EDUCATING FOR MISSION, MEANING, AND COMPASSION

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As A MEDICAL EDUCATOR, I know little about education or educational theory. The only preparation that I have had for teaching is that I've studied medicine myself and have been successful at practicing it. There is a certain arrogance in this: rather like saying that the only qualification a person might need to teach kindergarten is that they were successful at being a five-year-old.

This chapter is based on two curricula that I have designed and taught since 1991. One is a semester—long course for first— and second—year medical students at the University of California at San Francisco School of Medicine, called The Care of the Soul. The other is a postgraduate continuing medical education course accredited by the California Medical Association that I teach for physicians at Commonweal. The latter is a year-long curriculum entitled Relationship Centered Care. The hundred physicians who have gone through this postgraduate course since it began are all traditional practitioners and academics: surgeons, internists, cardiologists, oncologists, emergency room physicians, and the like.

Although designed for those at very different stages in a medical career, both of these courses focus on the individual's experience of compassion and meaning. The medical students' course might be seen as preventative, while the physicians' course, unfortunately, is often re medial. I have learned a great deal about the strengths and shortcomings of contemporary medical education from these two very different groups of learners, and would like to share some of this insight with you.

Compassion, of course, cannot be taught. Compassion is discovered, or perhaps simply remembered. So teaching a course on compassion is fairly audacious in and of itself. Compassion is not a behavior; neither is it an action. Compassion is a lived experience of profound connection from which all of the behaviors and actions that we might call "compassionate" emerge.

Most important, compassion is not an act of obedience. We do not act in a compassionate way because someone has told us to act com passionately, or even because we want to be good people. Such acts are not really compassionate. Compassion emerges from a sense of be longing: the experience that all suffering is like our suffering and all joy is like our joy. When we know ourselves to be connected to all others, acting compassionately is simply the natural thing to do.

True compassion requires us to attend to our own humanity, to come to a deep acceptance of our own life as it is. It requires us to come into right relationship with that which is most human in our selves, that which is most capable of suffering.

By recognizing and attending to that basic humanness, our basic human integrity, we find the place of profound connection to all life. That connection then becomes for us the ground of being. It is only through connection that we can recover true compassion, or any authentic sense of meaning in life: a sense of the mysterious, the profound, the sacred nature of the world.

Recovering compassion requires us to confront the shadow of our culture directly. While relatively few people carry a gun, we all carry with us the values of the frontier, such values as self—sufficiency, competence, independence, and mastery. These are core values of our culture. We are a culture that values mastery and control. But in the shadow of these values lies a profound sense of isolation from our human wholeness. As individuals and as a culture we have developed a contempt for anything in ourselves and in others that has needs, and is capable of suffering. In our isolation, we also tend to develop a suspicion of anything beyond ourselves, anything that falls outside of our control. So we become separated, both horizontally and vertically.

Shadow is the wound that a culture inflicts on its people: a diminishing of innate wholeness through a collective judgment or disapproval. Every culture diminishes wholeness in its own way. All people born into a culture find approval for certain aspects of their own wholeness and suffer judgment for certain other aspects. It is only human to trade our wholeness for approval, and share in the collective wound. Some of us are more deeply wounded than others, but no one escapes.

Of all of the contemporary cultural institutions, education holds the greatest promise for healing the wounds of the cultural shadow. In some ways, education has historically held this responsibility. *Educare*, the root of the word *education*, means "to lead forth the hidden wholeness," the innate integrity that is in every person. And as such, there is a place where "to educate" and "to heal" mean the same thing. Educators are healers. Educators and healers both trust in the wholeness of life and in the wholeness of people. Both have come to serve this wholeness.

Now, as educators, we cannot heal the shadow of our culture by educating people to succeed in society as it is. We must have the courage to educate people to heal this world into what it might be come. Medical education does not yet do this. The current charge of medical education is to create successful doctors and technicians, most successful and

admired members of a wounded society are those who carry the cultural wound most deeply. In my experience, many doctors embody the cultural shadow. In fact, we are trained to embody it.

As a student in medical school, I was rewarded for my woundedness and punished for my wholeness. My sense of cultural wound was actually deepened and reinforced by my experience of medical education. It took me many years to realize that medical education is not an education at all: it is a training. An education evokes wholeness and attends to integrity, while a training specializes, focuses, and narrows us. And in specializing, we disavow parts of our wholeness. We sacrifice our wholeness for expertise.

Many years ago when I was twelve years old I was taken to Quebec. During a visit to a historic graveyard I saw a tombstone which said: "Here lies George Brown; born a man, died a gastroenterologist." Now, I come from a medical family. In two generations of my family, there are nine physicians and so I was inspired by this epitaph. It never occurred to me that this was not a step up.

In the medical culture, we do not engage with our full humanity. In fact, authentic human connection—connecting to the humanness in yourself and in others—is actually seen as being something undesirable, unprofessional, even dangerous. We have become ashamed of our wholeness and may come to see it as a weakness. We are taught to fear connecting with our humanness, and especially our emotions, because this will destroy our scientific objectivity and mar our judgment.

Objectivity is seen as a requirement for those who wish to be good physicians. To this end, we are literally trained to distance, to expect that truth is best perceived at arm's length. We are taught that if we lose our objectivity we will make mistakes. Many physicians believe that keeping distance will protect them from making mistakes. After thirty-seven years as a physician, I think I would have to say that many more mistakes are made in medicine because of objectivity than were ever made in medicine because of objectivity than were ever made because of knowing sick people too well.

Sir William Osler is often misquoted as having said that objectivity is the single most important trait of the true physician. He spoke in Latin and the word which is usually translated as "objectivity" is ***aequinirnitas. Aequinimitas*** does not mean "objectivity," it means "mental stillness" or "inner peace." Inner peace is an important quality for anyone whose daily work puts them in contact with human suffering. But this is not the outcome of distancing oneself from life, rather it is about knowing life so intimately that one has become able to trust and accept life whole, embracing its darkness in order to know its grace.

One of the early things we do in the continuing medical education curriculum is help physicians to "unload the baggage" they carry from their training. We do this by asking them to tell their stories. Telling these stories to a group of physician colleagues is profoundly healing. Often it feels like freeing oneself from some sort of collective spell.

At the close of one of the first storytelling sessions, one of the physicians said that he understood how the statue in Pygmalion must have felt when it was freed to come to life.

One of my own stories is typical of these kinds of stories. On the second day of my internship in pediatrics I went with my senior resident to tell young parents that the automobile accident from which they had escaped without a scratch had killed their child. When they heard this news, they broke down and cried. Very new to this doctor thing, I had cried with them over their loss. After it was over, the senior resident took me aside and told me that I had behaved very un professionally. "These people were counting on our strength," he said. I had let them down. As one of the only women in the training pro gram, I desperately wanted to get it right and I took his criticism very much to heart. By the time I myself was senior resident, I hadn't cried in years.

During that year a two-year-old baby drowned in a bathtub. I directed a team which fought determinedly to resuscitate him but after an hour we had to concede defeat. Taking the intern with me, I went to tell these parents that we had not been able to save their child. Overwhelmed, they began to sob. After a time, the father looked at me standing there, strong and silent in my white coat, the shaken intern by my side. "I'm sorry, Doctor," he said, "I'll get a hold of myself in a minute." I remember this man, his face wet with a father's tears and I think of his apology with shame. Convinced by then that emotion was a useless, self-indulgent waste of time, I had become the sort of a person you could apologize to for being in agony. In many ways, medical training is like a disease; you need to recover from it. Fortunately this is possible: I am a recovering physician.

I'd like to tell you about beginning a program of recovery in the heart of a major training institution, the UCSF School of Medicine. It is a program whose goal is to enable people in the midst of their medical training to remember their wholeness, to attend to it in them selves and in others, to connect deeply with themselves and others, and hopefully to preserve a sense of compassion and meaning in their professional lives.

A course such as this can become a strategy for healing the collective wound of the medical culture. The wounds of the cultural shadow are very difficult for an individual to heal alone because they are reinforced everywhere. Every social interaction reinforces these wounds; every innuendo reinforces them; in expressing greater whole ness you see judgment in the eyes of everyone around you. No this is different from recovering from the wound inflicted by family shadow. Not everyone has grown up in your family. So when you leave home, you can find people who can offer you through their relationship a different perspective from the one you grew up with: a permission for greater wholeness. There are many healers of family shadow, but few healers of cultural shadow; we carry the cultural shadow collectively.

But just as culture wounds, culture heals. Healing the shadow of a culture may require the formation of a subculture of credible people who value that which has been devalued by the dominant culture. This subculture confers on its participants permission for a greater wholeness and heals them.

It is possible for a single course in a medical school to become such a subculture. The students in this course recognize each other. During the course they learn to share honestly with each other. They come to know and trust one another. They support each other's wholeness. Because a medical school is a relatively small community; these students will continue to associate with each other long after the course has ended. They see each other in elevators. They see each other in the halls. Sometimes they simply pass each other. Other times they talk with each other. But each time they meet, they create for each other a place of refuge from the cultural shadow, a reminding of a greater wholeness. The Healer's Art is an elective course that enrolls between fifty and sixty first-year medical students each year. It has been taught continuously for the past eight years. At this point, one out of every three medical students currently enrolled at UCSF has been through this course.

The UCSF catalogue does not say that The Healer's Art is a course in compassion and meaning but states that the purpose of the course is attending to human wholeness: one's own wholeness and the whole ness of others. The course is experiential rather than didactic and based on a discovery model. These sessions are each three hours long and take place in the evening, in the very large living room of the faculty/alumni house, an informal, homelike setting. By choosing this time and place, we change mental set from the very beginning; we take students out of the familiar physical environment and the customary time frame where the shadow dominates. Let me describe the first two sessions of this course.

That first evening, everyone arrives wearing masks. Masks of professionalism, masks of expertise, and masks of confidence and invulnerability. By their second year, many students have worn this mask so constantly that they may not realize or remember that they are wearing it.

Gathered in the room are the fifty to sixty students, and ten to twenty practicing physicians who are either graduates of our physician's training program in Relationship-Centered Care or favorite UCSF faculty selected by the student advisors to the course. These doctors—who represent all the major medical specialties—serve as course faculty and teach from a level playing field, sharing their own personal experiences, vulnerabilities, concerns, and satisfactions in the practice of medicine. This in itself is unique. Many students have told us that they have never before known a practicing physician person ally, as a friend.

At the beginning, the room is not a comfortable place to be. As we sit together the first night, you can actually feel a certain wariness, the competitiveness between the students and their isolation from each other. And of course you can also sense fear, because isolation causes us to be vulnerable and afraid.

I begin that first evening by offering the students silence as a substitute for fear and isolation. Now, this itself is a very rare thing in a medical school classroom—having permission to be silent together. Yet silence is the way we connect, both to each other and to ourselves. I say a few words about the importance of silence and initiate a brief

period of sitting in silence together. After fifteen minutes of silence, I ask the students a single question: "Is there a part of you that you are afraid you may forget in this process of becoming a doctor?" This question is a shock. It directly addresses a hidden fear shared by almost every medical student: the personal experience of the shadow of the medical culture.

I ask them to reflect upon this question first within the privacy of their own consciousness. Then I ask them to find a symbol or image for the part of themselves that is vulnerable to becoming lost, and to name its quality or qualities. I ask them how old this part is; how long it has been with them; and how precious it is to them. I ask them to consider what this part of themselves has added to their lives and what would it mean for a person who is ill to meet with this part. Finally, I ask them to write down their responses to the questions. There is such a taboo around these dimensions of the self that students often need to write their insights down first before they can openly discuss them.

Then we break into small groups. The students will be part of the same small group for the length of the course. Each group is made up of five or six students and a physician. The physicians facilitate the group as well as share their personal responses to the experiential exercises—in the same honest way that the students do. This is very important and quite powerful, as most of the students know physicians mainly as admired and seemingly infallible experts or as teachers who evaluate them. Over the course of the semester the students will get to know these doctors as genuinely as they will get to know them selves and each other.

The groups begin by sharing what they discovered in the exercise: at first very hesitantly, and then more and more openly as it becomes clear that, despite appearances, everybody has a part that they fear losing. The masks of control and professionalism fall away, and the students find an acceptance for personal aspects and concerns they have hidden because the dominant culture disavows them. The groups then develop and discuss ways to feed and nurture these parts of them selves, ways to attend to them. Very specific approaches—which may involve ritual, imagery, journal writing, poetry, music, and meditation—are designed by the students, shared with the small group, and validated.

Each small-group session ends with a healing circle exercise. This, too, involves sitting together in silence. The physician rings a bell, and then the student to his or her left says their name aloud. In silence, the group attends to the humanity of that student. They listen. They remember the part of their humanity that that particular student is struggling to preserve. And in perfect silence, they send strength: they believe in the student; they value their humanity; and they may even pray for it. They offer their silent support for each student's struggle to be whole.

After a minute or so the bell is rung again, and the next student to the left says their name. Everyone attends to this student for a minute; and we continue around the circle until the doctor has said his or her name and everyone has attended to him or her as well, As we do this exercise, the group moves into what might be termed a right relationship

with each other for the first time, a supportive collegiality based on affirming the wholeness of every person in the group.

Now, I do this same closing exercise in our continuing medical education training with postgraduate doctors, but there is a difference. When I do a healing circle with a group of oncologists, radiologists, surgeons, internists, emergency-room doctors—middle-aged men who have lived with the cultural shadow for most of their professional lives—they are often moved to tears.

The first time I led this exercise, I was startled by its emotional power for the group. After the exercise was complete, one of the doctors explained this by saying, "I've never been wished well by another doctor before." The medical profession is a culture of profound isolation.

The second three-hour medical-student session is held two or three weeks later and is an exploration of loss, grief, and healing. Using the discovery model, I ask the faculty and the students to reflect on and identify their own style of dealing with loss, often a style learned from family and enforced by medical culture. We discuss all the things people do to manage loss, strategies such as denial, rationalization, busyness, substitution, spiritualization, and the like: strategies that numb pain but do not heal loss. I then present grieving as the way that loss can heal. Then, I teach them to grieve together.

Once a student stood at the close of this session, and said to me, "You know we've already had two lectures on grieving from the psychiatry department." I was horrified to hear this and apologized, saying that had I known I would have chosen another topic.

"Oh, no," she responded. "This is different. Our lectures were focused on the grief of patients. They told us many of our patients would be grieving, and that we would need to make allowances for this. That their minds would not be functioning clearly because of their grief, and we would have to repeat things—often several times. We even learned the medications you can give to numb psychological pain. But they didn't tell us that we ourselves would have anything to grieve."

In a medical lifetime, a physician encounters a great deal of loss and disappointment, often on a daily basis. These range from small events such as discovering that a treatment is not working as hoped to the large blow of a patient's death. But as professionals, we are not supposed to be personally touched by any of this. This is a bit like walking through water and expecting yourself to emerge dry. After a lifetime of ungrieved loss it is not surprising that depression, cynicism, and burnout are so common in medicine. Grieving allows us to heal from loss, to risk closeness in situations where loss is a possibility, to be openhearted and present with patients. Grieving allows us to become close enough to feel compassion. So in this course, the students are given the opportunity to revisit one of their own personal losses and begin to heal it.

In the small groups, students will tell each other the story of one of their own losses. The students are asked to listen to each other's stories of loss with respect. They are told that

many of the things they will hear about cannot be fixed, and are encouraged to listen without thinking about how to fix things. If you believe that your job as a physician is to fix everything, you may not want to hear about the things that cannot be fixed. But this is not about fixing: it is about witnessing and validating the feelings of others. I make it clear that fixing is often disrespectful to loss, and that it is a subtle form of judgment.

So they share their losses, and listen to the losses of others. They cry. They experience the healing which can happen when we simply attend to each others' losses. For many, this session will be a form of metta practice, an experience of authentic compassion. Students learn to see loss as simply one stage in a larger process of life, and to distinguish loss from brokenness. They hear about the hidden vulnerability in others who appeared to be less vulnerable than they knew them selves to be. They examine their own pain and discover what has begun to grow in the places of pain: what has been revealed or learned through loss and suffering. They discover what really matters. Most important, they have the chance to see the qualities of love, devotion, loyalty, and courage in the same people that they were competing with just four weeks ago.

By witnessing the commonality of loss, they come to see loss not as shame or weakness but as a natural part of life. They learn that things that cannot be fixed can still heal, and experience some of that healing personally. The body language often graphically reflects a change in the students' attitudes about loss. At the beginning of the evening, many students sit with their arms folded, often leaning back, away from the center of the circle. By the end, each small group is leaning so close together that their heads almost touch.

In this exercise, students move from an experience of isolation and judgment to an experience of compassion for themselves and each other. In this shift, they find a sense of acceptance, and of intimacy, which is very new. Students often write to us about this. They tell us how it felt to be listened to without judgment. They express surprise at the easing of their pain. They comment on how letting go of fixing the pain of others has enabled them to receive the feelings of their classmates in a new and caring way. They are surprised by the genuineness and depth of their caring. For the first time, they write, they truly want to hear how it is, and know how it feels for others. True compassion naturally arises out of this sense of openness and connection. Out of listening.

In the continuing medical education physicians' course, I do an exercise in listening which is actually a form of reflection and contemplation. I draw on the work of my friend and colleague Angeles Arrien for this exercise, but adapt it for physicians.

I suggest they spend a few minutes each evening, with a special bound journal just for this purpose, and ask themselves three questions about their day. The three questions are: What surprised me today? What moved me or touched me today? What inspired me today? The answers need not be long. What is important is to review the experience of the day for a brief time, looking at it in a new and different way.

A cancer specialist, a surgical oncologist, took this exercise on. He committed to spending five minutes a day considering and answering these questions. This was a very

burned-out, profoundly cynical man whose basic attitude was: "You know, everybody dies anyway. What's the use?"
So the first night, he considered these three questions, and wrote in his journal: "Nothing, nothing, and nothing." The second night, he got the same results: "Nothing, nothing, and nothing."

After two more days of this, he called me up, and said, "What's the trick, Rachel? I don't like to fail at things." I said to him: "Pay attention from the heart. Look at your life experience as if you were a novelist or a poet, not a doctor."

Over time he has come to see his work very differently. "Rachel," he told me, "the most extraordinary people are in my practice!" He has gotten to know them; he has become close to them. He now feels himself enriched by the very same work that he had experienced as a terrible burden.
For most people there is a time gap between experience and perception. At first, people often do not see what's going on around them. After a while they see only several hours after they have lived through an experience. But in the privacy of their living room or their bedroom, in the company of a little journal, over time they begin to see again: to reconnect to their lives and to themselves.

As they do this journal practice—over and over, day after day—the gap diminishes until eventually people are inspired, surprised, moved in the very moment that life is happening within and around them.

Sometimes seeing differently comes spontaneously as a sort of grace. Another doctor found his eyes while he was delivering a baby in the emergency room. Now, emergency-room doctors are like Blue Angels; they're the fighter pilots of medicine. They deal with life and death daily, often at high speed. They rarely get to know anybody whom they treat in any depth. These doctors generally enjoy a sense of competence and mastery. This particular doctor is a man very much like this.

One evening, a woman came into the emergency room within minutes of delivering a baby. The doctor realized that the woman's personal physician probably wasn't going to get there in time, and that he was going to get to deliver this baby himself. Now, this pleased him. In fifteen years of ER work he had delivered hundreds of babies and had always gotten a sense of satisfaction and competence doing it. He told the mother that her doctor was on the way, but if the baby came first he would deliver her. He assured her he had delivered many babies, and that she and her baby were safe. He had barely time to finish speaking when her birth began and he successfully delivered her baby, a little girl. Then, as he was suctioning out the infant's mouth and nose, suddenly she opened her eyes and looked deeply and directly into his eyes. In that moment, the doctor realized that he was the first human being that this child had ever seen. In this moment, something softened in him. Something that had stood between him and the meaning of his work. And he could feel his heart open to her in welcome from the whole human race. His sense of fatigue and cynicism dropped away, and he knew that no matter how

foolish or un deserving we may be, the new ones keep coming and with them comes hope.

As he tells it, in this moment too, all his years of hard work—all the stress and all the sacrifices—were worth it. He felt a sense of the endless grace that life offers us, and a deep sense of gratitude at being there. Compared to this sense of gratitude, he said, the satisfaction that he had found through pursuing competence was nothing. This doctor had delivered hundreds of babies, but he feels he had never really been there as a human being before. He had been there only as a competent professional, an expert, and had missed something important. If you are willing to bring your human heart and eyes to the work of medicine, even the smallest patient will show you the meaning of your work.

Often genuine meaning comes to us as a sense of revelation. Since much meaning is carried in the unconscious mind, in these two curricula I use the unconscious mind as a resource. I use symbols, art, and even poetry. A renewed sense of meaning requires a kind of double vision. We know what we have come to do and we remember why we have come. We have not come to be experts, we have come to be friend life.

In times of crisis, meaning can be a source of strength: meaning enables us to endure and prevail through difficult times. Meaning heals us not by numbing our pain or distracting us from our problems but by reminding us of our integrity: of who we are, of what we are doing, and how we belong. Meaning gives us a place to stand: a place from which to meet the events of our lives; a way to experience life's true value and its mystery. Most of us live far more meaningful lives than we realize. It is possible for physicians to do profoundly meaningful work without ever experiencing a sense of meaning. Objectivity can make you blind.

Meaning is a practice. The recovery of compassion, the recovery of meaning is, in the words of Proust, a "voyage of discovery that lies not in seeking new vistas but in having new eyes." Recovering a sense of original mission and meaning in medical education has been my work for many years. Looking backward, I remember just when and where I recognized the need to recover something lost.

During my second year of medical school, I was invited to a for mal dinner to honor one of our most famous professors, who was re tiring. He was an elderly physician who had made a huge scientific contribution and had the highest international reputation for his medical research.

The occasion was a black-tie affair, and people came from all over the world to honor him. Everyone was invited, even we second-year medical students. During the evening, the professor gave a talk synthesizing the progress of scientific knowledge over the course of the fifty years that he had been a physician and pointing out the directions for future scientific research. The talk was brilliant, and he received a long standing ovation.

I and the other students were completely awed by him, by his life and work. He was the quintessential role model, the doctor we all wanted to become. So afterwards a little

group of us went to talk to him for a minute, really just to be close to him. And one student asked if there was anything that he wanted to tell us now, at the beginning of our careers as doctors.

He looked at us. And an unreadable expression came over his face. In a quiet voice he said that he felt we should know that he didn't know one thing more about life now than he had at the beginning. "I am no wiser," he told us. "It has slipped through my fingers." Then he turned, and just walked away.

Now, we were all very young at the time. The other students thought that the old man had gone gaga. After all, he was sixty-five years old. I didn't think so, but I simply could not understand what he meant. Now, having been a physician myself for close to forty years, I think that I do, and my heart goes out to him.

He was one of the most outstanding alumni of his school. I am certain that his teachers were very proud of him. But I also feel that they failed him in the same way that my own teachers failed me. They did not recognize our need to remember and strengthen our humanness, they did not help us to seek and find the meaning of this work and to hold it close, so that at the end of fifty years of being a physician we might feel grateful for the privilege of living this life of service.

In putting together these thoughts, I remembered an incident that happened at the end of one of the physicians' workshops. I wrote a poem about it, which in closing I'd like to share with you.

A MALA FOR THE TEACHER

At the close of the CME curriculum,
a physician tells me, "I have a gift for you."
His eyes shining.
His face filled with an unaccustomed joy.

In his surgeon's hands he holds a mala of bone beads. "To count your blessings," he tells me.
"To remember life's promise and its grace."

My mala is of different stuff,
My blessings known by heart:

A surgeon who has learned to pray;
An internist who has found he is a healer;
An oncologist who has remembered how to cry.
A cardiologist who once again hears the heart.

Like them, this physician is a blessing,
the giver far more precious than the gift.