Storylines of family medicine V

Family Medicine and Community Health

Storylines of family medicine V: ways of thinking—honing the therapeutic self

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ABSTRACT

Storylines of Family Medicine is a 12-part series of thematically linked essays with accompanying illustrations that explore the many dimensions of family medicine, as interpreted by individual family physicians and medical educators in the USA and elsewhere around the world. In 'V: ways of thinking—honing the therapeutic self', authors present the following sections: 'Reflective practice in action', 'The doctor as drug—Balint groups', 'Cultivating compassion', 'Towards a humanistic approach to doctoring', 'Intimacy in family medicine', 'The many faces of suffering', 'Transcending suffering' and 'The power of listening to stories.' May readers feel a deeper sense of their own therapeutic agency by reflecting on these essays.

INTRODUCTION

Family physicians can use the perspectives they bring to their encounters with patients as therapeutic tools applied in service of improving patients' health and well-being. To accomplish this health-promoting ability, three tasks are essential: (1) appreciating the importance of compassion and humanism in the practice of medicine, (2) recognising and observing the nature of clinical encounters as relational experiences between physicians and patients and (3) reflecting on (1) and (2), not simply to catalogue interesting interactions but to improve one's therapeutic repertoire through ongoing attention and thoughtful contemplation.

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REFLECTIVE PRACTICE IN ACTION

Johanna Shapiro and Cindy Haq

> *The art of reflection in action—attending simultaneously to the emotions and processes of care while managing the content and timing of the clinical encounter—is an essential component of successful family medicine.*

'I can't breathe!' said Sandy, a 56-year-old woman who came to our after-hours clinic during the pandemic lockdown. A patient with asthma, Sandy had recently been laid off from her job as a server. She was hungry, frightened and feared eviction. Despite normal respirations and blood oxygen, and no wheezing, this urgent visit was a pleading call for help from a patient who was suffering.

Reflection in action refers to continual self-awareness and other-awareness while in the midst of ongoing practice.[1] For busy family physicians, the capacity to develop this moment-by-moment awareness is crucial.

The goal of reflection is to modify and refine behaviour in real time to improve clinical outcomes, build the patient–doctor relationship, and enhance physician well-being and joy in practice.[2] Thus, reflection in action results in continual refinement and adjustment of attitudes and behaviours, tailoring these to the clinical situation as it emerges from moment to moment. To use the word of the Brazilian educator and philosopher Paolo Freire, what results is 'praxis'—action informed by reflection rather than automaticity.[3]

Family physicians can enhance their reflection-in-action skills by practising the following (figure 1):

- Set an intention to care for patients as if they are the most important person in the world.
- Maintain awareness of the patient's affect, words and non-verbal communications throughout the visit.
- Note personal thoughts, emotional reactions and physical responses.
- Check for assumptions, biases and premature closures, even when feeling pressured to conclude visits and move on to other demands.
- Manage the flow of the visit to elicit patients' concerns and perspectives, collect essential information, conduct

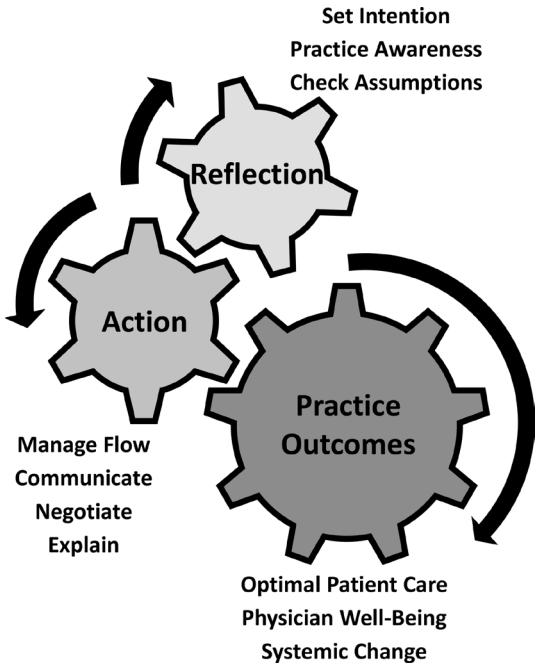

Figure 1 Reflection in action in clinical encounters.

appropriate examinations, manage time and attend to other essential tasks.

- Assess, discern, negotiate and explain what you recommend for patients, noting context, resources and circumstances beyond the patient's or your control.

In learning how to reflect while doing, it is important to recognise that the emotions patients and physicians experience can both enhance or detract from clinical encounters. The goal is not to ignore the patients' emotions nor suppress one's own feelings. Rather, by recognising, acknowledging and being curious about the emotional currents in the exam room—all the while not identifying too strongly with them—physicians can soften and settle negative emotions to open space and promote expressions of empathy and compassion.

Through reflection in action, family physicians can learn to act on values to serve patients' needs. They can also learn to acknowledge frustrations and moral distress resulting from the gaps between the patients' needs, professional convictions, available resources and dominant institutional norms. The clarity and perspectives gained from reflection in action enable family physicians to become coaches, advocates and change agents. Family physicians can practice reflection in action to provide the best care for all patients and to transform healthcare to become more just and equitable.

In the case of Sandy, reflection in action facilitated acknowledgement of her very real fears and anxieties. Reassured that her breathing was normal, she received information to access local food banks, rent support and social services. Her urgent appointment was a step towards continuity and follow-up visits to address health maintenance and provide support.

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THE DOCTOR AS DRUG—BALINT GROUPS

Jéssica Leão and Don Nease

Balint groups—peer-led group discussions that review emotionally challenging encounters with patients—can enhance clinicians' abilities to nurture their therapeutic relationships with patients.

One of the main ways to enrich clinician–patient relationships is through Balint groups, named after Michael and Enid Balint.[4] Michael trained and practised psychiatry in Hungary prior to immigrating to the UK just before World War II. Enid was trained in the UK as a social worker with a keen eye for assessing group dynamics and interpersonal relationships. On Michael's arrival at London's Tavistock Clinic, both worked to raise awareness of the therapeutic importance of the doctor–patient relationship in the generalist practice of medicine.

The Balints sought to use a group-based case discussion format as a crucible to reproduce the forces at work in relationships between generalist doctors and their patients (figure 2).[5] The structure was basic: a general practitioner (GP) would present a troubling case, and the other doctors in the group shared their respective perspectives on concerns of relational interest. There was little focus on the medical aspects of the case.[6]

What emerged during these group sessions was the recognition that the main therapeutic agent GPs used in their interactions with patients was none other than themselves—doctors. The main 'drug' employed by GPs, especially in challenging encounters, was the manner by which they attended to their patients' expressed problems. The key goals of Balint groups were thus to help the

Figure 2 Balint group structure. Adapted with permission.[5]

physicians in attendance (1) recognise the healing value of their relationships with patients; (2) develop a commitment to hone their relational skills as a therapeutic tool; (3) accept that, as with all medical treatments, there are risks and benefits to any intervention (including relational ones) and (4) work to minimise side effects and maximise the effectiveness of their relational interactions with patients.[7]

Balint groups are still, for the most part, run in the same fashion as started by the Balints.[8] A clinician presents a bothersome patient case—in reality, a bothersome patient relationship—to their peers in the group. Groups meet regularly, and one or two group leaders guide the ensuing discussion, encouraging group members to articulate emotional responses to the case presentation. As trust develops between group members, often deeply intimate aspects of human concern emerge. Much of the work of such groups is intrapersonal in nature—physicians organically learn more about their own emotional intelligence and relational agency through dynamic group reflection in a supportive environment.

Traditionally, medical education reduces the patient in question to the study of disease and promotes distance between doctors and patients. Thus, doctors often fail to recognise the importance of relationships to the therapeutic process. Few see themselves as potential agents of healing.

In that one key element of family medicine is its focus on clinician–patient relationships, however, Balint groups can help.[9] They can help family doctors develop ways to deal with the feelings that challenging encounters with patients can stimulate.[10] They also help promote empathy and lessen the risk of burn-out.[11 12] Most important, they are one way for family physicians to reconnect with their own personal therapeutic power and bring that power to their encounters with patients.

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CULTIVATING COMPASSION

Bill Ventres, Liz Grant, Stewart Mercer and John Gillies

To show compassion—a cognitive and emotional act—one must recognise distress in others and feel moved to validate and reduce this suffering. Compassion is an important therapeutic skill when working with patients; physicians should work to cultivate self-compassion as well.

Compassion is an important therapeutic skill, yet the experience and expression of compassion remain one of those 'I know it when I see it' concepts. Patients can sense when their clinicians are genuinely compassionate and when they are not.

Psychologically, being compassionate in medicine means (1) understanding the connections between illness and suffering and (2) recognising suffering in individual patients and, collectively, in communities; it also means holding uncomfortable feelings while working to alleviate suffering.[13] Practically, being compassionate means approaching patient encounters with virtuous intent, a willingness to listen to patients' stories in an attempt to fathom their experiences, and a readiness to forge healing alliances to help ameliorate suffering.[14]

Many words touch on key elements of compassion. Care, empathy, respect, kindness and consideration are but a few, and scholars of medicine and the humanities have dedicated significant effort to tease out the essential features of these elements.[15] They have also worked to transform the idea of compassion into practical applications; several models of compassionate behaviour have emerged from these efforts.[16]

Here, we approach compassion differently. We focus on the need to cultivate compassion within the community of medical professionals. We believe that although words and applications are important to learn and apply, family physicians and other clinicians are more likely to express compassion authentically by attending to several personal building blocks[17]:

- **Notice what is happening**—It is often easier to focus on the strictly biomedical aspects of medical work, isolating it from the other aspects of patients' lives; be curious and open-minded vis-à-vis patients.
- **Accept the power of emotions**—Feelings inevitably shape how patients experience illness and often influence whether patients participate in healthy decision-making; acknowledge this fact.
- **Cherish feelings of empathy**—Traditionally, physicians have been taught to remain emotionally neutral in respect to patients; accepting their own human nature and the emotions that go along with that recognition can help physicians engage with patients as appropriate.
- **Dare to act with kindness**—Create opportunities to build and grow thoughtful kindheartedness towards patients, families, colleagues and others.
- **Risk receiving compassion in return**—No one works in isolation; rise above challenges with the help of others and reciprocally help others rise above their own challenges.

The experience and expression of compassion reflect a mixture of knowledge, attitudes, skills, intentions and relational attributes (figure 3). Compassion is a learnt belief, not an automatic response. It is a wish to be helpful that involves a process of discernment and reasoning.[18] It is a learnt habit that physicians are compelled to provide.[19] Compassion is therapeutic for both patients and practitioners; it enhances trust, improves medical outcomes and increases clinicians' joy of practice.[20]

Community	C	Seek out caring colleagues
Openness	O	Listen first before judging
Mindfulness	M	Reflect on the moment at hand
Perspective	P	Consider implicit/institutional biases
Accompaniment	A	Practise *with* patients
Self-Awareness	S	Grow in self-knowledge/awareness
Systems	S	Advocate for collective well-being
Inquisitiveness	I	Develop interest in patients' lives
Organisation	O	Promote cultures of compassion
Nurturance	N	Engage in life-long learning

Figure 3 A framework for cultivating compassion.

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TOWARDS A HUMANISTIC APPROACH TO DOCTORING

Pablo González Blasco, Maria De Benedetto, Graziela Moreto and Marcelo Levites

Engaging a humanistic outlook is key to caring for patients in family medicine. The humanities offer a means to cultivate this outlook.

Guidelines, outcomes and clinical trials are at the forefront of medical training and practice. Objective knowledge is considered scientific, and valuable emerging technologies often monopolise students' learning efforts and practitioners' clinical attentions. Subjective information—key to a humanistic approach to doctoring—is regularly thought to be soft and second-rate; however, the idea that subjective information is of lesser value is not only false but also an impediment to relieving suffering and promoting health.[21] Doctors exist to care for patients.

This care clearly includes the ability to collect informative histories, perform thorough physical examinations, choose and interpret suitable diagnostic studies, apply technical knowledge in search of appropriate treatments and adeptly perform necessary procedures. However, caring for patients also implies that clinicians appreciate the people they serve and work to understand the human condition, including the effects of such circumstances as sickness, suffering and—ultimately—death, as well as those of recovery and renewal.

Especially important for family physicians and other generalist clinicians, the humanities help doctors cultivate humanistic approaches to caring for patients.[22] The humanities provide a source of insight and understanding, enabling doctors to understand patients in the context of their lived experiences. Rather than just an appendage to medical knowledge and the application of clinical skills, the humanities are necessary instruments in the therapeutic toolbox of proper doctoring. Without the humanities and the humanistic spirit they engender, doctors would simply act as mechanics trained to fix patients' immediate presenting problems and not as the compassionate professionals patients hope for.

Integrating the humanities into family medicine education and practice can take many forms. Literature, theatre, poetry, opera, movies and even music can help promote consideration of personal values in the face of life's challenges.[23–26] Stories—personal narratives—can serve as launching points for emotionally rich discussions and ethical reasoning.[27] Art, in all its sensory forms, can stimulate both emotion and imagination, which through reflection and dialogue can in turn sharpen awareness, enhance empathy, and facilitate a constructive approach to uniting the affective and cognitive facets of patient care into one wise therapeutic process—plain doctoring,[28] the generalist practice of family medicine.

Family medicine is an art that recognises the uniqueness of each patient: it considers pathology and the way in which pathology is experienced by any one person. Such a practice necessitates uniting a humanistically informed approach to patient concerns with the traditional biomedical, disease-oriented approach. By incorporating the humanities, family physicians can provide person-centred medicine, an elegant exercise that merges science and art in service of holistic care (figure 4).

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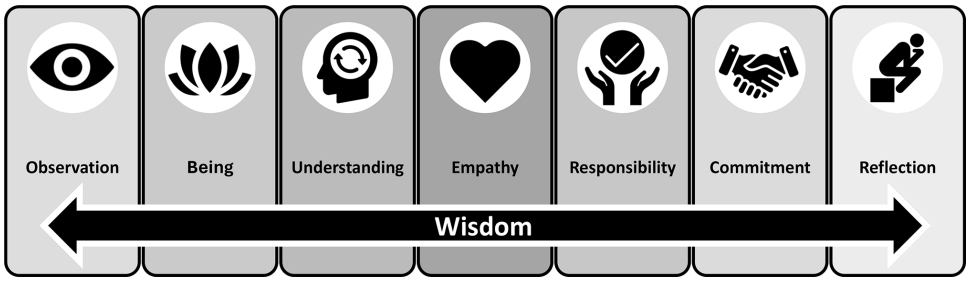

Figure 4 What the humanities teach doctors.

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INTIMACY IN FAMILY MEDICINE

Jen DeVoe

The work of family medicine is often an intimate one. Why? Because working with patients means a closeness of spirit, hope and—inevitably—loss.

A few weeks into the COVID-19 pandemic, I logged into a virtual visit with my 80-year-old patient Henry. He was to see me for a preventive health visit following a gruelling but successful 18-month battle with lymphoma. His cancer was in remission.

I expected our conversation to be one of celebration. Instead, I learned his wife of 61 years was dying of pancreatic cancer. I did not know what to say. After fumbling my way through a few condolences, I managed to ask Henry how he was doing. After a long pause, he responded.

'My wife is dying right before my eyes, and I can't do a damn thing about it.'

I learned that Henry's wife had recently entered hospice and that all her care was virtual; no one was visiting due to COVID precautions. I recommended we schedule routine calls for blood pressure monitoring; these calls would give me a chance to talk with him regularly.

At our next call, after briefly chatting about his blood pressure, I again asked, 'How are you doing?'

Barely audible, he stammered, 'I can't live without her. My heart is broken.'

Henry and I had a few more calls during his wife's last weeks of life, and then she was gone. When he called to inform me, I could hear in his voice that it was the beginning of the end for him.

I recommended we continue our follow-up calls, mostly so I could offer Henry grief support. He declined all other services. When it was safe to return to in-person visits, I saw Henry in clinic. We hugged, and he whispered in my ear, 'Thank you, Dr. DeVoe. That is the first human contact I've had in six months.'

Soon after, Henry started falling, alone at home, late at night. Many mornings, upon opening my electronic medical record, I saw his name on my list of patients on our hospital service, for lacerations, broken ribs, and compression fractures. Our routine clinic visits became regular hospital visits.

When I recommended that Henry consider moving to an assisted living facility, he politely told me he would never leave his home—a move would dishonour the memory of his wife. Our team scheduled home health services and strategized on ways to offer support. Eventually, a home health nurse informed me he had died at home.

When his death certificate arrived in my mailbox, I paused before writing 'undetermined cause of death' in the appropriate space. What did I really want to write? 'Cause of death: broken heart.'

Every time a patient dies, a jumble of emotions fills my mind and my soul. I am grateful to have had the privilege of being the personal physician to these patients, now deceased. I also often struggle. Did I achieve the right balance between working to keep patients alive and helping them die with grace and dignity? Such is the nature of my work in family medicine. Sharing professional intimacy with patients opens the door to many joys; there also exist the inevitable challenges inherent to any close relationship (figure 5).

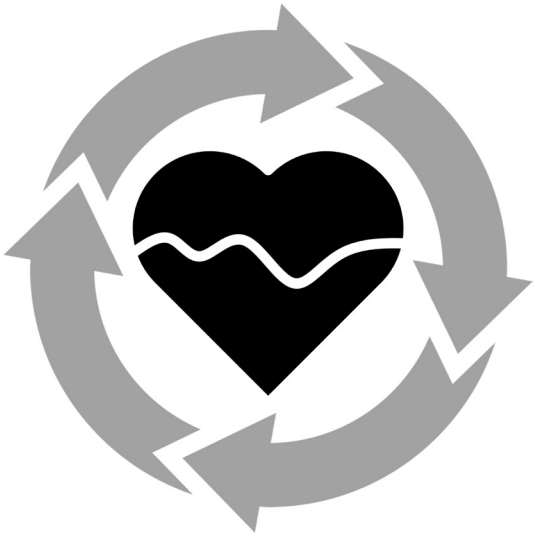

Figure 5 Intimacy: human caring made 'real'.

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THE MANY FACES OF SUFFERING

Bill Phillips, Jane Uygur and Tom Egnew

> *'Healthcare is more about love than about most other things. It is built on the relationship between physician and patient, one in which the physician works to relieve the suffering of the patient.*[29]*—Donald Berwick, US paediatrician and healthcare consultant*

Patients experience suffering when they perceive a threat to their integrity as whole persons. When illness threatens the body, mind or spirit, it is the physician's duty to identify, manage and relieve suffering.[30] As doctors, we see suffering in the faces of our patients and hope to understand the experience of illness in their lives. Through our quest to know disease, understand people and comprehend health, we work towards finding a way to relieve suffering.

Patients suffer because of medical problems or treatments, as illuminated by patient narratives, research in a variety of specialties, and the insights of nurses, social workers, mental health professionals, and others on our caring teams. As comprehensive physicians, family doctors traverse whole landscapes of human health and illness and see patients and their suffering in the full context of their lives: work, families and communities. We walk with patients through their days, seeing suffering across problems, through time and over the span of human life.

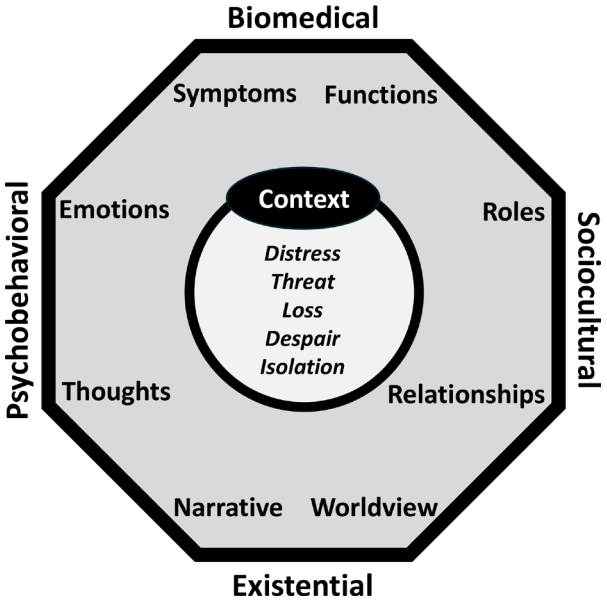

Figure 6 Comprehensive clinical model of suffering. Copyright 2021 WR Phillips, TR Egnew, JM Uygur. Adapted with permission.[33]

Thus, the perspective of family medicine is a natural foundation for navigating the breadth and depth of suffering. The biopsychosocial model is the map of the territory of health, illness and suffering.[31] Patient-centred care is the compass to find the way into—and perhaps out of—each patient's personal experience of sickness and suffering.[32]

We suggest family physicians use a *comprehensive clinical model of suffering* to translate this multidimensional perspective into clinical action reflecting multigenerational experience, cross-specialty responsibility and interdisciplinary synthesis (figure 6).[33]

At the core of this model, we see that suffering arises when illness and distress threaten loss. Loss—or fear of loss—can lead to despair and isolation. Physicians must first identify signs of distress and recognise patients' suffering. This requires the skills, time and care to observe and see, to listen and hear. Every patient is unique, illness is complex and suffering is personal.

Suffering can manifest in any or multiple domains of life. It can arise from (1) troubling symptoms, (2) loss of function, threats to (3) roles and (4) relationships, distressing (5) thoughts and (6) emotions, (7) disruptions to the narratives of patients' life stories and (8) conflicts with patients' spiritual or intellectual worldviews. These eight domains of suffering can be organised for clinical care, teaching and research on four axes: biomedical, sociocultural, psychobehavioural and existential.

This comprehensive model helps organise the inquiry. It serves the clinician as a ROS—not a 'review of systems' but a deeper 'review of suffering.' Our goal is to see patients' particular views of illness and to understand their unique experiences in the full context of their lives. To help heal, we need to comprehend how their sense of wholeness as a person is threatened.

The chief aim of medicine is to alleviate suffering. By recognising the patients' suffering, we can offer care and hope. Sometimes it can be hope for a cure—always it is hope for control of symptoms, relief of distress and emotional support. By understanding suffering, we can better help patients rediscover meaning, gain acceptance and reconstitute wholeness.[33]

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TRANSCENDING SUFFERING

Tom Egnew and Bill Phillips

By recognising and addressing the existential challenges of chronic, serious, or terminal illness, physicians can help patients find meaning, transcend their suffering and achieve holistic healing.

Family physicians provide comprehensive healthcare for patients from cradle to grave. Most patient encounters involve little or no overt suffering. With self-limited or curable disease, the patient recovers and resumes their journey on the road of life. With more serious, chronic or terminal illnesses, greater distress and disability challenge the patient's sense of integrity as a person. Losses mount, personhood is threatened and suffering deepens.

Illness is a personal passage from the realm of health into the regions of sickness. Suffering arises when a person believes that they can no longer be the person they have known themself to be. Suffering evolves not only from biophysical changes but also from threats to any aspect of personhood, including the psychological, social, vocational and spiritual. It is rooted in the meaning a person ascribes to such changes. Suffering reflects existential challenge, interpreted through the patient's narrative and personal story of brokenness.

Medicine's foundational goals are to cure when possible, comfort always, relieve suffering and heal patients. Most biomedical discussions of healing focus on tissue repair and the diagnosis, treatment and cure of disease. Illness is more than disease, understanding is more than diagnosis and care is more than treatment. Holistic healing is more than repairing tissues and curing disorders.

Holistic healing can be defined as the personal experience of the transcendence of suffering.[34] Transcendence occurs when patients discover meaning in or come to accept their changed circumstances. When patients find meaning and acceptance in their experience, transcendence of suffering can lead to holistic healing despite incurable disease, debilitating impairment or impending death.

While patients must find healing themselves, physicians can assist them along their paths. Doctors can turn towards the patient's suffering, listen attentively to their struggles and help them refocus and reclaim that which brings meaning and purpose in their lives.[35] This requires mindful management of one's own anxiety, willingness to share some of the patient's distress and courage to control the interventional imperative inherent in the culture of medicine.

As trusted and empathetic witnesses, physicians can ease some of the isolation of suffering and foster hope. Sharing a history of continuous, comprehensive care steeped in deep contextual knowledge empowers family physicians to help patients navigate their experiences of illness. Using narrative medicine skills, they can guide dialogue to assist patients in editing their stories, perceiving new meaning in life, finding acceptance and reconstituting a sense of wholeness.[36]

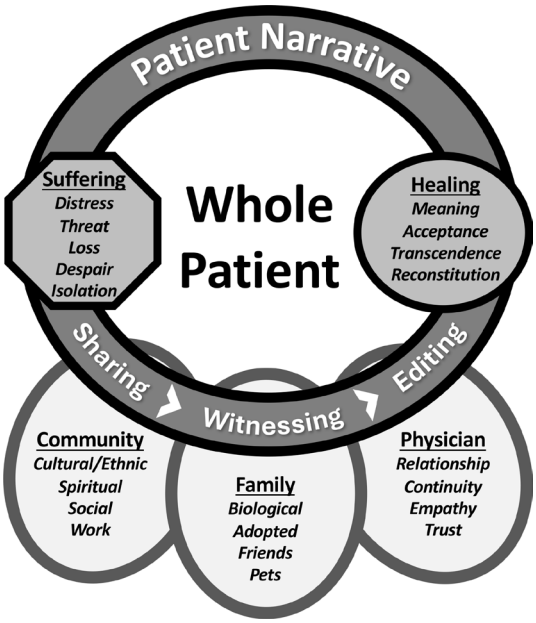

Figure 7 Healing suffering through whole patient care. Copyright 2024 TR Egnew and WR Phillips.

In caring for patients across the lifespan, family physicians engage the full spectrum of illness, loss, crisis and death. These transitions create existential challenges in patients' lives and new challenges for their caregivers and loved ones. Comprehensive care calls family physicians to recognise suffering, manage effective responses to patients' needs and contribute to healing.

Caring for patients in this way can be challenging. Yet physicians who explore patients' experiences of serious illness and help them edit their stories of brokenness often discover this care to be some of the most fulfilling work of their careers (figure 7).

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THE POWER OF LISTENING TO STORIES

Colette Stanley

Family medicine is built on stories. Our visits with patients create the foundation on which these narratives are built.

Patients share their histories with us, those of present concerns and past experiences: these are the stories of their lives. Throughout our training we, as family physicians, hone our abilities to listen to these stories, retell them during rounds and rewrite them in our notes. These stories are truly why we are family physicians.

Figure 8 Stories as meaning and purpose in practice.

I became a family doctor because I reveled in the idea of walking with someone through various stages of their life. For me, there is nothing more rewarding than caring for a woman during her pregnancy, delivering her baby, and sharing the joy as that baby achieves all their milestones over time. At the other end of life's spectrum, it is an honor to care for someone through health and sickness, helping them find comfort as they face their mortality. Becoming an integral part of patients' life stories is a gift to be treasured.

Sometimes the stories we hear are heavy burdens carried from room to room as we navigate our days. I once sat with a patient during a prenatal visit, listening to her tell me that she hadn't felt her baby move in a few days. My worst fears of fetal demise were confirmed on an in-office ultrasound. After sending her off to Labor & Delivery via ambulance, I walked into my next patient's room. He was a 70-year-old man who smiled at me as I walked in, eager to show me his improved blood sugars over the last month. The emotional roller coaster can be overwhelming at times.

Our jobs are difficult, but often also rewarding in the most surprising ways. Making the right diagnosis is great for my ego, but it's the relationship-building that keeps a lasting smile on my face day after day. On a particularly challenging day in clinic, I walked into my two year old's well child check-up. He was pulling at everything he could reach in the room as mom attempted to reel him in. My laptop seemed to catch his eye as I sat down while mom told me about plans for his upcoming birthday party. The little guy walked over and motioned to be picked up. I sat him on my lap as mom repeatedly apologized. Little did she know, this was the highlight of my day.

There is much that sidetracks us from our core family medicine values, creating for us a version of mission impossible: insurance companies, rising costs of vital medications, RVUs (relative value units, measures of clinical productivity) and never-ending piles of paperwork are all contributing agents. To re-centre ourselves amid these distractions, we need to find ways to stay true to our purpose—reconnecting with why we embarked on this mission in the first place. Listening to and relating stories are what keep me grounded (figure 8).

Hearing and recounting these narratives serve to release the emotions I do not usually get to process as I am hustling from patient to patient, bearing witness to people's suffering and joy. It's a therapeutic process that keeps me rooted in my 'why'—my purpose in practice—a constant reminder of who the lead characters really are in my own professional story: my patients.

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