2024 Fall 8-15-2024 FINAL

HCB501 Compassionate Care, Medical Humanities, and the Illness Experience

Instructors: Stephen G. Post, PhD & Jeffrey Trilling MD (with Maria Basile MD & Krisha Mehta)

Semester: Fall 2024

Schedule: Mondays, 6-8:30 pm

Location: FPPM Conference room 067

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COMPASSIONATE CARE, MEDICAL HUMANITIES & THE ILLNESS EXPERIENCE

The care of the patient is both a science and an art. It is on the one hand the competent application of science and the mastery of technical skills; on the other hand, it is the art of being attentively present to the patient in the subjective meaning of their illness experience. In general, being present to the patient facilitates their well-being, security, adherence, and healing itself. *Kindness* is a relatively uncomplicated mode of acknowledging patients, and is close to what Dr. Trilling means by "gentle curiosity" in his book *The Circle of Change: Beyond Technology's Reach.* More complex than kindness is *cognitive empathy,* which requires attentive listening and understanding, and a willingness to reflect back to the patients for accuracy. *Affective empathy* includes *cognitive empathy* but adds an emotional presence that patients usually pick up on. *Compassion* is *cognitive and affective empathy* in the context of suffering and accompanied by the will or intention to alleviate said suffering.

Of course, this begs the question of what suffering is, who is suffering, and how to detect it across various illnesses? We will consider the ways in which compassionate care (along with kindness and empathy) can be manifested and expressed clinically, as well as passed on to colleagues and students. Is compassionate care less something taught didactically than it is transmitted in community and through role models and narratives of illness experience. But there can also be "compassion tool kits" that teach specific practices and techniques.

Big Questions: Are some people more compassionate than others by nature and/or nurture? How do role modeling and narrative fit into this process? Where does the classical idea of the "wounded healer" enter in? How can certain practices, including mindfulness, help with becoming a compassionate healer? How do empathy and compassion influence patient outcomes, such as adherence to treatment in cases of chronic illness, or even biochemically? How does compassionate practice contribute to clinician meaning, well-being, and resilience? What is the fate of compassionate care in today's healthcare culture/system, especially with the advent of AI? What is "moral injury"?

READINGS

Required Inexpensive Paperback Books

(Purchase on Amazon)
Jerome Groopman, MD. *The Anatomy of Hope: How People Prevail in the Face of Illness.* New York: Random House, 2005.

Paul Kalanithi, *When Breath Becomes Air*, "Foreword" by Abraham Verghese. New York: Random House (2016).

Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023.

All assigned articles will be provided in a weekly email from the instructors as attachments.

Recommended
Arthur Kleinman. *The Illness Narratives: Suffering, Healing & The Human Condition.* Basic Books, 1988.

BIG QUESTIONS **Big Questions for each class**

Students will bring to class each session one thoughtful Big Question, written out in one careful sentence. Please have your Big Question ready to read during small group class discussions. We will not be collecting these but be ready if called upon.

2024 COURSE OUTLINE (Mondays)

August 26, 2024
Instructor SGPost; Facilitators: Post/Trilling
Topic 1: Thinking About "Disease," "Illness," and "Suffering"? What is Suffering? How Do We Diagnosis It? How do we treat suffering?

Compassion is affective empathy that includes at least an intention to alleviate suffering. Eric J. Cassell MD (d 2021) was the foremost physician writer on illness and suffering in the last half century. His book *The Nature of Suffering and the Goals of Medicine* is considered a classic. Cassell suggests that "disease is something an organ has; illness is something a person has." He maintains that the goal of modern medicine must be to treat the individual's suffering and overall well-being, and not just the disease. Cassell's views on suffering are close to canonical in medicine today, as he advanced a subjective view of suffering, in which the beliefs and perceptions of the person experiencing the disease are paramount. Suffering and illness revolves around big questions: What has happened? Why has it happened? Why me? Why now? What does it mean? What do I fear most? What are my hopes? How can I be resilient? What about my core relationships?

Is everyone suffering all the time, to some extent, as the Buddha and various others (including western philosophers) have argued? Is anxiety a form of suffering? What is the opposite of suffering? Drawing on the two articles by Cassell below, try to come up with your definition of suffering and how you might manage it in patients.

Before Class Video:
https://www.youtube.com/watch?v=cDDWvj_q-o8
(Empathy: The Human Connection to Patient Care)

Readings:
Norman Cousins, "Anatomy of an Illness (As Perceived by the Patient)." *The New England Journal of Medicine,* Vol. 295(26), 1976, pp. 1458-1463.

Eric J. Cassell, "Diagnosing Suffering," *Annals of Internal Medicine*, Vol. 131, 1999, pp. 531-534.

Eric J. Cassell, "Illness and Disease," *The Hastings Center Report*, Vol. 6(2), 1976, pp. 27-37.

Questions about suffering and assisted suicide: Do you think that someone with ALS suffers "enough" to qualify for pre-emptive assisted suicide? Someone with a progressive dementia such as Alzheimer's disease who does not want to deteriorate? A mother who is deeply and seemingly intractably grieving over the loss of a child? A man who is deeply saddened after a leg amputation? A late teen who does not wish to go through any more chemo? Someone who is intractably and deeply depressed? How do you diagnose suffering? How do you ask about it with different patients?

September 2 (Labor Day) NO CLASS
Read independently *When Breath Becomes Air,* a best-seller in 2016. The words jump right off the page. It seems to touch everyone who reads it. Pay special attention to themes of suffering, resilience, love, hope, meaning, grit, and the like. Come to class on September 9 with some ideas about these virtues in the author's illness narrative. Also, what does this book tell you about *success* in life? What does the book say to you about meeting life's struggles?

Readings:
Read Paul Kalanithi's, *When Breath Becomes Air*. New York: Random House (2016).

September 9 Facilitators: Post/Trilling/Basile
Topic 2: Hope: Drawing on *When Breath Becomes Air*
What is hope? Hope is variously defined, but seems to pertain to a confidence in future events and circumstances. What are the characteristics of hope? Is it different than optimism? What is it and how does it impact health, well-being, and even the will to live? How do patients gain, sustain, or lose hope? Where does it come from? Is hope different

under different conditions of illness? Is hope rooted in community, spirituality, evolved cognitive structures, environment, past experience, etc.?

Should physicians cultivate hope in their patients? If so, how so? What is the relationship between hope and truth telling? Is there a biology of hope and of despair that impacts health outcomes? How does "hope" play out in the contexts of patients with dementia and their families? How does it play out in individuals with severe spinal cord injuries? Patients with metastatic cancer? How can you as a physician respect the dynamic of hope in patients, and why is this important?

Hope for a patient is about the uncertain expectations around which they constitute their lives in time of serious diagnosis or illness. It is a passion for the possible and a way of staying afloat in uncertain times. Hope is deemed a virtue in hard times, while optimism is perhaps a dispositional quality, although these are discussable distinctions. The opposite of hope is despair – an unhappy resignation, an admission of defeat, a giving up of expectations. The skilled clinician must handle hope empathically, and be able to help shift patient and family hopes from one goal to another, for in a general sense, there is always hope if we see it.

September 16
Topic 3: Empathic Virtues: Humility, Kindness, Empathic Care (Cognitive & Affective), Compassionate Care

Facilitators: Post/Trilling/Basile
Readings:
S.G. Post, L.E. Ng, J.E. Fischel, L. Bily, et al., "Routine, Empathic and Compassionate Patient Care: Definitions, Developmental Levels, Educational Goals, and Beneficiaries," *20th Anniversary Issue of the Journal of Evaluation in Clinical Practice: International Journal of Public Health Policy and Health Services Research,* Vol. 20(6), 2014, pp. 872-880.

John L. Coulehan, "On Humility," *Annals of Internal Medicine*, Vol. 153(3), 2010, pp. 2000-2001 (Is humility the mother of all virtues?)

John L. Coulehan, Frederic W. Platt, Barry Egener, Richard Frankel, Chen-Tan Lin, Beth Lown, William H. Salazar, "'Let Me See If I Have This Right…': Words That Help Build Empathy," *Annals of Internal Medicine*, Vol. 135(3), 2001, pp. 221-227.

Auston Hake, "Kindness: Definitions and a Pilot Study for the Development of a Kindness Scale in Healthcare," *PLOS ONE* Vol. 18, No. 7, e0288766. https://doi.org/10.137/journal.pone.0288766

SG Post, M Basile, R Iuli, P Migdal, JS Trilling, A Wackett, L Strano-Paul, "Professional Identity Formation: A Tripartite Taxonomy of Character Strengths & Virtues in Physicians and Medical Students," (in submission)

(Due Sept 23rd: Reflection Essay # 1 Due (20%) 4 to 5-page essay on When Breath Becomes Air with an emphasis on illness in relation to suffering, hope, and resilience. Email attachments are fine.)

September 23
Topic 4: Illness and the Wounded Healer
Facilitators: Post/Trilling

Sometimes healthcare professionals only realize the importance of healing relationships when they themselves become ill and are suddenly wearing the shoes of a patient. The psychoanalyst Carl Jung referred to the "wounded healer" who, through his or her own illness experience, can heal others through increased empathy. Very few ideas are new ideas. Prior to Jung, the ancient Roman philosopher Seneca wrote, "The wounded doctor heals best." Falling ill and seeing the other side of the coin can be tremendously instructive and transforming. Perhaps it is the "wounded healer" who can most be trusted to carve out time in daily practice in which connection and personal care receive their rightful place of honor. Yet, the conceptual advantage of a "wounded healer" is somewhat controversial, especially in psychiatry. (The shaman in historical and global perspectives is always someone who has suffered from illness and recovered, and therefore plays the role of the 'wounded healer.")

How comfortable would you be introducing your own illness experience (wounds) into your conversations with patients, if at all? Pitfalls and advantages of doing so?

An excellent account of compassionate transformation comes from a book entitled *A Taste of My Own Medicine*, written by Ed Rosenbaum about Jack MacKee, MD. The author, a successful surgeon whose bedside manner is unkind, arrogant, and discourteous. He is too busy to show personal concern toward his patients or family. One night he coughed blood and was soon diagnosed with throat cancer. During protracted treatment, he befriends June Ellis, a fellow cancer patient who eventually dies. Jack's cancer is cured, but the experience transforms his practice as he begins to teach medical interns the importance of compassion and personal concern for patients in making them better doctors. We will discuss segments of *The Doctor*, a movie based on MacKee's book.

Before Class Video:
Watch "The Doctor" starring William Hurt (try any on-line venue)

Readings:

R. Klitzman, "Improving Education on Doctor-Patient Relationships and Communication: Lessons from Doctors Who Become Patients," *Academic Medicine*, Vol. 81, No. 5, 2005, pp. 447-453.

Katie Lynch, "Consideration for the Wounded Healer" (unpublished essay, 2015)

M.E. Pagano, S.G. Post, S.M. Johnson, "Alcoholics Anonymous-Related Helping and the Helper Therapy Principle," *Alcoholism Treatment Quarterly,* Vol. 29, No. 1, 2011, pp. 23-34.

September 30, 2024
Topic 5: More on Hope in Clinical Ethics
Facilitator: Post/Trilling

Any caring professional must be a minister to hope. From the early 19th century American Codes of Medical Ethics have emphasized the physician's responsibility to sustain hope in patients. This is a perennial aspect of the "art of medicine." Thomas Percival famously described the physician as "minister of hope and comfort to the sick." How can professionals respect the dynamic of hope in patients? Harvard hematologist-oncologist Jerome Groopman, in his *The Anatomy of Hope* (2004), writes that hope is "the elevated feeling we experience when we see – in the mind's eye – a path to a better future. Hope acknowledges the significant obstacles and pitfalls along the path. True hope has no room for delusion" (p. xvi). Without endorsing the exaggerated popular literature on hope and healing, Groopman notes that belief and expectation, two aspects of hope, are fundamental to the placebo effect, and activate brain circuits that release endorphins (natural opiates) and dopamine (a feelgood chemical). A careful assessment of the existing research compels Groopman to conclude, "Hope, I have come to believe, is as vital to our lives as the very oxygen that we breathe" (p. 208). Current researchers focus on the neurobiology of optimism, psychological resilience, physical health and optimism, and the promotion of optimism and hope. Significant NIH-funded investigations link hope to longevity, enhanced wound healing, stress reduction, dopamine release, and endorphin release. Hope for patients is about the uncertain expectations around which they constitute their lives in time of serious diagnosis or illness. The skilled clinician must handle patient hope empathically, and be able to redirect hope from one goal to another – e.g., from cure of cancer to the comfort care of hospice, from an earlier vision of a flourishing life to a modified vision, etc.

Skilled healers, aware of how the emotion of hope can make or break a patient, must be builders of hope, even while facilitating a shift in patient goals.

Questions (focused on Groopman)
**Is there such a thing as false hope in patients?*
**Where does patient hope come from? Individual experience, special relationships, communities, spiritualities, religion, the physician?*
**Is it justifiable to disclose diagnosis, but not a clear prognosis, in order to sustain hope?*
**What is the difference between optimism and hope?*
**Does a state of hopelessness have any bearing on respect for decisional capacity?*
**Do surgeons prefer toe operate on hopeful patients? If so, why?*

Pre-class Video (6 minutes):
https://www.youtube.com/watch?v=5FWn4JB2YLU

Readings
Jerome Groopman, MD, *The Anatomy of Hope: How People Prevail in the Face of Illness*

October 7
Topic 6: The Art and Science of Compassionate Care
Facilitator: Trilling/Krisha Mehta MD

Krisha Mehta MD *Stony Brook Class of 2022 (Yr. 3 Resident, Internal Medicine, Stony Brook Medicine; Certificate from Stanford Program)*

"In the midst of hate, I found there was, within me, an invincible love.
In the midst of tears, I found there was within me, an invincible smile.
In the midst of chaos, I found there was within me an invincible calm.
I realized, through it all, that in the midst of winter, I found there was,
within me, an invincible summer. For it says that no matter how hard the
world pushed against me, within me, there's something stronger – something
better, pushing right back."
~Albert Camus

The World Health Organization has designated "compassionate care" as a goal of all medical education, and the AAMC has stressed this as a goal of US medical schools (*Kindness in the Curriculum* AAMC News, Sept. 18, 2018 https://www.aamc.org/news-insights/kindness-curriculum). The National Health Service in the UK published *Intelligent Kindness: Reforming the Culture of Healthcare* (2014) because both staff and patients felt a loss of human connection. Morale within the NHS had never been so low, they state. The NHS sees a solution in restoring its core founding principles - *kindness and compassion within a service that functions for the common good.* They argue that healthcare is more at risk now than ever from a deteriorating humanism, and assert that doctors must promote kindness and restore compassionate relationships between clinicians, across inter-professional teams, and with patients.

A 2011 U.S. survey looked at 800 recently hospitalized patients and 510 physicians; 85 percent of patients and 76 percent of physicians said that compassionate care is "very important" to positive outcomes (Lown, 2011). However, only 53 percent of patients and 58 percent of physicians reported that compassionate care was generally provided in the U.S. healthcare system (Lown, 2011). In a benchmark study of practicing clinicians, 87% of the 58% of physicians who report erosion in enthusiasm for medicine (58% of 2,608 surveyed nationally in the U.S. 20 years ago) attribute this loss to the inhibition of empathic care (Zuger, 2004). Increased clinicians' satisfaction with their relationships with patients reduces professional stress, burnout, substance abuse, and even suicide attempts (Shanafelt, 2009).

Revisiting Kindness, Empathy & Compassionate Care

What is kindness? Dr. Trilling refers to "gentle curiosity," and Austin Hake (MD Class of 2023) speaks of simple "kindness." This does not take much work. It can be as simple as, "Did you have a nice weekend?" We all know what it means when we could have been a little kinder, instead of dismissive (Hake 2023). Every doctor can be kind always. (Fitzgerald FT. Curiosity. *Ann Intern Med*. 1999;130(1):70-72.

What is compassionate care? Compassionate care is affective and cognitive empathy in response to suffering, and including at least the desire and willingness to alleviate suffering. Dr. Eric Cassell suggests that suffering involves "a specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted." He suggests that doctors ask patients directly, "Are you suffering?" "I know that you have pain, but are there things that are even worse than pain?" "Are you frightened by all this?"

Readings

Fitzgerald FT. Curiosity. *Ann Intern Med*. 1999;130(1):70-72. doi:10.7326/0003-4819-130-1-199901050-00015 or https://www.acpjournals.org/doi/pdf/10.7326/0003-4819-130-1-199901050-00015

Chochinov HM. Dignity and the Essence of Medicine: The A, B, C, and D of Dignity Conserving Care. *BMJ*. 2007;335(7612):184-187. doi:10.1136/bmj.39244.650926.47

Cultivating Compassion in Medicine: How Healthcare Professionals Can Build Compassion Toolkit

Krisha Mehta MD, SBM Class of 2022, Presenter

Okay, this is all pretty abstract and maybe useless. You need a tool kit, a how-to kit. About seven years back, then Year One med student Krisha Mehta, MD class of 2022 stopped by the office, fresh from her research study with the Tibetan refugees in India. Dr. Mehta will introduce herself, but her achievements are many and I hope you join her many research projects. FYI, SB was the first med school to include the term "compassionate care" in a center or department title, followed by Stanford, UC San Diego, and 25 others. The list is growing. Dr. Mehta has developed many research projects, attended and completed the Stanford course on Compassionate Care, and as a former student here always wanted to see more emphasis on "how to" (aka a "tool kit") hence why she built a class on teaching this toolkit to medical students. This is not something that we find in med, nursing or social work schools, although "child life specialists" and "doulas" go through extensive training, including the "verbatim exercises" that we need more of.

How can we train our minds to remember our shared humanity and maintain the same level of connectedness and understanding with all?

Objectives

- Use introspective exercises to distill the dynamics of human thought in order to understand patient motivation
- Reflect on the internal motivations of our behaviors and actions and use that introspection to be build an interconnectedness with others
- Understand how evidence-based resources can be used to build compassion toolkits for healthcare professionals
- Use practical tools that incorporate compassion to allow for effective communication with colleagues
- Cultivate resilience and well-being through the training of compassion

Readings

Weng HY, Lapate RC, Stodola DE, Rogers GM, Davidson RJ. Visual Attention to Suffering After Compassion Training Is Associated with Decreased Amygdala Responses. Front Psychol. 2018 May 22;9:771. https://doi.org/10.3389/fpsyg.2018.00771. PMID: 29872413; PMCID: PMC5972817.

Scarlet, J., Altmeyer, N., Knier, S. and Harpin, R.E. (2017), The Effects of Compassion Cultivation Training (CCT) on Health-Care Workers. Clin Psychol, 21: 116-124. https://aps.onlinelibrary.wiley.com/doi/full/10.1111/cp.12130

Fall Break Oct. 14

TRILLING ON BEING A GOOD IMPASSE DOCTOR

October 21
Topic 7: The Case of Ms. Forevermore – An introduction to Impasse, First-Order & Second-Order Change
Facilitator: Jeffrey Trilling (Session 1 of Circle of Change series)

Please view this TED Talk by Abraham Verghese MD

https://youtu.be/sxnlvwprf_c?si=l8MqAUx-eLUJWiHe

Educational Objectives

This session begins to address the relevance of the clinician-patient relationship within a meaning-centered model of illness, one in which *the experience and meanings of illness are at the center of clinical practice*. It introduces the importance of *context* (the circumstances in which a problem occurs), including the mistakes we make when context is ignored. Through stories , this section is an introduction to clinical impasse, inviting the reader to appraise the need for a contextual approach to primary care problem-solving. Additionally, it lays the groundwork for conceptualizing and applying principles of Systems Theory, such as “First” and “Second-Order Change”, to clinical situations.

At the conclusion of this session, you will have the information necessary to:

1. Define and understand "impasse" within the medical setting, distinguishing it from "conflict."
2. Be able to articulate some of the consequences that conflict and impasse may have on patients, clinicians, and society.
3. Define" context" and how understanding the context of disease may be helpful in prevention, diagnosis & management.
4. Define, understand, and explain the application of First and Second-Order Change
5. Critique my management of Ms. Forevermore's case from a straight-linear, biomedical standpoint – had I done my job?
6. Critique my management of Ms. Forevermore's case from a biopsychosocial standpoint – had I done my job?
7. Define and explain the need for and application of "Gentle Curiosity" in good doctoring.
8. Explain the nature of a meaning-centered model of illness.
9. Explain the nature of the biomedical model of medicine.

Readings

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read the Preface & Chapter 1 for class)
2. George L. Engel, "The Clinical Application of the Biopsychosocial Model," *American J of Psychiatry*, Vol. 137 (5), 1980, pp. 535-544.
3. https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:308fbc06-fea0-4c96-bedf-1f9e9cce5b42

October 28
Topic 8: The Significance of the Patient's Story
Facilitator: Jeffrey Trilling (Session 2 of Circle of Change series)

Educational Objectives:

Session Two highlights the significance of uncovering the patient's story (and the luggage they carry) in helping us understand how impasse and conflict occur. It is within the patient's narrative that one may find explanations to otherwise inexplicable behaviors such as non-adherence to treatment plans, aggressive attitudes, and resistance to change. Through narrative, this session makes a case for appreciating the human element in the practice of medicine, stressing that the clinician-patient relationship is not unidirectional. Clinicians may also have "stories" carried beneath the surface, laden with perceptual memories of negative impact that manifest behaviors that foster or maintain impasse and conflict. As such, self-awareness is not simply ornamental or a soft, curricular cake-topping, but a key aspect of good doctoring to be emphasized and taught.

At the conclusion of this session, you will have the information necessary to:

1. Appreciate the involvement of both patient's & clinician's individual stories (and the "luggage they carry") in the formation of clinical impasse & conflict.
2. Understand the difference between natural science and applied science.
3. Self-reflect on what feelings arise within you when someone does not follow your advice.
4. Self-reflect on how far you should push when your advice is not followed.
5. Be acquainted with the clinician-patient relationship and its variations.
6. Appreciate, understand, and be able to articulate how differences between clinician style and patient expectations can be a source of clinical impasse.
7. Self-reflect on what your own natural tendencies are towards clinician style, and the response you might expect patients to have pro or con about you.
8. Self-reflect on the appropriateness of changing your "style" of practice to meet a patient's expectations.
9. Self-reflect on the expectations you hold as a patient when it comes to your own physicians, and ponder any instances where expectations were not met.
10. Appreciate, understand, and be able to articulate how clinician self-knowledge can contribute to good doctoring.

Readings:

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read Chapter 2 for class)

November 4
Facilitator: Jeffrey Trilling (Session 3 of Circle of Change series)
Topic 9: Formulation of the Doctor-Patient Impasse

Educational Objectives

Session Two introduced personality differences in both clinician style and patient expectations that can often result in impasse. Session Three illustrates additional predisposing factors contributing to the genesis of impasse, while identifying and defining specific components of the patient's story such as explanatory models of illness and consequences of change that help us understand impasse formulation and other seemingly inexplicable negative behaviors.

At the conclusion of this session, you will have the information necessary to:

1. Understand and articulate how lack of self-awareness may lead to judgmental thinking.
2. Think about what "luggage" you carry with you that may trigger reactive behavior.
3. Appreciate and articulate the usefulness of obtaining knowledge about the patient, family, and physician perceptions of a patient's illness experience and attendant meanings.

4. Be able to explain how inability to categorize or diagnose symptoms contributes to the genesis of a clinician-patient impasse in the face of acute illness vs. chronic illness.
5. Define and discuss the components of the Explanatory Model of Illness
6. Understand and explain how differing illness attributions amongst members of a system can precipitate impasse.
7. Explain how a patient's hidden fears, previous experience with an illness, or previous encounters with the medical system can foster and maintain an impasse.
8. Define and discuss the Consequences of Change
9. Understand and explain how the Consequences of Change can foster and maintain patient impasse to change.
10. Define what is meant by dependent and independent variables.
11. Explain the clinical and research significance of the Perceptual Frame as a function of Explanatory Models and Consequences of Change
12. Articulate some of the medical consequences and social ramifications of clinician-patient impasse.

Readings:

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read Chapters 3 &4 for class)
2. Jeffrey Trilling, R. Jaber R., W. Mendelson, A. Pandya, "Attribution Models, Consequences of Change and Chronic Sleep Symptomatology: A Pilot Study," *Family Systems Medicine,* Vol. 12, 1994, pp. 61-64.

November 11
Topic 10: Problem-solving Clinical Impasse utilizing the Circle of Change
Facilitator: Jeffrey Trilling (Session 4 of Circle of Change series)

Educational Objectives

In Session Three, we introduced *explanatory models of illness* and the *consequences of change*, the two major elements of the patient's story or *illness experience* that underlie the patient's *perceptual frame*. We also noted that when the patient's and clinician's perceptual frames differ, an impasse may occur. Delineating and understanding the formulation of the clinician-patient impasse is the first step in problem-solving its resolution. Understanding a problem's formulation, while not solving it, often has its own positive ripple effect in that it may effect change, first, in the clinician. Once the patient's story has come to light and the fears or concerns emanating from past experiences are understood, clinician frustration is often replaced by feelings of empathy or even compassion. The opportunity for problem resolution is then increased by the resultant maintenance of the clinician-patient relationship.

In this session we explore what follows problem-delineation, introducing the components of the structured, six-step, problem-solving technique, **The Circle of Change.** We will

examine this problem-solving model's utility in assessing, organizing, and implementing second-order change solutions in situations of impasse and conflict.

At the conclusion of this session, you will have the information necessary to appreciate and have a basic understanding of how to:

1. Assess patients' assumptions regarding symptoms and signs.
2. Assess developing patterns leading to impasse.
3. Uncover and change implicit rules of interaction.
4. Re-evaluate solutions attempted and their contributions to maintaining impasse.
5. Hypothesize when negative consequences of change are an obstacle to problem resolution.
6. Implement the six steps comprising the Circle and understand their reciprocal nature.
7. Generate hypotheses from information garnered from the Explanatory Model of Illness, Generated Patterns, and Consequences of Change
8. Implement the art of reframing and co-creating (together with the patient) a new and more inclusive Perceptual Frame

Readings:

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read Chapters 5 &6 for class)

(Due today Nov 11: Reflection Essay # Two (20%) 4 to 5-page essay on the Doctor-Patient Relationship. This should be an essay reflecting upon your thoughts about such items as the clinician-patient relationship and its utility, impasse and conflict within the relationship and its consequences, impasse formulation & resolution, the purpose of medicine, the importance of the patient's story, what's wrong with today's medical system, or any of the topics that may have interested you from the seminars we have had.)

November 18 WRITING TIME
send topic and abbreviated outline to SGP & JT by tonight for quick response

Nov 25 Presentations Class Meets

Facilitator: Post/Trilling
Topic: Student Presentations of Rough Drafts of their Papers for Peer Feedback

Topics: As you wish, but focus on the nature of suffering in some identifiable constituency that you care about in some special way, and how their suffering can be addressed through compassionate care.

Prepare 3-5 PowerPoint Slides

1. Big Question and Significance & Beneficiaries
2. Thesis and Approach
3. Outline with Clear Headings and Subheadings
4. Conclusions and New Questions Raised
5. Four References beyond Assigned Readings and Selection Process

These should be based on a developed draft. Present for about 15 minutes and take feedback from peers and faculty for about 10 minutes. Peer feedback is vital. This contributes **10% to your final grade.**

Just FYI, a nice little article: Brian W. Roberts, et al., "Development and Validation of a Tool to Measure Patients Assessment of Clinical Compassion," *JAMA Open Network 2019* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6537812/

December 2 WRITING TIME
Research Papers due December 9 (50% of final grade)
No class

GRADING AND ATTENDANCE

Active participation in class, including attendance. (10%)

Grading:
Reflection Essays (2 X 20 = 40%)
December 9: Final Research Paper Due (50%)
Participation including Big Questions (10%)

Research Paper

Focus on the nature of suffering in some identifiable constituency that you care about in some special way, and how their suffering can be addressed through compassionate care.

Students write an **8-page (max)** final research paper (plus a page of references in alphabetical order per APA reference style) **due December 9. (50% of grade).** It is fine to focus on articles and books assigned in the course, but students should also use at least 7 carefully self-selected outside articles from journal sources (these can be on-line journals or hard-copy journals).
Use APA format in all papers.

Structure of Final Paper
Writing Your Final Paper
1. Introduction
A successful thesis-driven piece of scholarship will always begin **with a very clear big question replete with careful definition of terms. Then state your answer to the question in a clear thesis statement. This is best placed in the first paragraph of the**

paper. You will need to work on this and revise as needed, but do not ever lose sight of your thesis statement. You do not want to veer off course, because the rest of the paper is an argument supporting your thesis. Every sentence in your paper ought to be connected to your thesis in some way. It might help introduce your audience to the nuances of the topic you are discussing so that they will understand how your thesis differs from claims made by others.

A good paper usually includes a second paragraph that discusses in brief why the question and thesis are important. Is the thesis important for solving a major problem? Is it innovative? Who might be impacted by your paper? What is your audience?

A third paragraph usually describes how you are planning to structure the paper, and some mention of key sources. It is a good idea to ask about every topic or point in your paper, "how will adding this information help my reader understand my thesis?"

The outline and headings (i.e., the organization of the paper) should be designed to move your thesis forward in a constructive way. Outline your thoughts before you begin to write.

2. Main Body

Be certain to use headings well. Headings are a roadmap for the reader. They are like signposts on the highway. They should not be complex or long, so choose a few effective words. Subheadings can sometimes also be quite helpful. **Headings** should be in bold, and *subheadings* should be in italics.

Develop your ideas and use transitions to link the major strands of your exposition. Remember, though your interlocutors may be able to follow certain moves you make because they are familiar with the literature the public will not. Make sure that an intelligent person who is not an expert in your topic could easily follow your argument. If you jump around without an indication of why, it will be extremely difficult for your reader to follow you.

When agreeing or disagreeing with an author don't merely state that you agree or disagree but make a case for why you do. Clearly identify the views of the author whom you will be discussing. Highlight important distinctions and concepts of which the author makes use. It is essential to use citations when doing this. This will indicate to your interlocutors precisely the point at which you disagree, while introducing the public to an important aspect of the conversation you are engaging in and of which they may not be aware.

If you plan to disagree with an author's position, then raise at least one objection that you would advance against the view as you understand it. While the public may be interested in simply learning alternative views on the matter, your interlocutors will want to know why your position differs from those already accepted. If you plan to agree with the author's position, then be sure to explain why it is important that you agree. Others may

have raised objections to the position with which you agree. Explain these objections and then explain how it is that the position you endorse overcomes them. Once again, proper citation is essential to this aspect of your paper.

When in doubt, break up long sentences and split up long paragraphs. Semi-colons are hard to use well, so avoid them unless you are sure of your grammar and avoid page-long paragraphs that beg to be broken up into two or three.

Be careful to select quoted phrases, sentences, or segments of several lines with scholarly precision. Only quote the material that makes your point best, and always reference it. There is no need to quote excessively, and you should help the reader understand what you want them to get from a block quote, rather than leave it dangling at the end of a paragraph. We will talk about quotes and style in class. Block quotes are okay if used wisely, but they should rarely, if ever, exceed five to ten lines.

So often, a student really gets clear on their thesis in the final and concluding paragraph of the paper. Therefore, it can be very useful to try placing that final paragraph up at the front of the paper as you go through drafts and incorporate it into the thesis section. Then write a second conclusion in a later draft.

Conclusions
Conclude with a summary of your paper. Also, be sure to point to another Big Question (or two) that your paper has not answered, but that seems now to be the next one you would want to see answer in your topic area (and why).

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If you have a physical, psychological, medical or learning disability that may impact your course work, please contact Disability Support Services, ECC (Educational Communications Center) Building, room128, (631) 632-6748. They will determine with you what accommodation, if any, are necessary and appropriate.

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Each student must pursue his or her academic goals honestly and be personally accountable for all submitted work. Representing another person's work as your own is always wrong. Faculty are required to report suspected instances of academic dishonesty to the Academic Judiciary. Faculty in the Health Sciences Center (Schools of Health Technology & Management, Nursing, Social Welfare, Dental Medicine) and School of Medicine are required to follow their school-specific procedures. For more comprehensive information on academic integrity, including categories of academic dishonesty, please refer to the academic judiciary website at
http://www.stonybrook.edu/uaa/academicjudiciary/

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