the moment (Shapiro et al., 2006). While engaging with *positive reappraisal*, the evaluative cognitive-affective process of beneficial reperceiving, Jha et al. (2007) suggest broadening the scope of appraisal to trusting that even unpleasant experiences, thoughts, and emotions are opportunities for transformation. Reperceiving should not be confused with distancing or detaching from one's experience but rather a deep knowing and intimacy with one's moment-to-moment experience and all that arises (Shapiro et al., 2006). Positive reappraisal involves reframing stressful events as inherently meaningful for personal growth and transformation; it is not simply "positive thinking" or the desire to deny reality (Jha et al., 2007). James Gross (2002) submits that reappraisal shifts the way a situation is interpreted

to lessen the emotional effect. It creates a pivot in perspective, decreasing the experience of negative emotion while increasing the experience and expression of positive emotion (Gross, 2002). This creates a physiological response that results in escalated arousal of the parasympathetic nervous system (Gross, 2002), a part of the body's autonomic nervous system which controls the body's ability to relax. In my experience of reperceiving, or positive reappraisal, and in conversation with my coaching clients, this relaxation, this easing of the body, is when *presence* emerges and the opportunity for rapport comes to light.

Baer et al. (2006) identify five mindfulness traits that, with regular practice, can become intrinsic traits of an individual (Siegel, 2009). These traits, or attitudes, include the inclination *to act with awareness*—being in the sensory now; *to be less reactive*—one may be emotionally reactive yet is able to come back to a place of calm presence; *to be nonjudgmental*—knowing that judgment and assessments may arise but one need not act on them; *develop the ability to label with words the internal world*; and to *self-observe*—being able to observe oneself objectively (Baer et al., 2006). In my practice, my clients and I will often spend a week or more exploring and putting into practice each of these traits, noticing how they are inclined to act and where and how there is room for growth in developing interprofessional presence and rapport.

Through the practice of mindfulness, we develop the capacity to witness our emotional states from a distance, ultimately freeing us from automatic behaviors that steer us away from being present (Shapiro et al., 2006). Michael Baime (2003) posits the absence of attention in our daily lives can become a habit that results in functioning on autopilot, neither seeing nor experiencing what is in front of us. When we take time, pause, and pay attention, we begin to notice how little time we are fully engaging with our moment-to-moment experiences (Baime, 2003). Parker et al. (2015) suggest presence is the central mechanism at the core of the internal

attunement of mindfulness and the interpersonal attunement of healthy relationships. How this energy flow is shared in dyads or groups is how relationships are defined (Parker et al., 2015). With mindfulness, this energy flow is a form of *integration* that honors differences and the interpersonal attunement that arises between individuals and the communication that links them to each other; presence cultivates integration, and when this sharing is integrated, relationships thrive (Parker et al., 2015).

To be in service of the patients is paramount, and yet the physicians I coach often feel, just as Michael Baime (2003) proclaims— there is no time for presence, to simply 'be' with a patient; the physicians I work with often feel the same lack of time for their colleagues. Baime (2003) reminds us that it doesn't take time to maintain one's presence and, in fact, it is much easier if instead of 'doing' (a constant activity that encompasses physical and mental busyness), one can simply be in the moment, and with practice, it becomes effortless. "It can happen as many times as we walk into a patient's room" (Baime, 2003, p.46). Or, as is often the case in my coaching practice in the hospital, as many times as a physician interacts with other clinicians on the floor.

Conclusion

Just one week prior to submitting this paper, I received this intake note for a new client:

> *Surgical Resident*
>
> *"...my program director... suggested this [coaching] as an opportunity to learn more about leadership*
>
> *And about conflict resolution*
>
> *We spend so much time in school*

Focusing on science, math, and other very specific content

Then you are leading a team all of a sudden

Without the skills to do this

Want to be more intentional about this"

This request for support is not an anomaly. Many of my clients have told me they wish that interprofessional communication was a priority in medical education and resident training. That they didn't realize that positive emotions have a purpose and support well-being. I believe embedding principles and actions of mindful awareness, presence, and rapport should be part of the medical school curriculum and physician's continued education.

It is my hope that I will further my work by seeking opportunities to collaborate with scholars, researchers, mindfulness practitioners, and physicians to bring presence and rapport, conflict transformation, healthy dialog, and deep listening communication skills to the present and future physicians as they develop greater transpersonal interprofessional relationships. As a fellow of the Institute of Coaching (IOC) at McLean Hospital and Harvard Medical School, I engage weekly in discussions with remarkable scholars, physicians, and coaching practitioners. Over the past several months, I've been in dialog with a physician who is also a researcher and writer who proposed that we explore collaborating on research and writing a paper to inform further studies.

Engaging medical students and residents in the practice of mindful awareness would prepare them to navigate the difficulties and complexities of clinical care and residency, so I propose that mindfulness and presence as a mechanism for rapport and well-being be required consistently throughout one's medical education and beyond. I'm in the early stages of creating a

curriculum and positive interventions for coaches in the clinical setting so they may be well-versed in mindfulness, presence, and rapport. ensuring they can deliver the content in one-on-one coaching engagements or through facilitating group coaching sessions with residents and other providers.

As a fellow of the Institute of Coaching (IOC) at McLean Hospital and Harvard Medical School, I have access to remarkable scholars and coaching practitioners. I would like to build on what I have started and present my work and future findings at an IOC CoachX event or IOC webinar.

In addition, I am an artist, a minimalist printmaker. I have an appreciable interest in the Positive Humanities and have recently connected with Harvard Medical School's Arts and Humanities Initiative, where I've joined in their research meetings and discussed new ventures. This group currently brings the humanities into medical education, and I have expressed my interest in exploring minimalism in the visual arts, music, and poetry as a means to explore the development of mindfulness and presence. Over the next year, I expect to add minimalism and the humanities to the work I have brought forth in this capstone.

Until I can implement these ideas, and even after the time arrives when mindfulness and presence are embedded in medical education, I will be an advocate and teach positive psychology to physicians within the hospital setting.

Promoting the tenets of positive psychology in coaching creates a shift toward positivity and the ability to engage in healthy behaviors individually and collectively. I will continue my work developing individuals' self-efficacy. I will support my clients in aligning with their strengths as they navigate conflict and will encourage them to engage in relationships with less

judgment and more open minds. I will share that their growth depends less on positive thinking and more on embodying positive emotions.

When there is a feeling of hopelessness, I will share passages from Victor Frankl's *Man's Search for Meaning*, and together, we will read from the pages of Emily Esfahani Smith's *The Power of Meaning* so they may understand and articulate their intrinsic motivators and re-establish their purpose, reminding them why they have chosen this path. We will turn to the writings of Michael Baime and will engage in mindful awareness practices in and out of our sessions. I will always encourage my clients to pause, be deliberate, and embrace curiosity in their quest for presence and rapport

Quieting the mind and engaging with mindful awareness, presence, and rapport is a gift we can give and receive numerous times a day. Many physicians choose the practice of medicine with a desire to help others and to live a life of purpose. They are curious and hopeful, yet by the time they have exited medical school and are practicing residents, the fear of speaking up and the lack of feeling they are valued or add value can inhibit their ability to be present. The deliberate commitment to embodying presence and developing rapport takes no more time than washing one's hands prior to surgery, and yet the resulting mindful awareness, like hand hygiene, is just as critical to safety and quality healthcare. To express appreciation to a colleague and to let them know they matter takes no more time than buttoning one's white coat and putting a stethoscope around one's neck. And when delivering difficult news to a patient or supporting a peer who has suffered a loss in their own practice, the ability to be in a state of mindful awareness and to communicate compassion without words is the pinnacle of presence and rapport.

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