

BEING HUMAN IN MEDICINE: BEYOND HIERARCHY

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INTRODUCTION

A decade ago when I was in training to teach the Mindfulness-Based Stress Reduction (MBSR) program and preparing to modify the program for physicians¹ I asked my University of Massachusetts Center for Mindfulness teacher (Florence Meleo-Meyer, the current Director of Oasis) if being a psychologist would be a hindrance when teaching a room full of physicians. Her answer has guided me ever since. Florence replied, "In mindfulness there is no hierarchy." From that moment on, I let go of various thoughts, such as: "Having not gone through medical training may undermine my credibility. When I co-lead with my colleague, a palliative care doctor, will they turn to him, rather than me, as a teacher?" These thoughts revealed certain insecurities that were, in fact, unwarranted. My clinical and research training, as well as 25 years of clinical and teaching experiences prepared me well to instruct medical students, residents, physicians, and allied health care professionals in Mindful Medical Practice. Another person who influenced my attitude about hierarchy was Paul Jurkowski, a psychiatrist who trained alongside me; he would say, "I need to go now, there is a human being in the waiting room."

Our first eight-week course, Mindfulness-Based Medical Practice (MBMP), included 15 doctors from various disciplines. In parallel, we introduced mindfulness via one-day workshops which included nurses, psychologists and allied health care professionals who expressed an interest in taking the eight-week

program. We wondered if doctors would be open to this idea; given that many work in multidisciplinary teams suggested that it may, in fact, be beneficial to mix our groups. The way we taught modeled how a physician and psychologist could complement one another. This was our first step out of the rigid hierarchy. When role plays were used to teach skilful communication it was an asset to have others, such as psychologists who had direct experience noting process and interpersonal dynamics, provide feedback to those working out an unresolved situation from a particular clinical setting. Following the course, we heard comments such as, "I am more aware of the challenges doctors face." Mutual respect was enhanced. Since then our groups have been mixed. Yet, once we included complementary therapists such as acupuncturists and osteopaths. Apparently, this was one step too many out of the comfort zone perhaps due to the different underlying paradigms of human health and illness from these various disciplines. We backtracked by including only those who had direct contact with patients in mainstream medical settings from then on.

Another instructive experience was when I was asked to teach a group of family medicine residents. Several of their supervisors wanted to join the course. Given the unequal power relationship between the trainees and their trainers I hesitated. I asked the residents how they saw this before accepting to go forward with the plan. In the first class I addressed the potential for difficulties directly; the group agreed to notice if issues arose and deal with them in an open manner. As the weeks passed, the residents and their supervisors participated fully. Then I realized that teaching them together could reinforce the practices learned in the course when the residents were applying mindfulness during their work hours. For example, typically residents do not take lunch breaks; this reflects the time pressures and lack of self-care behaviours that are common in medical settings. If his or her supervisor (who also took the course) observed the resident taking time to eat perhaps this would not be viewed negatively. Importantly, the supervisor could model mindful medical practice and teach in a student-oriented manner².

Next, while I was on sabbatical leave in Paris, France, we ventured into another levelling field. The rest of this narrative will highlight what was observed during the three months of offering three MBSR courses: one to patients with chronic illness (Group 1); one to clinicians (Group 2, consisting of physicians, nurses, psychologists, dieticians); and the third to doctors and patients together (Group 3) – not their own patients, as this may have inhibited participation. The first author (PLD) taught the courses and is the narrator throughout this paper, except for the section written by the third author (MS), a psychiatrist who participated in the third group.

The Context: French Society and l'Hôpital Pitié-Salpêtrière³

France, for centuries, was dominated by Royalty, the Catholic Church, and a strict social structure into which one was born. Historically, physicians originated from the upper echelons of society that had the opportunity to be educated. In 1612, a noble woman, Madame Marie de Médicis funded the Notre-Dame de la Pitié Hospice as a means of containing beggars and providing a home for orphans. King Louis XIV, in 1656, expanded the plan by authorizing the Hôpital Général to be divided into five sections including a prison, workshops for the orphans, confined spaces for mentally ill and prostitutes, as well as care for infants and the homeless elders. "Hospice" referred to a refuge for the needy i.e., charity extended by nuns and the church, not a hospital or care for those dying as we currently use the term.

The French Revolution in 1789 shook the very foundations of society, including the medical world. Prior to this monumental event, patients who had the means to pay were treated by doctors who made house calls. The impact in medicine was seen in who could become doctors. No longer restricted to those of high birth, self-made professionals became physicians based on ability, learning, and personal endeavor⁴. The "Medical Revolution" brought forth the notion of the universal right to health and medical services. Nonetheless, rivalry between Professors of Medicine originating from the "*haute bourgeoisie*" who were educated in the prestigious universities and doctors who trained in the hospital trenches remained intact.

History helps one to understand why French doctors retain positions of power. Yet, the past decade has brought forth significant changes in their social status. Currently less respect and appreciation is anticipated from patients who are seen as "consumers" with more knowledge about diseases and treatment, acquired through the Internet. Patient associations have formed with a political role in society promoted by the "patient empowerment movement." Moreover, recent legislation pertaining to patients' rights must be taken into account; this has had direct implications for therapeutic choices, as well as mandatory patient participation (and patients' representatives) in institutional missions, especially those found in public hospitals. As with most social changes, resistance has been evident. In the field of patient education, a law was passed in 2009 ("*Hôpital, Patient, Santé et Territoires*") that requires patient representatives to be involved in the design of counselling programs for patients with chronic illness. While incomplete, these changes are leading to more egalitarian relationships between physicians and patients, contributing to whole person care.

Given that change is stressful, it is not surprising that those working in the public sector are experiencing distress and sometimes burnout. This is compounded by challenging work environments which have deteriorated in the past few years with the economic downturn. Thus, there is a critical need to support those whose profession is to aid the sick and relieve their suffering.

In this context, we posted on-line to 45,000 individuals in our institution an invitation to participate in a study about the relationship between mindfulness training and therapeutic relationships. To our surprise, nearly 300 completed a form indicating their interest; not all met our criteria and this was many more than we could accommodate. As planned for our study, three groups were formed, one with patients living with chronic illness (Group 1), one with health care professionals only (Group 2), and one with a mix of doctors and patients (Group 3). This latter group was experimental as never before was MBSR taught to clinicians and patients together.

Group 1

I (PLD) was struck by the use of the term “*les malades*” translated as “the sick ones”; patients were called this rather than “a person with an illness”. Thus, they were labelled by others and they donned this categorization like a heavy cloak hiding their true identity. I gently tried to help them discard it. A few participants in this group were health care professionals, but they chose to be in the patient group given they each had a particular health problem. I found it interesting that they were able to “cross-over” with regard to status. A nurse wanted to cope better with chronic pain and anxiety; a social worker hoped to heal physically and spiritually from an immune disorder.

During the first class an unexpected, undesirable event occurred. Eighteen individuals were on yoga mats just beginning the body scan meditation when a tall, dark-haired doctor wearing a white coat pushed open the door, almost stepped on a person, seemingly confounded. He stated in no uncertain terms that he required the room for a staff meeting. I replied that I was working with patients. He left, but stomped back in the room a moment later using all of his authority insisting that we leave immediately. I pointed out that these were patients; nonetheless, we gathered our belongings and left. For this doctor, sharing a conference room with patients may have seemed like an invasion, even though he had been informed about the room agenda changes.

During the second class, after the body scan meditation, I invited the group to examine what had occurred. One patient said she saw this authority figure loom over her when she tried to practice the body scan at home and it was hard to get him out of her mind. She had similar experiences with doctors who were domineering and it called up difficult emotions. The women beside me said she noted that he seemed confused like a small boy and he reacted to that feeling by exerting his power. A third person said this is typical behaviour – a lack of respect by medical staff. Finally, someone commented upon my behaviour. My assertiveness was based on the notion that a hospital is for patients and serving them is our purpose; I was neither angry nor aggressive; I gave in to his demands as it was clear that I had no choice.

This group was fully engaged throughout, sharing their experiences, asking pertinent questions, and seemingly happy to be together. I found renewed inspiration in leading this group of women and men with kidney transplants, distressing symptoms, some who were depressed, and others who were anxious about the next illness episode, all willing to come and face their suffering. While some were also caregivers they did not distinguish themselves as such.

Midway into the course I became aware of the fact that I am both a provider and recipient of health care services. For many years I resisted the notion that my spine was narrowing (stenosis) and osteoarthritis was gradually gnawing away at my bones located at L4-5, despite MRI images suggesting significant damage. It took a few pinched nerves and referred pain to make me look closer at what I wanted to avoid. It also took my family doctor a few years to convince me that while swimming, yoga, and meditation retreats were good, medical treatment was called for. Thus, I was able to use this experience in class consciously so that those living with chronic illness or pain knew that I was truly one of them. I checked my intention for sharing before I disclosed how I manage what has become an intermittent chronic condition.

Group 2

In a way, this could be considered the control group since it is the only one that did not include individuals with chronic illness. As we began, what was most striking was the lack of participation. The 16 professionals were a mix of two physicians, two nurses, a dietician, an osteopath; most were psychologists. They seemed reticent to speak, even after a simple invitation to share what was noticed when observing the breath during a brief introduction to meditation. The group was a good size; one that usually invites engagement. As the weeks passed it seemed as if these health care professionals dared a bit more to risk opening up to themselves and each other, but much less than in the other two groups. Only following the silent retreat day did they begin to share their experiences with some ease. Several mentioned the importance of group support. Commenting on the silent retreat day in which the three groups were mixed over the weekend, a physician stated that she noticed patients who had difficulty with the yoga practice; the way she articulated her remark suggested the “us/them” distinction. I wondered how she knew who was a patient and who was not. For example, an older woman who uses two canes to walk is, in fact, a physician. When we opened this up for discussion insight was gained with regard to our common humanity.

In the final class, a psychologist who had not attended the retreat expressed her view with regard to the difference between caregivers and patients; she did not appreciate how I led the inquiry with the

physician. She did not think one could ignore the clinician/patient distinction. When I asked the group how they applied mindfulness to their clinical work, several were forthcoming. For instance, a doctor working in an addiction clinic sometimes teaches patients how awareness of breath can be relaxing. A nurse stopped multitasking when with patients. The doctor who had made the remark about “us/them” showed deep insight when she described how her original goal was to improve relations with her patients; with time she realized that she needed first to be well in herself before she could do this. She noticed that she was calmer and listened more deeply to those she serves. Her compassion clearly revealed the transformation that had taken place in her.

Once the course was over I spoke with the third author (a psychiatrist) about this group being difficult to engage: he suggested that if the room was dominated by psychologists the psychodynamic influence of their training may have been the foundation of the seemingly unproductive silences. While this is a hypothesis, I observed that those who did speak were not psychologists. A doctor in the group pointed out to me (individually) that learning may have occurred that was not disclosed publically. Lastly, another physician proposed another hypothesis (individually). She described how the French education system instills fear of failure in young pupils who remain silent rather than risk being punished for making a mistake. She stated that clinicians are competitive and choose not to reveal themselves as a defensive measure in order not to appear inferior.

Group 3

This was the official experimental group: we wondered if it was feasible and/or desirable to have caregivers and those who were cared for take the program together. I (PLD), in line with mindful practice, observed the group dynamics while remaining aware of my own thoughts and feelings. Up until this point my work with clinicians was the modified MBSR course⁵; but here was the standard version, with less emphasis on communication. I wondered if the caregivers would benefit as much as in our previous work. Motivations for taking the course varied: clinicians voiced the desire to have better relations with their patients, see the difference between Mindfulness-Based Cognitive Therapy and MBSR, and improve communication with other professionals. Many wanted to manage stress better and learn how to meditate. Those with illnesses, on the other hand, hoped to cope with medical problems, deal with stress better, and overcome depression and anxiety.

At the beginning I pointed out that the difference between those who provide health care and those who receive it is temporary. If we live long enough we will all be patients – suffering from arthritis, low back pain, or diagnosed with cancer. Mindfulness prepares us for this as we all must come to terms with: the fact that we will all grow older, perhaps become disabled, and certainly die. In the second class I realized

that sometimes it was obvious who was the patient (the artist with a grey ponytail awaiting a transplant) and sometimes not. I wondered what would happen when they worked in dyads. I simply paired them based on seating arrangements. Did it matter who was with whom? I observed a vibrant cardiologist interact with the aging artist. When he seemed confused as to how to follow the instructions she automatically fell into her role as the person in charge. I intervened so she could experience the exercise for herself rather than guide him. During the debriefing a patient stated that to speak so frankly with a stranger felt intimidating suggesting the exercise itself may challenge French people who tend to be reserved.

In the third class, when we all wore badges with first names only (not typical in the French culture) the participants began to relax. Was this a result of the yoga practice which eliminated some stiffness or was it due to my reassembling them into three groups of six people? Nonetheless, a gynecologist wanted to use her hospital badge rather than the simple one we each made; I discretely replied that it was not a good idea as it would distinguish her from the others.

Relating their experiences of positive events allowed them to share their common humanity. While in subgroups (all '1s', '2s' and '3s' placed together – this ensures people do not form cliques) a young psychiatrist told of how he was kinder to a clerk and how they both enjoyed the encounter. His face expressed delight. A physician with post-polio symptoms smiled. Later, in the larger group the clinicians began to share informal mindfulness experiences; an oncologist noted that he changed his attitude and thus was more patient while waiting for an elevator. A patient expressed her dismay at being unable to rid herself of worrisome thoughts. Another psychiatrist who had been on call throughout the night shift looked exhausted; the yoga practice did not increase his energy level as it did for others.

I noticed in the fourth class, when the participants were regrouped by seasons (e.g., the 'winters' formed a small circle) there were two professionals and two patients in two of the subgroups. Twice I redirected doctors who were leading patients, e.g., helping them to clarify when they recounted an unpleasant event. The patients fell into line, i.e., maintain their roles i.e., "*les malades*." I tactfully indicated that the instructions were to 'simply listen' to others' experiences. During the debriefing with the larger group, the cardiologist related that each time the telephone rang she reacted (in a conditioned manner) with her heart sounding an alarm and negative thoughts (e.g., What else will I be asked to do now?!) dominating her mind. She was beginning to witness her own reactivity.

In the context of the stress management aspect of the course, I directly addressed those with chronic illness when I spoke of managing pain – an internal stressor. Without using the psychological term 'disidentification', I spoke to all with regard to changing one's relationship to thoughts, physical sensations, and emotions. Suffering is exacerbated when we react to what we cannot change.

Rumination was named as another internal stressor: one common to patients and professionals alike. A physician spoke of her body tightening each Monday morning as she neared her worksite. She was unaware of thoughts connected to this experience. I wondered what those with chronic illnesses thought when they heard about difficulties faced by clinicians.

As part of communication training I used Insight Dialogue practice⁶ in dyads: the topics for reflection and sharing were: pleasant, neutral and unpleasant interpersonal relationships. The steps were guided using: pause, relax, open, trust emergence, speak the truth, and listen deeply. The listener is instructed to not respond by nodding, talking or encouraging the speaker in any way. S/he is requested to offer her/his full attention. The speaker is asked to relate what is occurring in the here and now while contemplating the subject of reflection. Being the listener usually is most challenging as we are socialized and conditioned in our speech habits (e.g., interject one's own experience; think about what you will say when it is your 'turn'). Indeed, an internist could not control herself and continued to interact even when I asked her not to twice.

The full group discussion afterwards is always animated. A surgeon with burnout scores off the chart revealed that being allowed to express herself was a relief, as she finds that others are impatient and often interrupt her. This disclosure informed the internist who thought it unnatural not to respond. She realized that she was projecting what she would want the other to do if it were she speaking. Such is the insight aspect of the practice. I used this as an example to highlight the need for clinicians to use deep listening skills with their patients, making that point that they will likely practice better medicine in doing so (e.g., diagnose accurately when taking into account the patient's narrative).

By the sixth class, this group was in full swing. Who was with whom seemed not to matter. Occasionally reference was made with regard to the application of mindfulness in the clinical context, but it did not seem to separate participants. During the retreat, one doctor who usually sat next to his colleagues was closer to the patients at the end of the day.

One physician dropped out of the course after attending four classes. He wrote in an email that he was not at ease with the mixed group configuration and that he did not appreciate the emphasis on listening skills. Yet, during the final class when a discussion was opened with regard to this mix, many expressed an opposite view. Most stated that they did not really know who was who in terms of patient or professional unless it was obvious from the exchanges in the dyads. The cardiologist indicated that it was illuminating and that she was more open and honest as a consequence of the presence of patients. A patient revealed how much anger she was living with: rage related to her illness, how it limits her life, and how powerless she felt as a consequence. She was able to release this anger with each exhalation and this practice was healing. I noticed that the physicians spoke much more than the patients during the

course. Perhaps this was related to the fact that there were more of them than patients; two patients dropped out due to advanced illness, leaving only five at the end. Or, given their status maybe they are more accustomed to taking the lead in discussions. The following section, written by one of the physicians in this group, has been included to provide insight into these matters. It was agreed that he would contribute only after the course was completed so as not to impact his participation.

A participant doctor's perspective on Group 3

My (MS) intention for taking the MBSR training stemmed mainly from curiosity and the apparent opportunity to improve the quality of my attention when with patients. As a pediatric psychiatrist I sometimes felt overwhelmed by stressful situations, especially those related to child abuse. I hoped the program would give me a break and help me relax somehow during the 60-hour-work-week-rush.

Prior to taking the course, I had only a vague notion about mindfulness. I had heard about it from other physicians and a few of my patients' parents. I had even tried to follow one of my Parisian colleague's audiobooks⁷ but stopped after a week as I could not find time for regular practice. It seemed then that MBSR was a trendy relaxation technique or some novel type of psychotherapy. Yet, after the first couple of weeks, with practice, I realized that it is neither a technique nor a form of psychotherapy. Gradually meditation began to transform my life.

While MBSR requires engagement, above all it demands honesty towards oneself. The invitation made during the first class to "come as we are" or more precisely as "human beings" without our habitual social roles was intriguing and encouraged me to give it a try. I kept a journal and in my notes I wrote about the fear of not finding the daily hour for practice but, surprisingly, mindfulness shows us how to gain time by being more present in what we are doing each moment. I was confronted by clinical demands, preparing classes for my students, endless paperwork following consultations, scheduling meetings – all the while harboring worries about renovating my bathroom before the birth of my child. My pregnant wife needed my help and more support. Being emotionally available for my patients, colleagues, and family was an everyday challenge.

For me, the experience of change was the most powerful motivator for perseverance. I woke up earlier to practice; day after day, I involved my wife and family thereby was able to reorganize my personal life.

We were informed that our group would be a mix patients and health care professionals. Except for a few participants who spoke about the burden of their conditions, there was no clear difference between us. I wondered if some of my colleagues participated "as patients" or "as professionals" but the absence of

indications made such distinctions irrelevant. We were all at the same level. Usually people define themselves by their work, their origins, family status or, in a hospital their medical condition. We all have multiple identities and depending on the context we choose more or less consciously which one to display. The special frame of the course invited us to discard these masks and created a space where participants felt confident enough to express themselves freely. Nonetheless, when one of the participants expressed the emotional impact of her cancer diagnosis, it was hard not to try to advise her as I usually do with patients who need support and care. During those very moving moments, the instructor (PLD) guided me towards an appropriate relational distance and reminded me about the frame of the course in a tactful and discreet way.

Personally I felt more comfortable with sitting meditation and awareness of breath than with yoga. MBSR has certain flexibility and allows us choose our practice – those that suit our expectations and personality. It offered me the possibility of discovering my own internal landscape.

The group dynamics were fundamental and helped me to maintain my involvement. It also encouraged vicarious learning. By sharing our individual experiences with the instructor and the other participants we learned how we all dealt every week with adapting what we were learning to our own lifestyles.

The experience of the silent retreat day made me feel a little bit more part of my group. However, eating lunch in silence was most perplexing as it presented a paradox of a pro-social context without the possibility of sharing impressions or simply thanking the other participants for the delicious meals they prepared.

I was impressed by the quality of the presence of the instructor as she was available for every participant during the entire course. She guided us and maintained the frame of the teaching with a disconcerting ease. At the end of the silent retreat day a young woman started to cry explaining how the silence echoed her inner feeling of solitude and loneliness. My automatic reaction would have been to reassure her but I noticed how gently the instructor asked her to focus her attention on this emotion and guided her to take a little step backward to cope with this intense experience. The woman calmed down without having to avoid the feelings.

I reflected upon the meditation practice and the instructor's personal involvement- wondering which touched me the most. From a Frenchman's perspective, the intercultural aspect of her explanations - a native English speaker working in transatlantic hospitals and universities – she probably contributed to my being able to accept several points, such as the badges with the first names or the open group discussions about French hospitals and life in Paris. The quality of her attention and the evident joy of sharing her impressions were definitely an example for all of us. Would my experience with another

instructor or in another group be the same? I will never know. But by the end I knew that one's function in life (e.g., I am a doctor) and hierarchy don't matter so much since all personal experiences are true and of equal value.

The last class coincided with the birth of my little girl. I am convinced that this course helped me to become a better clinician, colleague, and hopefully father. For example, in the past I would not have told my patients or their parents that I was off work because our baby was just born. Then I realized that by sharing this personal information I was modeling the importance of the father in a child's life, in the context of pediatric psychiatry. I did not need to wear a mask: I am a human being who is also a physician and can be my real self with them.

CONCLUSION

This experience addressing hierarchy in medicine head-on was enlightening. We are encouraged to mix patients with health care professionals in future groups. Our next research step will be to analyze data pertaining to audiotapes of doctor-patient encounters pre- and post-MBSR to determine if improvements in communication and patient care are evident for those doctors who took the course. Patients in those encounters (not in the MBSR course) have independently rated their doctors using the Rochester Communication Rating Scale, developed by Dr. Ron Epstein's team where mindful practice is taught and studied⁸. Thus, we will have independent ratings of the impact MBSR has on the practice of whole person care. ■

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