Chapter 5
Ethics and Teaching Mindfulness to Physicians and Health Care Professionals

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The Ethical Imperative of Attending to Burnout and Building Resilience in the Medical Profession

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The Nature of Health Professional Suffering

> More than any other time in history, mankind faces a crossroads. One leads to despair and utter hopelessness. The other, to total extinction. Let us pray that we have the wisdom to choose correctly. (Allen, 1979)

This "Catch 22" is unfortunately the experience of all too many of today's medical practitioners. Physicians experience the same objectification and dehumanization frequently complained about by patients. Depersonalization is one of the cardinal features of "burnout" and evidence reported over more than a decade demonstrates that physicians experience burnout and related maladies such as depression, anxiety, and suicide at rates that exceed those in the general population (Shanafelt et al., 2003). Physician burnout is associated with poorer physical and mental health, and, not surprisingly, poorer quality of care, and patients of burned-out physicians experience poorer quality of caring (Crane, 1998; Haas et al., 2000). Affecting up to 60% of practicing physicians, evidence of burnout can be seen as early as third year of medical school (Dyrbye et al., 2006).

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It is likely that burnout itself is a cultural phenomenon, reflecting the pace, complexity, and ongoing challenges found in the modern world. Holding much promise for the relief of suffering and already having brought under control many of the great scourges afflicting humankind, the world of medicine confronted only a handful of generations ago scarcities of water, food, and shelter. Commonplace infections no longer threaten one's survival or the survival of one's family. Despite these successes, stress-related medical conditions are epidemic and increasing and the future appears to only further this trend.

It is perhaps worth reviewing the history of modern, twenty-first century allopathic medicine, especially examining its foundations in the ancient world. Out of the Hippocratic tradition that took shape then, the ethical fundamentals that underpin the clinician–patient encounter can be viewed. Additionally, from the "mind-body" separation that took place in the centuries to follow, especially out of the enlightenment, some of the ethical challenges facing the modern medical practitioner can be better understood. This separation about the relationship between mind and matter, between subject and object, led to a dualism where mental phenomena are non-physical and the mind and body are separate and distinct. This Cartesian dualism, named for Rene Descartes, has influenced Western thought for centuries and has had a lasting impression on the study and practice of modern medicine. Some of its roots lie in classical Greek philosophy, from which also sprang forth many of our lasting ideas of modern science, in particular the art and science of medicine.

Roots of Twenty-First Century Medicine and Non-duality

> The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.
> Plato (427–347 BCE)

If you lived on the Peloponnesian peninsula in the year 350 BCE and needed healing, you might first seek out a local healer in your community who practiced one of many forms of healing popular at the time. If you were not satisfied and still suffering, you might then journey, at great personal risk, to one of the prodigious healing temples of the ancient world such as Epidaurus, one of the better known Aesclepion temples. Asclepius was a hero and god of medicine in ancient Greek religion and mythology, and from the fifth century BCE many pilgrims flocked to the Aesclepion healing temples for cures of their ills. It is thought that Hippocrates began his career in Kos, the site of one of the most famous of these healing temples. On your way to such a temple you would meet travelers returning from their healing experiences. You might hear stories about their therapeutic experiences. This might have the effect of initiating the process of healing within yourself as anticipation built, stimulating your physiologic, neurologic, and immunologic systems, indeed the entire expectant forces of what is now known to include the powerful placebo

effect (how many of us have patients who travel distance to our offices, telling us how much they feel better, just through the act of showing up in our clinics?).

Once arrived at Epidaurus, before even entering the temple, you may well participate in activities in the local community. You could take a swim at the local baths, shop at the marketplace, or go to the gymnasium. You might attend the theatre, and participate in the re-enactment of the mythological stories of the era as told through the words of the classical playwrights Euripides or Sophocles. The theatre of the time was an interactive one in which the audience was part of the action. It was a place where the collective mythos became personal, shared by both the players and the audience, where the great comedic and tragic stories would become personal and relevant, experienced by the one in need of healing, thus further initiating a transformation. It was a place where the nature of suffering was shared collectively, where illness and loss and grief were inseparable from the other experiences of life itself.

Finally, you would enter the healing temple. Once inside you would undergo purification rituals (think of the admitting process in a modern hospital, the donning of the hospital gown and the preparatory rituals for the modern surgery, rituals being about transformation). Within its walls, you would be attended to by physicians, healers, and priests who worked together. You would sleep and dream. Your dreams would be interpreted by a healer. Subsequently, a treatment plan would be devised which might include surgical procedures or a prescription from the pharmacopoeia of the time. Finally, you would be given instructions for care upon returning home. And then you would leave, returning home, hopefully healed, whole. And as you returned, you would share your experience of healing, and as a result be a source of inspiration, hope, and healing to others.

Case records exist from some of these encounters, inscribed in stone by the patients who experienced healing there. The detailed accounts of what occurred are obscure. Imagine pasting together the details of modern medical encounters, especially in the era of the electronic medical record where the narrative is created not through the syntax of human language but by the exigencies of templated phrases. However, what we read from these records are restoration narratives about a process that addressed suffering along many of its domains, and often required a transaction, a giving up something for a return to wholeness, not dissimilar to the modern insurance premium, co-pay, or lifestyle change prescribed within a modern medical encounter. Here is one example:

> Ambrosia of Athens became blind in one eye. She had laughed at being told of cures to the lame and the blind. But she dreamed that Asclepius was standing beside her, saying he would cure her if she would dedicate a silver pig as a memorial to her ignorance. He seemed to cut into her diseased eyeball and pour in medicine. When she woke in the morning she was cured. (OCR GCSE SHP Student Book chapter, n.d.)

At about the time of the pinnacle of this mythological-based health care system, an exciting and revolutionary new method, Hippocratic Medicine, was taking root. It is important to note that this new approach to medicine, with the empirical scientific paradigm that the Hippocratic corpus offered, radical in its implications, excit-

ing in its promise, and transformative in its effects, was not accompanied by a rejection of the Aesclepion healing tradition of the time. It is felt that Hippocrates freed medicine from magic, superstition, and the supernatural, and used data collection and experimentation to demonstrate that disease was a natural process and the signs and symptoms of disease were the body's natural reaction to the disease process. However, rather than rejecting the earlier mythological worldview, it built upon and operated in concert with this ancient and culturally reflective approach. In fact, Aesclepion priests and healers regularly called upon Hippocratic practitioners to assist in the care of patients. The body–mind split that Plato lamented was perhaps somewhat mitigated by including these time-honored methods within the practice of Hippocratic Medicine. The value of traditional Aesclepion healing in this new approach to medicine is demonstrated in the opening line of the Hippocratic Oath which invokes the contemporary mythos:

> I swear by Apollo Physician and Asclepius and Hygeia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath… (National Library of Medicine, n.d.)

The Hippocratic Oath is one of the oldest binding documents in history and reflects the deepest intentions of the one taking it. Like the Bodhisattva vow described centuries later that commits one who takes the vow to an altruistic ideal for the sake of all beings, the Hippocratic Oath binds one to attend to the relief of another human being's suffering. Because disease and illness and their resultant suffering are inevitable parts of the human condition, the oath taken to practice the science and art of medicine is a daunting one. It is a statement of ethics, of professionalism, and of an ideal to uphold specific ethical standards. Among those standards are obligations to fellow human beings to treat and prevent illness, to respect privacy, and an understanding that these responsibilities include the patient and family's health and economic stability.

Although Hippocratic medicine was incorporated into the spiritual tradition extant in ancient Greece, the current structure and practice of Western allopathic medicine has been separated from cultural religious contexts. That split is in part a result of the historical role of organized religion, political trends, and modern science through the Early Modern (Renaissance), the Modern, and the Post-Modern eras. However, more recent trends related to broader movements within Medicine in developing patient-centered and relationship-centered approaches in medical care have brought into focus the need to examine the patient and the practitioners' relationships with the many domains of suffering, including the existential and the spiritual.

On a personal note, as a third-year medical student I was given a copy of an article without which I feel I would have been lost, with no compass directing me on the right path. Written by Eric Cassel and entitled *The Nature of Suffering and the Goals of Medicine*, I kept it close in my white coat side pocket and read it often (Cassell, 1982). Sometimes, I just touched it with my fingertips, especially at moments when I felt I was losing touch with the goals and vision that I held in becoming a physician. Through its words, I reminded myself that a patient's suffer-

ing results from a threat to biopsychosocial intactness. And that biopsychosocial intactness includes existential, spiritual, economic, relational, as well as physical domains. The article encouraged me to consider the cure of disease as not the only one of many ways to relieve suffering. More importantly perhaps, I learned that one could not assume to know the nature of the suffering experienced by patients without openly inquiring. And that inquiry, in some ways more intimate than the physical examination, touches on those personal and intimate areas of values, beliefs, cosmology, and spirituality.

With time and experience, I learned from patients the many territories of suffering at levels physical, emotional, spiritual, and existential. As I witnessed and participated in the rituals of medical education, I became initiated into the craft of medicine. As my nascent understanding grew through real relationships with real humans suffering from real diseases, this mission, the relief of suffering, illuminated for me that the Hippocratic Oath lives as more than an ideal but rather a flowing ever-present reminder of one's ethical responsibilities. I have little doubt that at the core of their motivations, this is true for my colleagues as well.

Relationship-Centered Care

> Nothing endures but change.
> Heraclitus (535–475 BCE)

Relationship-centered care is an important framework for conceptualizing health care, recognizing that the nature and quality of relationships are central to health care and the broader health care delivery system (Beach and Inui, 2006). The existence of dynamic unending change as experienced at the micro and macro levels drives the illness experience, whereby no person alive is untouched. Near the time that Heraclitus lived, the historical Buddha gave a discourse named *Subjects for Contemplation* in which he presented the following regarding life's fragility: Each human is subject to aging, illness, and death; each will grow separate from all that is dear; and each is the owner and heir to all his or her actions (Bodhi, 2005). One can feel in these truths the multilayered dimensions of suffering described by Eric Cassell.

Amidst this awareness of one's mortality, human beings face the vital challenge of building a solid foundation upon which to live an inspired and rational life. Aaron Antonovsky's theory of health and illness, which he termed Salutogenesis, described several characteristics that help individuals develop resilience to stressors encountered in daily life, providing an individual with a *sense of coherence*, seeing life as a worthwhile challenge (Antonovsky, 1979). These include meaningfulness, manageability, and comprehensibility. Challenges are made more easily workable when they are understandable, when one has a sense of competency in addressing them, and when they can be understood in the context of one's personal cosmology.

Additionally, current understanding of human motivation posits three themes that drive human action and behavior even in the face of life's inevitable challenges.

They include: *Autonomy*—the universal urge to be causal agents of one's own life and act in harmony with one's integrated self; *Competence*—which refers to being effective in dealing with the environment in which a person finds oneself; and *Relatedness*—the universal desire to interact, be connected to, and experience caring for others (Ryan and Deci, 2002).

The importance of relationships in motivating the physician's work includes those with patients, patients' communities, and other health care practitioners. These relationships are central to quality of health care and are important in developing a paradigm of health care which integrates caring, healing, community, and the relationships involved including the patient, the practitioner, and the society. Consequently, health professional education should help developing practitioners to become reflective learners who understand the patient as a person, recognize and deal with multiple contributors to health and illness, and comprehend the role of relationship in health and healing.

In summary, movements in medicine toward relationship-centered care, also referred to as whole-person care, have evolved as a trend that asks all clinicians to turn toward the complex and multilayered ethical dimensions reflected in the Hippocratic Oath (Miller et al., 2010). These trends have resulted from a recognition that both the patient and clinicians' well-being are important. Individual and institutional approaches to personal health, population health, and effective health care delivery demand a deep understanding of the need to maintain a healthy clinical workforce for the sake of quality of care and quality of caring, but also as an ethical imperative for the relief of suffering. These trends include shared decision-making, greater patient autonomy, medical record transparency, greater disclosure of medical errors, and more detailed informed consent processes among others (Barry and Edgman-Levitan, 2012). The cultivation of mindfulness and the interventions that support it among health professionals can enhance the awareness of the connection between personal and professional well-being and the well-being of patients. In this way, it becomes an ethical act and a statement, to wake up, pay attention, notice the presence of judgment, and step into the present moment with patients.

The Ethical Challenges for Students and Medical Professionals

Patricia Lück

> To listen another soul into a condition of disclosure and discovery may be almost the greatest service that any human being ever performed for another.
>
> Douglas Steere.

The fundamentals of medical ethics that serve as accepted medical practice and behavior include the generally accepted four principles of beneficence, non-maleficence, autonomy, and justice (Beauchamp and Childress, 2012). Beneficence

means for the good of the patient; non-maleficence, to do no harm, is noted to go back to the time of Hippocrates as detailed earlier in this chapter; autonomy denotes respecting the capacity of the patient; and justice considers access to care within limited resources. Furthermore, the American Medical Association (AMA) lays out various responsibilities for the medical practitioner within the code of medical ethics that suggests a code of conduct with regard to the doctor–patient relationship, including: confidentiality; professional practice in best interest of the patient; support for access to care; and interprofessional relationships (AMA Code of Medical Ethics, June, 2001). While these certainly are taught in medical schools to a greater or lesser degree, the manner in which their multilayered complexity is enacted in practice is variable. Page, in a 2012 study attempting to measure the four principles and discover if they can predict ethical behavior, concluded that while medical ethics are valued they do not seem to directly influence the decision-making process, perhaps due the lack of a behavioral model that can describe or predict the use of these principles (Page, 2012). This variability shows up most vividly in that part of medical training referred to as the hidden curriculum. The hidden curriculum is that unconscious part of medical training, the behavioral modelling by senior colleagues, and the normative interactions of the training and treatment environment, that entrains students into the culturally and contextually common institutional approaches that they are being trained in. Lempp describes this as being that "set of influences that function at the level of organizational structure and culture. Including, for example, implicit rules to survive the institution such as customs, rituals, and taken for granted aspects" that can be categorized into six specific learning processes. These are identified as loss of idealism, adoption of a "ritualized" professional identity, emotional neutralization, change of ethical integrity, acceptance of hierarchy, and the learning of less formal aspects of "good doctoring" (Lempp and Seale, 2004). This transmission of these unwritten rules fosters greater distance rather than engaged intimacy with the patient. One of the identified processes involved in the hidden curriculum is that of change of ethical identity which may interfere consequently with the adequate development and fostering of the student's moral and ethical compass. This is especially active given the variety of experiences health care professionals and medical students encounter, which involve decision points of implicit and explicit ethics. Medical education policy makers have growing concerns about the erosion of ethical attitudes and behavior in medical students (Yavari, 2016). Yavari illustrates this when sharing their personal experience of witnessing patients being referred to in a derogatory manner by their senior colleagues and their shame at not speaking out against this behavior. Margie Shaw, of the division of medical humanities and bioethics at the University of Rochester Medical School, in conversation shared that she believes, given that the hidden curriculum by its very nature is not obvious, clinicians may benefit from more explicit training in medical ethics, especially in the practical aspects of applying medical ethics within the clinical setting. This highlights the perspective that not only is it important that medical ethics be taught while at medical school, but be taught in such a way that these principles are internalized and can readily be expressed and called upon in the medical decision-making process. How this internalization process may

be effected is an area of interest when considering applications of mindfulness-based programs within the medical environment.

Derek Doyle, founding member of the International Association for Hospice and Palliative Care, offered this thought on receiving the Lifetime Achievement Award from the AAHPM in 2005: "I suggest to you that palliative medicine should be an exercise in befriending and sharing as much as an exercise in therapeutics or clinical pharmacology" (Doyle, 2005). With this, he affirmed that the doctor–patient relationship is grounded in the whole person, comprising skills that include the ability to turn toward the difficult conversations within the clinical encounter. Engaged communication promotes flexibility, warmth, and acceptance with an open-minded approach that is genuinely empathic, self-aware, respectful, and non-dominating in all interactions (Ekman and Krasner, 2017). This manner of communicating shows a level of connection that demonstrates awareness of possible communication barriers, personal bias, and expectations while still understanding and respecting the importance of resonance within the physician–patient encounter, as well as awareness of intra- and interpersonal perspectives. These skills can be cultivated through the practice of mindfulness-based programs (MBPs). Mindfulness-based programs challenge participants to a deep reflection of the ground that we inhabit. The contemplative practices at the heart of MBPs engage a quality of mind that can interrupt the automaticity of conditioned behaviors that may not promote ethical decision-making. Mindfulness training supports the development of attitudes that are grounded in self-awareness and deep listening with an awareness of different forms of communication and observational skills that embody attitudes which enable trust building within the professional, interprofessional, and interpersonal environment. This supports the ability to detach from one's own personal values, ideals, and beliefs while being intimately present for our patients (Krasner et al., 2009; Sibinga and Wu, 2010). Listening well and responding to the patient's own telling of their suffering could be the most important service we offer a patient in need, with awareness and communication skills sitting at the heart of cultivating ethical behavior and practice within the health care environment.

Relating to patients with a quality of intimacy, presence, wholehearted engagement, and turning toward rather than away from difficulties can be challenging for the physician to learn when medical education often encourages a deconstructed experience of personhood where one experiences bodies as cadavers, clinical cases, diseases, and patients with diagnoses first and foremost, before these bodies can be re-experienced and engaged with as whole persons (Good, 1994, p. 73). Medical education encourages an emotional neutralization and distancing which inculcates less intimacy into the clinical encounter, and persists, through the influence of the hidden curriculum, into the working lives of many physicians. This distancing impacts the lives of physicians through rejection of the intimate and personal parts in their engagement with patients, rendering these as something akin to a public performance, and not a real, lived and in-the-moment experience. This distancing not only impacts the therapeutic connection the physician may have with the patient but also risks the well-being of the patient through the risk of cognitive errors driven by the inattention this distancing can cause. The imperative to cultivate closer and more intimate, yet therapeutically safe relationships with patients therefore can be

seen as not only for benefiting the well-being of the patient, but also to ensure greater emotional connection and balance for the physician.

Henry Marsh in his book *Do No Harm: Stories of Life, Death and Brain Surgery* illustrates how a physician, in this case a renowned and skilled neurosurgeon, risks errors of attention and judgment with his inability to contain the emotional discomforts that arise from within the patient encounter.

> Three days earlier the juniors had admitted an alcoholic man in his forties who had been found collapsed on the floor of his home, with the left side of his body paralysed. We had discussed his case at the morning meeting, in the slightly sardonic terms that surgeons often use when talking about alcoholics and drug addicts. This does not necessarily mean that we do not care for such patients, but because it is so easy to see them as being the agents of their own misfortune, we can escape the burden of feeling sympathy for them. (Marsh, 2014, p. 257)

With his description, Marsh clearly demonstrates the entrainment of junior doctors into certain behaviors of patient disdain that are characteristic of the hidden curriculum. This example, which threatens ethical considerations, includes showing a lack of empathy for, and bias against alcoholics and drug addicts through the "slightly sardonic terms that surgeons often use" as well as the perceived inherent dangers of the emotional burden, therefore relieving the physician of "the burden of feeling sympathy for them." Jodi Halpern, a well-known clinician and author on the role of empathy in the clinical relationship, asserts that the emotional receptivity of the physician helps the patient acknowledge their suffering by enabling words to be attached to the suffering, and that the emotionally engaged physician allows the patient to work through her own difficult emotions (Halpern, 2011, p. 145). This aspect can easily be neglected when clinicians are consistently exposed to the implicit teachings of the hidden curriculum, inhibiting their empathic development and extending into the ethical realm of practice.

The Importance of Empathy

The capacity for being ethically grounded shows up in the day-to-day lives of physicians through their interactions most vividly reflected in the physician–patient relationship. The capacity for awareness and the conscious ability to discern the impact of this relationship can be examined by looking at the decision-making process within the clinical encounter and the inherent risks embedded in it.

John Eisenberg, examining this decision-making process, asserts that patients desire physicians primarily to listen and be human, and outlines four areas that influence clinical decision-making: the characteristics of the patient; the characteristics of the clinician; the clinician's interaction with their profession and the medical system; and the clinician's relationship with the patient (Eisenberg, 1979). These four areas overlap within the clinical encounter and within each area the process of decision-making is vulnerable to uncertainty, to lapses of present-moment awareness, and as a consequence error is a constant possibility.

Eisenberg argues that: "The medical problem, together with the patients' characteristics … create the uncertainty inherent in the clinical encounter." Physicians bring to clinical encounters their own reactions to clinical uncertainty, both cognitive and affective. While physicians may claim to practice "detached concern," professing to not be swayed by other considerations, this is "an ideal not necessarily achieved." These overlapping areas, however, and the capacity of the physician to remain intimate and close to the discomfort inherent within the medical encounter significantly impact the clinical relationship.

Budd and Sharma found that many doctors are uncomfortable with the idea that the relationships that they form with their patients can be crucial to the patient's satisfaction or otherwise with their treatment, yet the importance of this relationship is supported by the research (Budd and Sharma, 1994). Another example of the importance of this relationship is evidence that demonstrates the decision to litigate in medical errors is often associated with a perceived lack of caring and/or collaboration in the delivery of the health system, through its personification in the physician (Beckman et al., 1994). This relationship is influenced not just by what was done during the medical encounter and the course of the treatment, but also the manner in which it was done, contributing greatly to the success of the encounter and the relationship.

Medical practice is filled with uncertainty. For the clinician, residing within the personal moments and emotional aspects of meeting the patient, there are numerous opportunities that can lead to improved decision-making that enhances patient care. Danielle Ofri, in her book *What Doctors Feel*, demonstrates a clear understanding of the four areas outlined by Eisenberg that influence the decision-making process and emphasizes the affective dynamic of the clinical encounter (Ofri, 2013, p. 3). She also concurs with Jerome Groopman in his book *How Doctors Think* when illustrating this point: "Most [medical] errors are mistakes in thinking, and part of what causes these cognitive errors is our inner feelings, feelings we do not readily admit to and often don't even recognize" (Groopman, 2007). She notes that doctors who are "angry, jealous, burned out, terrified, or ashamed can usually still treat bronchitis or ankle sprains competently," but it is when "clinical situations are convoluted, unyielding, or overlaid with unexpected complications, medical errors, or psychological components…[that]…factors other than clinical competency come into play" (Ofri, 2013, pp. 2–3). These moments when medical care is at its most uncertain and complex require the physician possess the capacity for awareness of her own emotional discomfort, rather than a denial of and turning away from it. This uncertainty and complexity requires that she be able to engage not only with the private and personal aspects of the patient, but also with her own subjective experiences that affect the clinical decision-making process.

The quality of engagement during these challenging clinical moments impacts multiple domains within clinical care: from the quality of care delivered including errors and near-misses to the quality of caring experienced through the presence of empathy and the compassion of the clinician; from the level of work-satisfaction and perceived stress and its effects on clinician well-being to the toll of burnout and the loss of self-efficacy or fear of personal inadequacy and failure; and from the

capacity for self-disclosure in the face of failure or errors to its impact on patient's trust. The perceived need for certainty and control over the clinical encounter by the physician stands in contrast to the enormous amount of uncertainty that is actually present. This uncertainty is inherent in the nature of the presenting patient's concerns, the need to gather and synthesize relevant information, and the ability to make appropriate decisions for diagnostic evaluations and effective treatment. Uncertainty in medicine is further influenced by the capacity to only partially master the vast amount of knowledge and skills needed, the uncertainty of the limitations and ambiguities of the knowledge and skills, and consequently the uncertainty of how these two relate (Gerrity et al., 1992). In medicine, it can be difficult to know how much one does or does not know in any given situation, and in which—an adequate or inadequate knowledge base—one is functioning at the present moment.

When patients present to the physician with a precipitously acute, or even a lingering chronic presentation, there may be a narrow window of opportunity which, when missed, creates a greater likelihood for error. The body, a complex system in itself, is not always well-appreciated or understood, especially at times by the person presenting with the complaint. The presentation of dis-comfort and dis-ease must be related by the patient to the clinician through the telling of a personal narrative, in a way that can be explored, interpreted, and investigated by the clinician that eventually leads to a plan of action. This all occurs within a dynamic that is open to misinterpretation, bias, stigma, and cultural misunderstandings. This complexity is compounded by the physician who may have been entrained into an approach of detached concern with limited curiosity about the individual details of the patient's life for fear of becoming too intimately involved. As a result, the likelihood of error in this scenario may further increase. Jodi Halpern found that curiosity about the patient's personal situation enhances medical effectiveness through the development of empathy and consequently intimacy in the patient–physician encounter (Halpern, 2011, p. 87).

The capacity to step into the emotional dynamic affecting the patient results in a connection and intimacy that allows the physician to listen to the patient embedded within the greater scope of needs and life itself, possibly preventing errors that could result from not listening carefully to the patient's needs, errors of attention and judgment. Sibinga and Wu point out that this element of "the performance of the individual clinician remains a crucial and largely unaddressed element of patient safety" (Sibinga and Wu, 2010). Furthermore, Sibinga connects mindfulness, as a debiasing strategy, to the clinician's capacity to counter their entrained cognitive dispositions unwittingly enhanced by the hidden curriculum.

When the professional ethic of to do no harm is unintentionally violated, many physicians find themselves deeply affected regardless of whether an error results in harm to the patient or not. Research with medical residents demonstrates that errors are associated with significant subsequent personal distress and impacts the levels of well-being, a decrease in empathy, lower quality of life, and increased levels of burnout and depression (West et al., 2006). Few resources go toward alleviating this distress. Most physicians have experienced the distressing realization that they have made an error, and the subsequent shame and exposure. Even though more empha-

sis is now being placed on disclosure of errors and training programs are developing within medical education to train for these eventualities, it is still with great emotional turmoil and distress that physicians face such occurrences. It is perhaps the loss of empathy in response to repeated exposure to emotional distress that is most pertinent here. Empathy is one of the capacities that allows the physician to stay closely connected to the relevant personal aspects of the patient experience, and empathic curiosity enhances the intimacy of the medical encounter and the physician–patient relationship. Therefore, the threat to empathy also threatens this important part of the patient–clinician relationship. In their yearlong resilience-building program of mid-career primary care physicians, Krasner and colleagues found significant improvements in empathy that strongly correlated with measures of mindfulness, supporting the value of mindfulness and contemplative training in improving empathy and psychosocial orientation within the practice of medicine (Krasner et al., 2009).

Intimacy—Why Does It Matter?

Faith Fitzgerald illustrates the power of intimacy and presence within the physician–patient relationship, describing the shift when the physician chooses to pause and listen deeply to the personal narrative of the patient without the immediate push to solve, but to instead remain present with the uncertainty and discomfort. (Fitzgerald, 1999) She, like Halpern, believes "it is curiosity that converts strangers […] into people we can empathize with." Curiosity is the spark that leads to empathy and connection, but resides in the intention held by intimacy and presence. A spark inhibited at times by aspects of medical education where anything less than purely biological medicine can be at times discouraged and discounted through the hidden curriculum. For Fitzgerald, there is a clear reward for both patient and physician in being curious:

> [T]o the patient it is the interest and physical propinquity of the physicians, which is therapeutic in and of itself. To the physician, curiosity leads not only to diagnoses but to great stories and memories, those irreplaceable "moments in medicine" that we all live for.

Historically, changes in medicine have mirrored societal movements toward greater individuality, from public to private within medical care, and from a more socially oriented approach to one more focused on the individual. This shift to the individual, however, requires the physician to correspondingly engage with the patient as an individual, and not as a system, something that has been a challenge in medical education, fixated as it has previously been on the approach of detached concern and valuing cognition over emotional attunement.

It is challenging for physicians to develop intimacy and clinical empathy with their patients rather than resort to detached concern even as this distance risks errors of attention and judgment, especially when the patient does not evoke natural affection in the physician. Research, however, into medical care and in particular with

medical narratives informs us that for the patient, being listened to and heard, and feeling that one's personal story matters to the physician improves therapeutic connection and benefits the physician–patient relationship (Charon, 2006). This type of relationship when highlighted by curiosity about the patient's personal circumstance may decrease error formation caused by lapses of attention or judgment and ward against the tendency toward particular decisions that may be premature, incomplete, or inaccurate. Such a relationship may also increase patient compliance, and when mistakes do occur, decrease patient litigation (Beckman et al., 1994). The capacity for clinical relationship building, and furthermore the capacity to develop clinical empathy, attunes the physician to the other's experience and is cultivated through curiosity. In the words of Halpern, "Although a physician cannot directly will herself to empathize, by cultivating curiosity she can develop empathy" (Halpern, 2011, p. 130).

The subjective experiences that physicians have with their patients are not commonly explored in medical education, yet when physicians are asked to remember moments of intimacy and connection with their patients they do so through recalling specific patients they have cared for. For example, in a study of a group of Internal Medicine specialists asked about their most meaningful experiences in the practice of medicine, they recalled that relationships deepened through recognizing the common ground of each person's humanity and discovered and were deeply gratified by the intrinsic healing capacity of simply being present (Horowitz et al., 2003). In another investigation physicians enrolled in a yearlong training program focusing on mindfulness, self-awareness, and communication skills realized that patients notice when the physician can be present and listening, focusing on understanding and empathy, leading to greater effectiveness and sense of meaning in their work (Beckman et al., 2012). Rather than re-enforce a sense of alienation through detached concern, the physician's obligation is to mitigate this by cultivating a capacity for intimacy in the clinical encounter, a capacity that can be cultivated and supported by the practice of mindfulness.

The Personal

The following narrative illustrates previous points of ethics, empathy, and the hidden curriculum, and the subsequent mitigating effect of mindfulness. My own medical school experience impressed on me that medical education and care is neither ethically nor politically neutral. Having chosen to study at the University of Cape Town, I was a student during the turbulent final years of the apartheid regime in the 1980s. At medical school I was confronted with the realities of politically biased care with separation of patients, differentiated care, and inequitable resource allocation based on race and color. I witnessed the "colored" colleagues in my tutorial group being unable to examine any of the white patients. Distressed by much of this, I sought guidance from a renowned activist and mentor. Her sage and ethical advice was to continue to attend to the ethical standard of my own behavior as best I could

within my day-to-day encounters with patients, colleagues, and staff. She advised me however within this day to day to keep an eye on the long view, especially the need for systemic change within health systems that impact patient care and patient caring. Underscoring this reality and wisdom of advice was my later understanding of Eisenberg's research that clinical decision-making process includes the four areas of influence of the patient, clinician, clinician–patient relationship, and importantly the clinician's interaction with their profession and the medical system. I developed an understanding that the expressed ethical dynamic of the medical system itself is influenced by the contextual reality of the political, social, and cultural milieu of its time.

Later, as an intern in an Australian clinical setting on surgical rotation I was challenged by the senior attending physician to keep a cancer diagnosis secret from a patient. This particular attending physician did not believe it was helpful to disclose distressing diagnoses and bad news to patients, especially to female patients, preferring to tell the husbands or families, and allowing them to make decisions regarding care as well as disclosure. This placed me in a difficult ethical dilemma when the patient herself asked me for my opinion and for disclosure to her of the diagnosis. Further discussion with the attending and appealing to him to reconsider his instructions on ethical grounds yielded no results. There was an additional threat to my career if I countermanded him.

I sought further assistance and advice, and after much thought concluded that my first duty was to my patient, who detecting a cover up was insistent that I be open with her. With the support of the nursing staff, I arranged a breaking bad news disclosure meeting, not simple for a young 24-year-old newly qualified physician. The outcome for my patient's mental and emotional well-being, and her capacity to make informed choices for her future care have left an indelible impact on the importance of trust and my ethical responsibility toward patients. I have learned a deeper understanding of disclosure imperatives, as well as gained insight into the hidden ethical pressures and impact of the hidden curriculum.

Needless to say, I was sidelined from further surgical assisting and received a less than complimentary end of rotation review. Fortunately, surgery was not my future specialty area. Had it been, I would be curious if my resolve in challenging my attending would have been as resolute in acting upon the ethical principles of beneficence and justice.

Ethical behavior in the workplace can differ substantially from that behavior in training situations (Soltes, 2017). It can be more difficult to adhere to ethical behavior when decisions at work are often quick, intuitive and set free of the slower reflective thinking of the training environment. These dynamics point to the importance of building awareness and attentional reflective training, training that mindfulness practice offers, to enhance the capacity for ethical behavior even in the reality of every day pressure-filled workplace environment.

Early in my palliative care career, I cared for a young man who impressed upon me the ethical imperatives of doing the least harm, of respecting individuality, autonomy, personal religious and cultural perspectives, as well as the value of presence and listening. He had terminal bone cancer and was experiencing severe and

difficult to control pain. He was paralyzed and bedbound, requiring his medical visits to be made at home. As our visits progressed and trust between us grew we began to explore in greater depth his diagnosis and prognosis. Having experienced a brutally frank and traumatic diagnostic disclosure from his surgical specialist, he clung to the last vestiges of hope and the denial of his approaching death. As time progressed and he was met with open acceptance, patience, and empathic care from his caregiver team, he was moved to openly acknowledge his condition and begin to explore what that would mean for him.

He spoke at length about the initial diagnosis and various treatments he had been through. Like many young people, he had given little thought to being ill and especially the possibility of dying. Now, no longer taking things for granted, he was finding meaning in the small moments of spending time with his family, beginning to accept that the rapidly increasing growth of the tumors in his body meant this would eventually shorten his life. The moment that will always stay with me from this encounter was when he asked to discuss his growing cancer and what that may mean for him.

In anticipation of delivering difficult and perspective-changing news to him, I asked him how he wanted this news to be communicated. His only response was "gently." He wanted to be told gently, for me to communicate in a manner that treated him with respect, compassion, care, and dignity, with his personhood recognized as central to the clinical interaction. This was a plea to physician and patient alike to inhabit with full presence this moment of engagement, recognizing with awareness the ethical complexities inherent in every physician–patient relationship.

How do we inhabit moments like this ethically as a medical community? How do we gaze through that window into our mutually unfolding lives when faced with another's deep suffering, as we simultaneously stand on the other side of that window, with our lives gifted to us? An invitation to do so is beautiful echoed through the words of Mary Oliver in her poem *Wild Geese* where she reassures us that "you do not have to be good… you only have to let the soft animal of your body love what it loves." This is an invitation to show up for this moment just as we are, where in this moment we fully belong by virtue of being alive, with a realization that for now the "world offers itself to (y)our imagination" (Oliver, 1992, p. 110).

There is much that can draw us away from this moment of engagement. Not just the suffering of this moment, but also experiences from the past, as well as fear of pain or discomfort that is imagined to arise in the future. This fear of past, present, and future continues to push us toward a longed-for better-than-now future. A future more rosy than the one we fear, or the present we inhabit and turn away from. "Tell me about despair, yours, and I will tell you mine. Meanwhile the world goes on." Mary Oliver continues encouraging us to turn toward the suffering inherent in this moment, especially within the compassionate presence of another.

This process of hoping for a different future in the encounters with suffering is met most poignantly when facing death. Death, depending on your perspective, is perhaps the ultimate loss, or the ultimate goal of our lives. As the ultimate loss, it encompasses loss of life, self, all the relationships that tether us to this world.

Working through these anticipated losses is an important step in preparing for death. Central to this work is the presence of hope. Hope unattached to an outcome, but embodied in a capacity of trust and openness, becomes a sustaining supportive capacity. But when hope is attached to achieving a better and different outcome that may not be attainable, hope becomes an unending cycle of expectation, disappointment, and loss. In this way hope often coexists uneasily with the suffering experienced when facing difficulty and death. The nature of hope may change as the focus of life shifts for many in the final days from a "doing" mode to "being" mode, from achieving to experiencing, from giving to receiving, from controlling to accepting, from tomorrow to today, to right now this moment. Hope unattached to an outcome allows the present moment to unfold as it can, even in the face of difficult suffering.

Greenhut takes this perspective with her description of the kind of hope that keeps us from experiencing the present moment through its constant looking forward toward the future with imagined expectations that may not be realistic or even supported by the reality of the current situation (Greenhut, 1995). She argues that by overly imagining positive results in the future, we suffer the results of ignoring what is happening in the here and now. That despite the presence of pain and discomfort, the moments unfolding in the realm of now are the only ones we truly have. Within that now are the only moments in time we occupy that hold the possibility of choices to change our lives and of actually impacting the future. These moments of now, moments that we attune to within mindfulness practice, are not only inhabited by pain and fear, but frequently and simultaneously also contain moments of joy and delight that are so often missed by focusing on how things could be different. We can only live our lives fully when we let go of that part of hope that denies the present experience by seeking unrealistically to change the suffering we experience in this moment. Therefore, letting go of hope is not a giving up on dreams but a giving up on the fantasy that this moment can be any other way than it is. The process of turning toward what is here now and being with this reality as it unfolds is living *in hope* rather than *a hoping for* things to be different. This capacity for being with and turning the difficult is cultivated with a mindfulness practice.

One of my patients, close to death, fluctuated between the hope of recovering her sight and the fear of going blind, the hope of a cure and her fear of dying, the hope she would beat her cancer and the fear that she could not manage the dying process. When she was hopeful and looking to an anticipated positive future, she was upbeat, but with each subsequent loss she experienced—stopping chemotherapy, further growth of the tumor, increasing pain—she found herself to be more depressed and bereaved again. When she was able to interrupt this repeating loop of hope and fear, and express how she felt in all she was experiencing, she experienced a greater sense of calm and was more able to cope with her suffering and with the uncertainty of the journey she was on.

Living in the hope that one has the resources to manage the present moment, rather than hoping for a different outcome, fosters resilience and self-confidence in our journey. When we live "in hope" rather than "hoping for," we cultivate the belief and capacity in our own resourcefulness. When one can look at the future with equa-

nimity, and be open to all outcomes, the present moment can be experienced as being okay despite the difficulties that may be present.

> Giving up hope does not take away our will to be alive. Rather, it gives us the strength to live in the present and to grow from our suffering. Releasing ourselves from hope allows us to accept life in the here and now regardless of its duration or the state of our health, and it helps us to gain as much from depression as we gain from joy. (Greenhut, 1995)

This meeting the moment with authenticity allows both the physician and the patient to be the person whose story has been lived authentically. In my experience as a palliative care physician who practices from a mindfulness perspective, I have found that being unattached to any particular outcome for my patients releases both of us from any need to show up other than how we already are. Being open rather than attached to outcomes may be the greatest gift that mindfulness and mindfulness-based programs have to offer when working within palliative care. Mindfulness lifts the need to have suffering present in any particular way; it meets suffering however it shows up with empathy, compassion, patience, acceptance, non-judging, curiosity, and beginner's mind, allowing paradoxically greater spaciousness for experiencing joy. A mindful palliative care approach also does not expect or strive for a particular death experience such as a so-called "good death." Rather, it allows the clinician to be present for whatever experience shows up, to cultivate the capacity for fierce embodied compassionate presence in the face of suffering. This capacity for presence cultivated through mindfulness training within medicine will be addressed in the following section on Mindful Practice in supporting the growth of a healthier community.

In an era of medical care driven by technology and in which patients decry the lack of the human connection within the clinical encounter, cultivating clinical intimacy and empathy, paying attention with curiosity and concern about how health professionals show up for ethical dilemmas, attending to the subjective and emotional dimensions of the clinical relationship, fostering curiosity, and listening closely to the personal and intimate concerns in the lives of patients may not only enhance the clinical experience of both the patient and the physician, but it may also decrease errors arising from lack of attention and poor judgment. I have found through my own medical practice in clinical palliative care and in my experiences teaching mindfulness, that an authentic embodied presence imbued with patience, non-judgment, kindness, and beginner's mind allows me to be less attached to outcomes that might be determined by my own needs, and allows me to deeply listen to the needs and suffering of my patients and class participants. Having less of a need for any particular outcome, whether it be in health, end-of-life care, or in teaching, but rather closely attending to what is actually present allows me to participate in the evolving outcome that is unfolding and revealing itself in the moment we live in with a deeper trust, greater compassion, and a greater quality of care and caring. I also believe this being unattached to outcome with patience, non-judgment, kindness, and beginner's mind strongly supports and encourages an ethical approach that is grounded in transparency, openness, integrity, autonomy, respect, mentorship, personal practice, self-awareness, and humility.

Mindful Practice: Supporting the Growth of a Healthier Medical Community

Michael Krasner

> Ars longa, vita brevis, occasion praeceps, experimentum periculosum, iudicium difficile.
> Art is long, life is short, opportunity fleeting, experiment dangerous, judgment difficult.
> Aphorismi, Hippocrates of Kos (460–370 BCE)

The first word of this aphorism, written not in Latin, but in Greek, is *tekhnê*, signifying that the art of medicine includes the technical. To paraphrase, medicine is a craft carried out with skill, acquired over a long period of study and practice, where the opportunities for learning are transient, yet require experiences of significant risk which challenge judgment. Patients, who at some point include every member of the human race—indeed all of us, suffer from illness. There has always been and will always exist a sense of urgency and need for those who skillfully practice the science and art of Medicine.

Mindful Practice

> The ultimate value of life depends upon awareness and the power of contemplation rather than mere survival.
> Aristotle (384–322 BCE)

Michael Kearney, palliative care physician, in his review of physician self-care, asserts that clinicians who adopt self-awareness-based approaches to self-care may be able to remain emotionally available in even the most stressful clinical situations (Kearney et al., 2009). These approaches paradoxically enhance the potential of the work itself to be regenerative and fulfilling for the physician.

He described the risks all clinicians have of compassion fatigue, and illustrates the possibility for *exquisite empathy.* This involves *highly present, sensitively attuned, well-boundaried, heartfelt empathic engagement* where practitioners are *invigorated rather than depleted by their intimate professional connections with traumatized clients*. It appears that this type of empathic connection protects clinicians against compassion fatigue and burnout.

But how does one cultivate a clinical presence that promotes *exquisite empathy* and assists healing in a bidirectional manner? One approach for the medical practitioner is through developing greater mindfulness—the quality of being fully present and attentive during everyday activities. Mindful practice can be described as the application of mindfulness in medical work, involving moment-to-moment purposeful attentiveness to one's own mental processes during daily work with the goal of practicing with clarity and compassion (Epstein, 1999). The development of greater mindfulness is enhanced through training in contemplative practices.

Research demonstrates that physicians who participated in a program on mindful communication experienced improvements in measures of well-being and demonstrated enhancement in personal characteristics associated with more patient-centered orientation to clinical care (Krasner et al., 2009). Additionally, burnout improved with decreased depersonalization and greater sense of personal accomplishment. This intervention included contemplative practices within which clinical narratives were shared among colleagues. Appreciative inquiry techniques focused discussion on capacities and strengths in sharing the narrative-based dialogues. The inclusion of self-reflective clinical storytelling highlighting positive aspects of challenging clinical experiences connected practitioners with regenerative and fulfilling aspects of their work.

Several themes emerged from these physicians' reflections on this program which was based on cultivating intrapersonal and interpersonal mindfulness (Beckman et al., 2012). These themes shed light on the ways in which the intervention enhanced physicians' ability to practice patient-centered care, improved their sense of well-being, and decreased burnout. They included (1) sharing personal experiences from medical practice with colleagues reduced professional isolation, (2) mindfulness skills improved the participants' ability to be attentive and listen deeply to patients' concerns, respond to patients more effectively, and develop adaptive reserve, and (3) developing greater self-awareness was positive and transformative, yet participants struggled to give themselves permission to attend to their own personal growth.

Additionally, participants reported that the program promoted self-awareness, presence, authenticity and greater effectiveness and meaning—at work and at home. It also helped to diminish their sense of isolation, helping them effectively and meaningfully share their experiences with peers in a facilitated, respectful, and supportive environment. Finally, participation in the Mindful Communication program enabled physicians to make time for self-development and to realize how lack of attention to oneself can erode the capacity to engage more effectively with peers, family, and patients. The following quote of one of the participants powerfully illustrates aspects of this:

> In general, I think that I am a pretty good listener. I will spend extra time with my patients if they need it, but I felt in some ways that it was kind of sucking me dry. I would be so empathetic, and then I would feel frustrated, like what else can I do?… I would think about patients at home, in the shower, thinking she can't get to her appointment, maybe I should pick her up and drive her…. I would empathize to the point of where I would be so in their shoes. I would start to feel the way that they felt and I mean, you know, take four of those in a row in a day, and I would be just wiped out … and, they don't really want to hear about me and my processes…. It's not that I don't empathize with them anymore, but [now] I feel OK just to listen and be present with them … and I think that in some ways that helps them more … and that is a wonderful thing that you can do for patients…. I just needed to learn that myself, I guess. (Beckman et al., 2012)

The health professional–patient relationship contains both technical and human aspects, and as discussed earlier one can refer to these as the *Hippocratic* and the *Aesclepian* aspects, respectively. The kinds of attention that are called for in the

clinical encounter include both an observational stance and an intimately connected stance as reviewed by Dr. Lück. In the Flexner's Carnegie Foundation report of 1910 that has had substantial impact on the shape of medical education over the last century, not only was competency in the basic sciences emphasized, but equally was the importance of a liberal education (Flexner, 1910). Elements of medical education that include experiential and reflective processes, the use of personal narratives, integration of self and expertise, and candid discussion among learners are approaches suggested to meet the objectives of medical professional formation designed to integrate the art and science facets of quality medical care (Rabow et al., 2010).

Situated at the center of these elements, mindfulness can be considered a universal human capacity to foster clear thinking and openheartedness. It assists in developing a greater sense of emotional balance and well-being. The original purpose of mindfulness in Buddhism is to alleviate suffering and cultivate compassion. This suggests a role for mindfulness in medicine (Santorelli, 1998). Likewise, mindfulness facilitates the physician's compassionate engagement with the patient (Ludwig and Kabat-Zinn, 2008). It has also been suggested that mindfulness is a central competency for effective clinical decision-making (Epstein, 1999). This competency may be promoted through practicing attentiveness, curiosity, and presence as part of a medical educational approach for developing useful "habits of mind" (Epstein, 2003). Indeed, not only can mindfulness be seen as a core competency that can be cultivated, but it can also be looked at as a potential antidote to the depersonalizing effects of the current medical environment (Stange, 2003).

Mindful Practice was developed by physicians at the University of Rochester School of Medicine and Dentistry as an educational intervention, currently part of the required third-year medical student experience, designed to be used in medical student, graduate medical education (residency) and postgraduate continuing medical education for practicing physicians and other health professionals. It can be thought of as an adapted mindfulness-based program (Crane et al., 2016) specific to the medical community, within which are several "technologies" used to encourage practitioners to reflect and share clinical experiences that are challenging and meaningful. It is hoped that from these reflections, contemplative practices, and dialogues, a greater understanding of their own self as clinician/physician health professional, and of their relationship with their patients and with their work develop.

These "technologies" include the following:

1. The use of narratives, the actual stories of the clinician with their patients, influenced by the broad field of narrative medicine, which provides a way of understanding the personal connections between physicians and patients and the meaning of medical practice and experiences for individual physicians. It also reflects the physicians' values and beliefs, and how these become manifest in the physician–patient relationship, and how that connection relates to the society in which it develops. According to Charon, narrative medicine helps imbue the facts and objects of health and illness with their consequences and meanings for individual patients and physicians (Charon, 2001a, 2001b). Narrative medicine

in the Mindful Practice programs includes the sharing of stories that arise from the participants' clinical experiences and takes the form of reflection, dialogue and discussion in large and small groups, specific writing exercises, and journaling. Narratives are chosen by the participants about their own personal experiences of caring for patients. Thus, the narratives are grounded in the real lived experiences of the physicians, not in philosophical or rhetorical—what-ifs that impact on cognitive and emotional challenges.

2. Appreciative inquiry (AI) strives to foster growth and change by focusing participants' attention on their existing capacities and prior successes in relationship building and problem-solving (as opposed to an exclusive focus on problems and challenges). Much of medical training focuses on what is wrong rather than what is right. Patients are described in terms of problem lists, but there are no defined places to describe their strengths and resources. Morbidity and mortality rounds focus on analyzing bad outcomes, but there are few opportunities to explore effective teamwork and joint decision-making. The theory behind AI is that reinforcement and analysis of positive experiences with patients and families are more likely to change behavior in desired directions than the exclusive critique of negative experiences or failures (Cooperider and Whitney, 2005). Appreciative inquiry involves the art and practice of asking unconditionally positive questions that strengthen the capacities to apprehend, anticipate, and heighten positive potential. It is an inquiry tool that fosters imagination and innovation. The AI approach makes several assumptions: (1) for every person or group there is something that is working; (2) looking for what works well and doing more of it is more motivating than looking for what doesn't work well and doing less of it; (3) what we focus on becomes our reality and individuals and groups move toward what they focus on; (4) the language we use to describe reality helps to create that reality; (5) people have more confidence to journey to the future if they carry forward parts of the past; (6) we should carry forward the best parts of the past.

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

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

The Mindful Practice program is facilitated in a modular manner, in which each module contains elements to cultivate greater mindfulness through contemplative practice and skills building. Additionally, each module includes a discussion of a

challenging theme or dynamic in clinical work, and asks the participants to reflect on their own personal experiences related to theme. Participants then engage in dialogues sharing their experiences, and directing them to use the approach of appreciative inquiry to explore the inherent capacities they have for working with these challenges. Among the themes of Mindful Practice modules are burnout, meaningful experiences, errors, suffering, grief, attraction, self-care, and others (Krasner et al., 2009).

The Personal

My own journey toward the teaching of mindfulness approaches in my medical work began over 25 years ago when exploring a personal contemplative practice amidst the increasing pressures of building a practice of primary care internal medicine, experiencing the challenges of a growing family of three young children, and finding myself at the time emotionally exhausted as I entered what was still the early stages of my career. At about this time my father became ill with pancreatic cancer and almost immediately, influenced by the book *Full Catastrophe Living*, he also began a serious contemplative practice (Kabat-Zinn, 1990). We were both affected deeply by the personal effects of a mindfulness practice. For my father, he lived another 24 months, most of that in relatively good health and high function. For me, I began a deeper inquiry into the power of this approach for me personally as well as professionally.

Within a few years, I began mindfulness facilitation training, and then teaching MBSR, initially with patients, then a broader community of participants. Among these participants were physicians of all types, representing many specialties and from community as well as academic careers. Prompted by these colleagues I began to offer health professional-specific MBSR course with continuing medical education credit offered. From a facilitation standpoint, the experiences with these predominantly physician groups were qualitatively similar to other MBSR groups. However, I began to hear from these participants about the effects that the course experiences were having on the meaning they derived from their work and their enjoyment and commitment to medicine.

After a number of years, the opportunity arose to direct a project that, in part, led to the creation of the Mindful Practice program. This project, originally called *Mindful Communication*, included a collaboration with medical communication experts at the University of Rochester, and enrolled in the yearlong training project that was developed, 70 local primary care physicians. Simultaneously, our team also trained in another yearlong program faculty at the University of Rochester School of Medicine and Dentistry to facilitate Mindful Practice seminars as part of the required curriculum for all third-year medical students.

Since those “early years” in 2005–2007, and since the completion and report on the Mindful Communication project in 2009 (Krasner et al., 2009), the Mindful Practice program has continued to be a part of the medical school curriculum.

Additionally, new training approaches for practicing physicians and other health professionals has involved over 600 health professionals in intensive retreat-like trainings held locally and worldwide (see www.mindfulpractice.urmc.edu). I would like to briefly summarize some personal reflections on the experience of working with health professional colleagues, and how this relates to the ethics and teaching of mindfulness to physicians and health professionals.

It is difficult to encapsulate the experience in a few paragraphs, but perhaps it would be helpful for me to share my impressions from facilitating one of the Mindful Practice modules to physicians and other health professionals, so the reader can gain some insight into the power of mindful attention and awareness applied to challenges faced by clinicians. That module has to do with an exploration of errors. Errors is certainly one of the most challenging experiences for anyone to contemplate, especially the physician in which medical errors can have such grave consequences for the patients, and can be associated with fear, shame, humiliation, exposure, self-doubt, anger, and hosts of other emotional states for the clinician.

During this module, we explore together, through a dramatized video demonstration, the disclosure of a serious mistake in medical judgment by a physician to a patient's family member (the patient died as a result of this error). After this discussion, and supported by formal mindful practices including loving-kindness practice, the participants are then asked to share in pairs their own personal experiences, and to discover, through the process of appreciative inquiry, the capacities and successes that were present for them and are part of them through this difficult challenge, and can be carried forward into future challenges.

It would be an understatement to suggest that participation in this module is difficult. Many of the participants, however, are able to share their narratives of experiences they have had but have never spoken of, reflected on with a colleague, shared openly or even considered that there were any worthy qualities within themselves related to the experience. These often emotional, cathartic, and healing conversations allow the health professional to be able to rediscover the complexities and the possibility for different framing of experiences rather than a black-and-white dualistic understanding of an absolute orientation toward errors. Additionally, what arises out from these conversations is an almost universal recognition of the deep caring, compassion, concern, respect, and love by the clinician for the patient involved in the error. This, I think, helps reconnect the ethics of the professional—autonomy, beneficence, non-maleficence and justice—with not only the internal thoughts and feeling but also the actions of the clinician.

In 1925, Dr. Francis Peabody said to the graduating class at Harvard Medical School *One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient* (Peabody, 1927). Mindful Practice helps connect health professionals with this caring dimension of the patient, and in doing so, becomes a process that supports the ethics of relationship of the health professional with the patient.

Conclusion

> A man who has been through bitter experiences and travelled far enjoys even his sufferings after a time.
>
> HOMER, The Odyssey

Jon Kabat-Zinn in his book *Full Catastrophe Living* presented the definition of mindfulness that guided the development of the Mindfulness-Based Stress Reduction Program (MBSR) as: moment to moment awareness (Kabat-Zinn, 1990, p. 2). Over time, this has become understood as the awareness that arises through paying attention on purpose in the present moment, nonjudgmentally. These definitions are accompanied by a number of attitudinal foundations that guided the cultivation of mindfulness: patience, non-judging, beginner's mind, letting go, trust, non-striving, and acceptance. At a recent symposium at John's Hopkins University in 2014 Kabat-Zinn offered an updated definition that included a more explicit ethical intention for the cultivation of mindfulness: *Mindfulness is the awareness arising from paying attention*, *on purpose in the present moment*, *non-judgmentally*, *in the service of self-understanding, wisdom, and compassion* (Kabat-Zinn, 2014).

This clarification of the definition of mindfulness for teaching within mindfulness-based programs reflects more explicitly the ethical intentions of self-understanding, wisdom, and compassion. It mirrors a growing recognition within the medical community for the need to be more explicit about the underlying professional ethics that not only support the provision of mindful health care, but also support the needs of the providers of health care. This emerging realization impacts the entire systemic professional ethics of health care itself. Promoting best practice in medicine includes paying attention to the patient as well as the physicians and other health professionals as people who, in order to deliver high quality and compassionate care, need to attend to the care of themselves as well.

For health professionals, the intentional turning toward the "full catastrophe" as a vocation and as an avocation on the surface may seem odd. For who would find not only a calling but also a deep enjoyment and satisfaction in attending to the aging, ill, and dying? Yet, as discussed earlier, the meaning found from simply being present to even the most difficult conditions and circumstances of their patients motivates the health professional (Horowitz et al., 2003).

We can begin to speculate why this might be. Might it be in the empathic resonance and recognition that supporting another human being's autonomy satisfies one's own desire for the same? Might it be in the beneficent actions by health professionals that one experiences the power of giving and receiving? Might it be in the efforts to do no harm, that non-malfeasance also helps the health professional to avoid harm herself? Might it be in the simple act of caring, utilizing one's knowledge and skills regardless of who the patient is or where she comes from or what her values are, that the health professional experiences the power of justice enacted within a moment of contact, and can see the reflection of that justice as the moral imperative flowing bidirectionally?

For physicians, physicians-in-training, and other health professionals, turning toward the most difficult and challenging aspects of the human condition with exquisite empathy may actually prevent burnout and the associated diminution in quality of care and quality of caring. Mindful awareness and communication skills sit at the heart of cultivating ethical behavior within the health care environment. Mindfulness itself creates the "ethical space from which to see, think, speak, act, and work in ways that are not conditioned by reactivity" (Batchelor, n.d.).

While working with practicing physicians and medical students in coursework designed to develop mindfulness, the sharing of their reflections about clinical narratives they are part of provides a rich source of meaning and relationship-centered connection. At the conclusion of these courses, students or practitioners are often asked to write their own Hippocratic Oath. From these words, we can all gain faith in those who practice the art and science of Medicine, and who will care for us as we age, become ill, and die.

> I promise to always put the patient at the center of my practice. I will treat the human being and try to consider the world in which he lives…I will try to stay aware of my own feelings, beliefs and biases as I treat my patients…I will remember that I am only one link in a long chain of caregivers…I will try to remember that neglecting my own health and well being may negatively affect my patients. Really caring about myself and my patients should be at the center of what I try to do. (Medical Student)

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