Mentoring a primary care resident: An example of reflective learning

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Allison, a first-year primary care resident was participating in a reflective learning session with me.1 I asked her to recall any patient recently seen in the primary care clinic. She thought for a moment and then began to speak: “Professor Alan, this is an elderly woman with many, many health problems and a very bad prognosis. I almost didn’t know where to start.” Allison sat very quietly, reminding me of an art patron thinking about a painting that was strangely appealing or had influenced her in some special and unusual way.

I asked her what it was like to be in the room with this patient. She hesitated and began to describe the interview with—something I was surprised to see—tears in her eyes.

Sometimes, but not always, we are privileged to enter a liminal space with our learners: an emotionally quiet and thoughtful space that is reserved to be without judgments or pretense.2 This is one of several places reserved for doing the important work of answering questions like “What is most important for me to learn as a physician in training?”

Allison posed about her ability to be a competent and effective physician. The knowledge to help this resident and all learners accept and understand their responses to patients in a thoughtful and formative way is needed. The ability to then incorporate these responses into the meaningful conversations they have with sick patients is also needed.3

I asked Allison to think about why the advisor’s words meant so much to her and had such an influential impact on her thoughts, and even on her self-concept as a physician. Allison’s answers came pouring out, like a dam suddenly releasing its water after being blocked for far too long. “I come from a family that was abusive to me and the other kids,” she said. She stopped and searched my face. I think I knew what she was looking for in my reaction. Allison hesitated but then continued. “There is much in my life that is unsolved, and much in my mind that gets in the way and confuses me, and I don’t know what to do with my feelings. They interfere in my patient care sometimes. I don’t know why I am even telling you all this.” I responded quietly, “Could it be, Allison, this is a time to begin to share your grief and suffering with another person? Maybe it is time.”

We created an action plan. Allison would learn how to use guided imagery to place this earlier voice and its troubling messages into a box and close the cover tightly for now. They could reappear later when her self-judgment is less harsh and viewed from a new and more enlightened perspective. She was encouraged to

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seek more reflective sessions with any faculty with whom she feels comfortable to create less harsh assessments of her patient-care skills.

I suggested that she schedule sessions with a therapist knowledgeable about the experiences of residents and the stresses with which they live and work. I also recommended she select a therapist experienced in the psychological treatment of persons suffering from their past. Allison was never responsible for her family’s abusive-ness yet shouldered the pain quietly until this point.

I chose the sequence of this action plan to enable Allison to select her options for the immediate and near future using her best inner wisdom, a deep and mindful wisdom, one seldom appreciated, sought, or utilized.

Allison has a lot of work to do. From simple awareness, to understanding to acceptance to conscious choice, the ability to best use emotions in an interaction is a skill well worth learning for everyone. Allison must reframe her experiences in caring for patients, some of whom will surely suffer and some of whom will die. Our interactions with patients, especially very sick patients, will frequently create intense and painful emotions, our response to their “emotionality of sorrow.” Allison—and all of us—must seek the opportunity and skills to explore and understand our responses and how to use them in an empathic and caring fashion for both our patients and ourselves. In other words, we must ask how we can best care for our patients and ourselves? This is a question not about denial of feelings but exploration of them, understanding them, and consciously using them in patient care. Empathy is not about a lack of personal boundaries or lack of propriety in the care of sick patients. It is about everything that makes for compassionate human beings and healing physicians. For Allison, it is about restructuring herself to tap into her own compassion, not only her knowledge. This is about her instinct for healing herself and others, not just her medical skills.

I do not yet know where Allison’s journey has taken her. She passed through the rotation and moved to another hospital setting. She called soon after to tell me she was doing well and would proceed with the plan. I hope her healing will be mindful, creative, and transformative. Empathy was always present in Allison, but the proper expression and use of it in an important conversation was not. Soon, if not by now, she will be capable of saying to her elder patient, “I am troubled by your many health problems. Come, let me sit with you and we will talk together about your worries and concerns.”

Even with these hopes, I have my own doubts and concerns about where Allison will go from here and about my role as her mentor. Could I have been clearer, more confident, and more capable in our limited time together? Have I muddied the waters for her? It is my desire that Allison will use her own strength, intellect, and instinct to navigate to the next reflective resting place, the next mentor, the next plateau.

An educational strategy, such as with reflective learning, is about integrating all of our essential teaching skills, including the ability to reflect on action. These skills do not come easily. They develop through hard work, discipline, and caring support from our colleagues and mentors.

Both authors of this article believe that many medical educators are transferring somewhat less knowledge with technology advances and increased access to medical information. While many medical educators retain traditional functions within education, especially within the sub-specialties, many in primary care function as guides and mentors to facilitate the human interactions and special relationships that our learners have in the field of medicine. It is quite possible that we will increasingly be looked upon to facilitate their processing of the emotional aspects of medicine as it relates to their professional careers and personal lives. We must do it and do it well.

Physicians travel with their patients as medical educators travel with our learners, and it is a journey of mentoring worth taking.

References
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