Attending

MEDICINE, MINDFULNESS, *and* HUMANITY

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To Deborah, Eli, and Malka, my inspiration

Author's Note

I believe that the practice of medicine depends on a deep understanding between clinicians and patients, and that human understanding starts with understanding oneself. This book is the product of a career in medicine seeking opportunities to know myself better as a clinician and to help others do the same—ultimately to make health care more mindful, attentive, and humane. Writing this book, I've explored realms that I had not previously imagined: the cutting edge of social and cognitive neuroscience, the psychological and philosophical underpinnings of contemplative practices, and the writings of Zen masters, baseball heroes, and ecstatic poets. At each juncture, innumerable friends, colleagues, and total strangers whom I contacted out of the blue offered guidance, correctives, consolations, and camaraderie that helped me find my voice as a writer: from the heart, personal, rooted in stories.

For privacy and confidentiality, I cannot name all of my teachers. Many of them are my patients, and it would be too much to ask them to make public the most intimate moments of their lives. I have altered details of each patient's story and in some cases created a composite of two or more similar stories. Thus, any resemblance of those mentioned in this book to actual living patients and their families is coincidental and not intentional. I have taken similar precautions with the health professionals mentioned in the book, as it is difficult to know if I might unwittingly reveal something that they would rather not have made public. For convenience and readability, when referring to health professionals and patients I have used the singular pronouns *he* and *she*

rather than use the more awkward *he or she* and *his or hers*. This is not to suggest any generalizations based on gender.

In medicine, the senior physician responsible for a patient's care is called the attending physician, or just "the attending." The attending's responsibility is to direct the clinical team's attention to the most important things, take charge, make the patient feel attended to, and provide attentive care. Attending means showing up, being present, listening, and accompanying patients when it matters most. Attending is also a moral imperative: by being attentive, doctors not only provide the best care, they also honor each patient's humanity.

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Being Mindful

Even as a third-year medical student, I knew that pink was good, blue was bad.

I was assisting Mark Gunderson, a senior urologist at a university teaching hospital during my first clinical rotation in surgery. Being in the operating room was engrossing and revelatory, but I felt some trepidation about how I'd fit into the rigid hierarchy of surgical culture. Gunderson was performing a retroperitoneal lymph node dissection, painstakingly removing the lymph nodes surrounding both kidneys and the aorta. The patient, eighteen-year-old Jake Willits, had testicular cancer and the stakes were high; one false move could result in sexual dysfunction or the loss of a kidney.

After Gunderson finished operating on Jake's left kidney, we traded sides of the operating table so that he could work on the right, keeping the left kidney within his peripheral vision. I had a straight-on view of the left kidney. After a few minutes, I noticed that the kidney was turning blue. Gunderson didn't seem to have noticed.

I agonized about what to do. As a lowly medical student, I knew it wasn't my place to offer an opinion to a senior surgeon, but I felt compelled to speak up: "I'm not sure you've got a good view, but the left kidney is looking bluish to me." I spoke loudly enough to be heard, but tentatively enough so as not to appear arrogant. No response. Gunderson asked the scrub nurse for a scalpel. His gaze didn't move. I became increasingly anxious and broke into a sweat. After a few more minutes, the kidney had turned an ominous dusky purple. I quietly

mentioned this to the scrub nurse at my side, who talked to the resident, who then talked to the surgeon.

Gunderson looked and didn't like what he saw. The left kidney had become twisted, blocking blood flow through the renal artery. He tried to untwist the kidney, first one way, then the other. No success. The room became tense and quiet. Now Gunderson was sweating too, knowing that with each passing minute a few more kidney cells would die. After what seemed like an eternity but was probably only a few minutes, Gunderson called in a vascular surgeon to do an urgent repair of the renal artery. Apparently, when the kidney twisted, the intima—the inner lining of the renal artery—had been torn, blocking blood flow. The vascular surgeon had to clamp the artery, make a longitudinal slice, open up the injured area, and excise the torn fragment—delicately, while leaving the outer layers of the artery intact—then sew up the artery. This mishap extended the operation by more than an hour, and while the operation was successful, blood tests just afterward showed that Jake's kidney function was not quite normal. While the surgery likely cured Jake of his cancer, no one knew when—or if—his kidney would fully recover. The next morning, on rounds, Gunderson informed Jake and his parents that an "unavoidable" complication had occurred.[1]

Today when I tell this story to an audience of doctors, I always see nods of understanding. I know that this situation does not mean that Gunderson is a "bad doctor"; so do they. Surgery is difficult and intense, and errors are easy to make. Even the most experienced clinicians—surgeons and otherwise—can suffer lapses of attention and ignore that which in retrospect seems obvious.[2]

The kidney getting twisted might have been unavoidable. But Gunderson's failure to notice and act was not. He was focused, for sure. But his inattention to that which was in plain sight—even after it was pointed out to him—was stunning, especially given that he was an accomplished surgeon at a major teaching hospital. Certainly, the light reflected by the blue kidney was picked up by his retina, and no doubt his ears could detect what I had said. Nevertheless, something happened in that crucial moment to prevent that visual and auditory

data from being fully transmitted to his conscious awareness. In essence, Gunderson hadn't engaged his whole mind.

This event had a powerful impact on me. I realized how easily I could put my patients' lives at risk in a similar way. I was distraught. I lost sleep wondering if I had done something wrong; perhaps, I thought, if I had spoken up more assertively, Jake wouldn't have suffered as much damage to his kidney. And I felt uncomfortable allowing the family to believe that the surgeon was blameless.

I made an appointment to speak with the chief of surgery the next week. I asked if I could talk confidentially. He was a good listener and assured me that I had done the right thing by talking to him and that the mishap was in no way my fault. He was visibly concerned and assured me that he would talk with the surgeon and check in with Jake and his family. We discharged Jake a few days later, in good spirits.

I never saw Gunderson again, and unfortunately I could never know what he truly believed. While I was upset that an error had occurred, it wasn't a surprise to me that even the most expert surgeons could be fallible. The most important lessons, though, were that mindless inattention could result in disaster and that competence is fragile and takes mindful vigilance to maintain. This experience planted the seed of an idea in me—that I'd need not only skill and expertise, but something else to be the doctor I wanted to be, something no one had spent much time teaching me in medical school: the ability to be self-aware, attentive, and present, especially when the stakes were high. I'd need to be a guardian of my patients' health and *also* of my own "inner operating system" in each moment.[3] Awareness of my own mind might be one of the most important tools I could have in addressing patients' needs.

I thought of this event again later that month, while working with Ashwin Mehta, a vascular surgeon at the same hospital. When I arrived at the operating room, Mehta had already made a large incision in Lena Hagopian's abdomen. Mehta was moving quickly, tying and cutting sutures faster than I could count. I couldn't help but notice his focus and intensity, his large hands moving rapidly and decisively as he got ready to repair a cholesterol-clogged aorta to open up blood flow to the patient's oxygen-starved legs. Soft rock music played in the background

as he worked and bantered with the operating room staff. Then, suddenly, the bantering stopped. The operating room grew quiet, a silence different from Gunderson's. The time had come to sew a large blood vessel back together, a procedure that required delicacy and precision. But, the anastomosis—the connection between the two parts of the blood vessel—was leaking. Unlike Gunderson, Mehta noticed that something was awry before anyone else did. By the time *we* realized it, Mehta had already shifted seamlessly from autopilot to more deliberately choreographed action—first tango, then ballet, then a few minutes later back to tango—all without missing a beat. No panic, only calm focus, surgical mindfulness in action. His shifting of gears was so smooth that I wondered if he was even aware of it.[4]

Only decades later did I understand. A surgeon colleague, Carol-Anne Moulton, made the connection for me. She was researching what made great surgeons great and had observed dozens of surgeons performing complex operations. She had documented in detail how during difficult moments masterful surgeons would shift gears. Those who "slowed down when they should" when encountering speed bumps were the true masters; those who kept going full speed ahead tended to make errors.[5] Mehta had slowed down when he should.

Yet when Moulton interviewed surgeons about these slowing down moments, many of the masters didn't realize that they had shifted gears until it was pointed out to them, and only upon reflection could they put into words exactly what triggered them to make the shift. Mehta was not any more technically skilled or knowledgeable than Gunderson; that's not what made him a master. His expertise resided in his exquisite moment-to-moment awareness: he was able to be present and to bring what was needed to each moment. While operating on Mrs. Hagopian, he could also monitor his own inner operating system so that he would realize when he might need to slow down or get help. He accepted and anticipated the possibility that something could go wrong. Whether he thought about it this way or not, Mehta was being mindful.

I discovered that mindfulness is also essential outside the operating room. Later in my third year, I worked with a senior psychiatrist, Dr. Peter Reich. Reich eventually became a mentor—from the first time I

met him, I felt drawn to him by his thoughtfulness, insight, and curiosity about the human condition. At that time, he was responsible for the care of medically ill patients in the hospital who also presented mental health problems. Halfway through the one-month rotation, he and I were called to the neurology unit to see Douglas McCallum, a man in his thirties who had sustained a head injury in a motorcycle accident. Doug was not cooperating with the specialists handling his rehabilitation program; he was moody and irritable and had angry outbursts that frightened the staff. Part of his brain was damaged, the part that had made him the Doug that he and others had known. You could see Doug trying to make sense of his situation, yet his thoughts would leap from one topic to the next and he was unable to retrieve what he had just been saying. His thinking was fragmented. He was frightened because he knew that something was very wrong. He had become a stranger to himself.

The medical team wanted Dr. Reich to help manage Doug's erratic behavior. Reich had a long list of patients to see; given that this one had apparently irreversible brain damage, I expected Reich to assign a diagnosis quickly and prescribe medications to control Doug's behavior —something I had witnessed other psychiatrists doing under similar circumstances. To my surprise, Reich did something radical: he temporarily set aside the imperative to diagnose and treat so that he could get to know Doug as a person. He asked, "What does that feel like?" and "Help me understand." Reich nodded and smiled kindly, indicating that he was not in a rush and was fully engaged. He sought to discover what *was* working in Doug's mind, as well as what wasn't.

While surgeons' tools are scalpels and forceps, Reich's tools were words and gestures. His interview with Doug would flow smoothly for a while, with Doug appearing almost coherent, remembering details and the order in which things occurred. Then Doug would freeze, unable to complete a thought. The circuits were jammed. These uncomfortable pauses reminded us how seriously his mind had gone awry.

Reich was mindful in the same ways as Mehta—he was attending and present—but I could see that there was more to mindfulness than attention and presence. Reich was curious about Doug's experience.[6]

He set aside preconceptions so he could see Doug in a new way. As impressed as I was by Reich's ability to help Doug construct a coherent narrative from a set of disorganized thoughts, I also noticed that Reich was gently persistent during those awkward moments. When Doug abruptly transitioned from one story to another with no logical connector—talking about riding his motorcycle the previous week and then about a camping trip with his brother twenty years prior—Reich encouraged him, saying, "What happened next?" If Doug's reply still didn't make sense, Reich would add, "Are you feeling sometimes that things aren't making sense?" That helped Doug achieve enough clarity to say, "Yep, my thoughts just come and go."

Reich was shifting back and forth between an expert's perspective—making a diagnosis—and a "beginner's mind," stepping into Doug's chaos rather than merely diagnosing it. Reich's openness allowed him to achieve an understanding of the patient as a person without imposing interpretations or judgments. How easy it would have been to reduce Doug to a category, a diagnosis, a problem to be solved. As Doug's attending physician, Reich understood that Doug needed to feel understood, and the more Doug felt understood, the less he'd need to express his distress through disruptive behavior. Reich's resolve to share his patient's experience, rather than ignoring it, distracting himself, or turning away, was courageous and compassionate. He responded to Doug's need—as a suffering human being—to feel understood and cared for, and in that way reaffirmed Doug's humanity.

TURNING INWARD

Mehta and Reich demonstrated to me what was possible. Their habits of mind and presence seemed instinctive. I'm not even sure Mehta and Reich could fully explain what made them mindful during those critical moments. I saw how awareness, flexibility, and attention are crucial for all clinicians, regardless of specialty or profession.

The question was how to get there. Because of the paucity of attention to self-awareness during medical education, I had to rely on other experiences. In my teens, I studied piano, then harpsichord,

hoping to be a performing musician—self-awareness of my breathing, tension, heartbeat, and emotions made the difference between a performance that was technically adept and one that sparkled. When I was sixteen, I learned how to meditate. I spent an evening with a friend's older brother who was a serious student of Zen Buddhism; he taught me how. In my first semester at college, I took a course called Emptiness.[7] In Buddhist philosophy, the concept of emptiness is fundamental; it means that much of what we believe about the world—and about ourselves—is merely an "empty" construct of our own mind and limits us unnecessarily. When you see the world only as perilous, you're correct, but you're only seeing half of the picture. The world is also safe and nurturing. To see it either way alone is incomplete—it is both. When you see yourself only as infallible, you are more likely to miss a blue kidney. When you see yourself only as fallible, you can feel paralyzed. Jon Kabat-Zinn, who popularized mindfulness training in the West, said that being unaware of the labels we place on ourselves is like being in a "straightjacket of unconsciousness."[8] You have no place to move, no place to grow. Emptiness, on the other hand, is being able to see yourself as fallible and infallible at the same time.[9] You are self-assured and confident, but equally aware that you could make an error at any moment. This vision frees you to be whom you need to be—and to do what you need to do—in each moment. Yet freedom takes work—the hard work of being still and cultivating an inner life.

I got a glimpse of that freedom and I wanted more. I left college to spend a few months at the San Francisco Zen Center. Doing sitting meditation for several hours every day was both easy and difficult. I learned that when I had strong feelings—restlessness, impatience, avoidance, self-criticism, loneliness, or fear—I could just *be with* those feelings without having to alter them in any way. I felt centered and resilient, with a sense of dynamic stability. I learned that meditation is not about bliss. Meditation is about a sense of presence, balance, and connection with what is most fundamentally important in your life. It is not about leading a cloistered life; in fact, my time at the Zen Center led me to engage more fully with the world.

Eventually I wanted to translate what I had learned about the inner life so that I could make a difference in the world, and I reconnected

with a childhood desire to be a doctor. Yet I was ill prepared for the culture of medical school. I had spent much of my youth in seminars, music studios, and Zen meditation halls. Med school was an environment of extremes. Altogether, I saw too much harshness, mindlessness, and inhumanity. Medical school was dominated by facts, pathways, and mechanisms; residency was about learning to diagnose, treat, and do procedures, framed by a pit-of-the-stomach dread that you might kill someone by missing something or not knowing enough. Given the life-and-death stakes, I found it jarring that, with few exceptions, medical training did not emphasize deep listening—to oneself or to others. While extolling the virtues of reflection and compassion, medical training largely ignores the development of these capacities—and an inner life in general. I felt disappointed and alone and didn't see a path forward.

Then, Reich sent me a groundbreaking article by George Engel about a "biopsychosocial" approach to care.[10] Engel was a prominent internist and psychoanalyst who practiced and taught at the University of Rochester. I wrote to him, and eventually he became a mentor. Engel showed, through exploring patients' illness experience, how patients' psychological makeup and social relationships were as important to illness and health as the biological, genetic, and molecular aspects of disease. His vision was humanistic; using dazzling illustrations, Engel demonstrated that what the patient reported about his illness and how it affected him was as important as any lab test or X-ray. Engel emphasized that physicians are human too—that their emotional responses to uncertainty, tragedy, grief, and loss would affect the care they provide.[11] This resonated with me. Doctoring was a relationship between two people, each of whom had an inner life. I moved to Rochester and worked with Engel and several of his protégés. Engel was fascinated with human experience, but, in my view, was too much of the cold scientist to offer a method for knowing one's inner life more intimately. Several of his protégés filled that role for me. Trained by Engel, they took his work one step further and offered opportunities for reflection, self-awareness, and mindfulness (so-called Balint groups,[12] family-of-origin groups,[13] personal awareness groups,[14] and

clinical supervision[15]) that were available in few other settings at the time.

Over time I became more comfortable with my level of knowledge and skill as a clinician, yet I still knew that each day, with each patient, sometimes I was the physician I aspired to be and other times I fell short. Falling short had little to do with knowledge and technique, but rather it had to do with my state of mind, what I noticed and attended to. Sometimes I practiced with clarity and compassion, and other times impatience, distraction, unexamined emotions, and defensiveness got in the way.

Lacking a guidebook, I had to look inside myself. Then I'd match up my states of mind with what I had been learning about the sciences of mind—psychology, philosophy, education, and neuroscience. Wading through a profusion of educational and psychological jargon,[16] I came to three conclusions—good doctors need to be self-aware to practice at their best; self-awareness needs to be in the moment, not just Monday-morning quarterbacking; and no one had a road map.[17]

Ten years after I finished my residency, the connections between my prior training in meditation and music and my medical practice finally crystallized. My dean tasked me with developing a new method for assessing the competence of students that would reflect the biopsychosocial values that Rochester had become known for—no small undertaking. I could find few guideposts, not even a coherent definition of professional competence.[18] I wanted to capture the habits of master clinicians, those to whom doctors might refer a friend or relative, as opposed to those who were merely competent—those who merely aced the test.[19] I started writing about "mindful practice"; I drafted a personal manifesto about excellence in clinical practice and proposed that mindful self-awareness, self-monitoring, and self-regulation were at the root of good judgment, compassion, and attentive care. I had not seen a similar vision articulated before, and I had no idea how it would be received.

The manuscript went back and forth to the *Journal of the American Medical Association* seven times, and each time Charlene Breedlove, my insightful and patient editor, asked me to clarify, hone, and condense before "Mindful Practice" finally went to press in 1999.[20] The article

struck a chord. I discovered that I was not alone. I received hundreds of letters and e-mails from other physicians. These practitioners, many of whom had found some form of contemplative practice on their own, felt isolated and in need of a community that would support their efforts to become more mindful, resilient, self-aware, and effective. I was deeply gratified, yet the next steps—to see if mindfulness makes a difference in patient care and how to help clinicians be more mindful—were daunting.

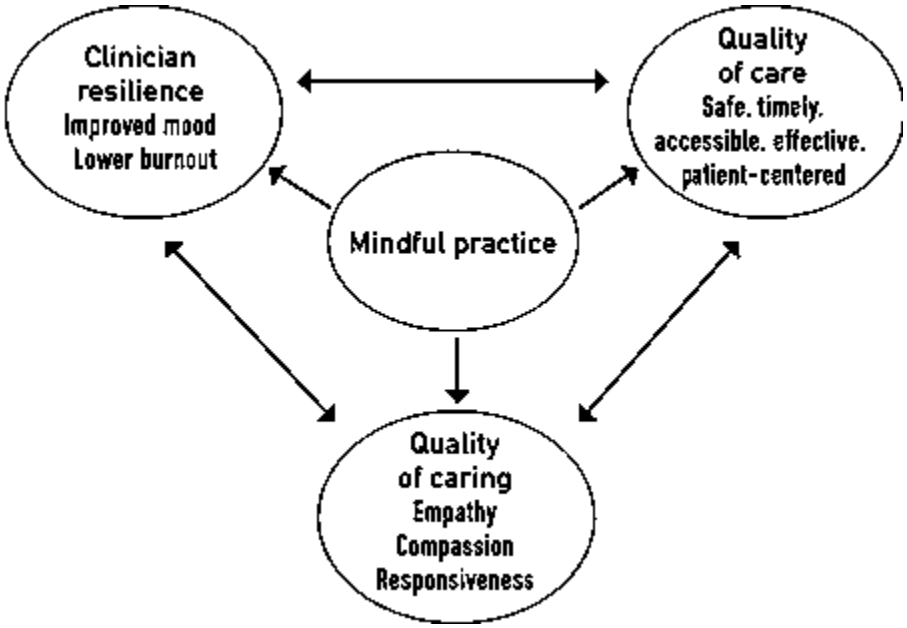
IN THE CLINIC

My colleague Dr. Mary Catherine Beach, at Johns Hopkins, helped to provide an answer. She studied interactions between patients and doctors in AIDS clinics around the United States.[21] People with HIV/AIDS often feel stigmatized and misunderstood, and not surprisingly, many are distrustful of the health care system. Beach and her team audio-recorded visits between doctors and patients and surveyed them afterward, including assessments of mindfulness. Physicians who were more mindful did better at developing rapport, following up on patients' concerns, and addressing psychosocial issues; their patients felt better understood, more connected, and emotionally supported. Mindful physicians won their patients' trust, no trivial matter. A patient's trust in her physician is the best predictor of whether she will take her medications, a crucial factor if you're HIV infected. Missing even a few doses could allow the virus to replicate and become drug resistant. Connection, understanding, and trust are essential.

Still, Beach's study did not answer whether practicing physicians could be *trained* to be more mindful and, if so, whether they would provide better care. For years it had been known that mindfulness training could help patients with a variety of mental and physical disorders. Yet the idea of mindfulness for physicians to enhance their *own* work was new. I found like-minded colleagues—Mick Krasner, Tim Quill, Tony Suchman, Howard Beckman, and others at the University of Rochester—and together we designed a year-long

program in mindful practice for experienced primary care physicians.[22] The sessions included different kinds of meditation practice and exercises to promote mindful communication, emphasizing how to bring mindfulness into clinicians' everyday work to help them be attentive and aware. Each session touched on a particular issue—responding to errors, witnessing suffering, facing uncertainty, grieving the loss of a patient, developing compassion, feeling attracted to patients, and others. We also addressed clinician burnout directly, knowing that burned-out physicians provide lower-quality care and are more likely to quit practice altogether. We drew a simple model of what we were trying to do—the technical quality of care, the qualities of caring, and clinicians' resilience and well-being—showing how these three domains were linked and how practicing mindfully could affect all three. We started out with a group of seventy physicians, nearly all of whom scored high on a burnout questionnaire. We didn't know if they'd have the energy and commitment to finish the program or if it would show any positive effects at all.

The results far exceeded our expectations.[23] Physicians' well-being improved and their burnout decreased. They became more empathic and oriented toward their patients' psychosocial needs. We were astonished that they scored higher on conscientiousness and emotional stability, key features of personality that aren't supposed to change in people in their forties and fifties (more about this in chapter 10).[24] They became more attentive and focused, less likely to be derailed by crises, and better able to rely on their inner resources to remain resilient. We interviewed some of the doctors a year later. They continued to affirm that cultivating a practice of mindfulness, creating a community of supportive colleagues, and giving themselves permission to focus on their own growth made them better physicians. They reconnected with the reasons they went into medicine in the first place: to provide effective and humanistic care, and to have meaningful relationships with their patients.[25] They set limits and had a more balanced work life.



A MINDFUL VISION

Medicine is in crisis. Physicians and patients are disillusioned, frustrated by the fragmentation of the health care system. Patients cannot help but notice that I spend more and more time looking at computer screens and less time face-to-face.[26] They experience the consequences of the commodification of medicine that has forced clinicians' focus from the healing of patients to the mechanics of health care—productivity pressures, insurance regulations, actuarial tasks, and demoralizing metrics that measure what can be counted and not what really counts, sometimes ironically in the name of evidence-based and patient-centered care.[27]

I have seen that it is possible to do better, and that is the reason I'm writing this book. Amid this crisis in health care, some physicians are making choices to reacquaint themselves with the heart of medical practice. By looking inward, they are expanding their capacity to provide high-quality care. They are seeing how they, as doctors, have the power to transform and humanize the practice of medicine and how patients can be better consumers of health care, build stronger relationships with their physicians, and identify those who can provide the care they need.