A preliminary summary about self-awareness teaching:

- What?
- Why?
- How?
- Who?
- When?

WHAT?

Self-awareness, Self-consciousness, Self-assessment, Mindfulness

The various aspects of an individual's ability to direct attention inwardly (i.e., to an insight or introspection into his or her own thoughts, attitudes, behavior, well-being, emotions, appearance, and competence) are commonly referred to as:

- self-consciousness
- self-awareness
- self-assessment

Self-awareness

- An individual's tendency to pay attention to his or her own emotions, attitudes, and behavior in response to specific situations. In the case of physicians, self-awareness is their insight into how their emotional makeup influences patient care.
- The ability to conduct oneself as a reflective and accountable practitioner including seeking out sources of informed criticism and valuing, reflecting and responding to them appropriately.
- Enquiring into own competence and evaluating own capabilities and personal effectiveness

It was developed the Situational Self-Awareness Scale as a psychometric measure of self-awareness.

- public self-awareness
- private self-awareness

Self-consciousness

A permanent personality trait. Its psychometric measure is the Self-Consciousness Scale:

- private self-consciousness subscale “I am constantly examining my motives”, as it is believed to measure an individual's insight into his or her own feelings, memories, and motives.
- **public self-consciousness subscale** “Usually I worry about making a good impression”, as it is believed to measure a tendency to focus on self-aspects, such as behavior and physical appearance, that are presented to others.
- **social anxiety subscale** “Large groups make me nervous”, that seem to capture a tendency to feel discomfort in the presence of others.

**Self-assessment:** ability to assess one's own performance and compare this self-assessment to an external, valid, and credible source of evaluation of this same performance. Self-assessment may be viewed as a specific aspect of public self-awareness.

**Self reflection**

1) "knowing-in-action”—the unreflective capacity for performing the majority of routine tasks;

2) "reflection-in-action”—thinking about what one is doing while doing it, engaged by and considered critical in "situations of uncertainty, uniqueness, and conflict"

3) "reflection-on-action”—reviewing and thus learning from past experience. From a mindfulness perspective, reflection-in-action is remarkably similar to the moment-to-moment awareness aspect of mindfulness.

**Mindfulness**, in the context of health care, is operationally defined as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment. As a link between relationship-centered care and evidence-based medicine, mindfulness should be considered a characteristic of good clinical practice.

**Mindful Practice:** Paying attention, on purpose, to one’s own mental and physical processes during everyday tasks to act with clarity and insight. ... leads the mind back from theories, attitudes and abstractions to the experience itself. **Mindful Practice** proposes Attentive observation, Critical curiosity, Beginner’s mind, Presence

**WHY? (A+B)**

**A. Demonstrated needs for self-awareness in medical practice**

- There are elements of medical errors that can and should be attributed to individual factors. These factors are related less commonly to lack of knowledge and skill than to the inability to apply the clinician’s abilities to situations under certain circumstances
- “Uninvited Guests” in Medical Practice: ambiguity and uncertainty, conflict between the needs of patients and clinicians, strong emotions: the patient’s and one’s own, technical errors, witnessing unbearable suffering, contradictory evidence, unanticipated serious illness, impermanence of knowledge, illusion of competence, lack of control, miscommunications and misunderstandings
- Physicians tend to reason tacitly to the extent of consciously perceiving only the tip of the iceberg of their own thinking processes. Beneath the surface there are quasi-automatic mental operations that are often useful mental shortcuts;
however, sometimes these same shortcuts can play tricks on reasoning skills. Failure to examine the reasoning process led to perpetuation of an error.

- Medical judgment is easily derailed by unexamined emotions, failure of curiosity, low-level heuristics, over-concreteness / rigidity, Inability to reframe the encounter
- Doctors' emotional makeup's (e.g., well being, fears, attitudes, and self-assessed level of competence) may affect their patients' care.
- Physical or mental discomfort, whether transient (e.g., fatigue, a recent conflict with another person) or chronic (e.g., alcoholism, depression, burnout), may impair clinical judgment and cause distraction and irritability.
- Doctors commonly admit that they may lack patience with certain patients; however, only few are aware that this may lead to discrimination against those patients, e.g., toward elderly and poor patients.
- Fear of malpractice litigation may result in avoidance of high risk patients and procedures, or in a defensive ordering of diagnostic tests even when clinical judgment deems them to be unnecessary.
- A doctor who expects patients to simply obey his or her orders may become intolerant of those who want to be informed about their diseases and to participate in making clinical decisions
- It may be taken for granted that health care professionals should "pay attention" in both clinical and learning situations. However, studies on attentiveness show that people are only briefly and unpredictably attentive. Attention habitually diverts to unrelated thoughts and feelings, leaving any task at hand to be managed "on autopilot." These studies suggest that mindlessness ("mind wandering," "zoning out," "task-unrelated thought") is "one of the most ubiquitous and pervasive of all cognitive phenomena" and that it often occurs unintentionally, without awareness, occupies a substantial proportion of our day, and leads to failures in task performance

B. Correlations between Self-Awareness and Clinical performance

- One study shows a positive correlation between residents' patient-centered interviewing skills and their progress in self-awareness training
- Another study shows direct correlation between self-consciousness, as measured by the self-consciousness scale, and medical students' assumptions of responsibility for the quality of their relationship with patients, as determined by a semi-structured interview.

- Another program at the University of Cambridge in the United Kingdom attempts to help students recognize how they resemble or differ from the rest of the student group with respect to their personal history, race, culture, gender, sexuality, class, and personality, and to identify what influence this self-awareness might have on their clinical practice. Students are asked to submit written reports on what they have learned from the exercises emotionally (How did they affect the way you feel?), factually (What new information came from them?), intellectually (What insights did they yield?), and practically (Are there things you will do differently as a result?)

- Other programs attempt to help medical students acknowledge and confront prejudices that they may harbor against certain patients. One such program is
implemented after a week of community medicine experiences (e.g., visits to an Alcoholics Anonymous meeting, a nursing home facility, a homeless shelter, and an underserved community center). It begins with a short classroom discussion of these experiences and is followed by small-group discussions. The points of departure of these discussions is a list of Have you ever... questions (e.g., Have you ever seen a morbidly obese patient and thought that he or she was lazy?). The topics cover race, culture, substance use, gender, sexual orientation, the elderly, nurse practitioners, and others. Students discuss one or more of these topics and then reconvene in order to share with the entire class their conclusions regarding possible prejudice against certain patients.

- Participants in direct teaching programs (Balint groups) have reported that the group discussions helped them to deal with their patients in a more competent manner, acquire a higher degree of self-awareness, and develop higher confidence in dealing with the behavioral aspects of patient care.

- Students who participated in (indirect) programs aimed at enhancing their self-assessment skills have reported that the adoption of self-assessment norms improved their motivation and self-awareness and reduced their anxiety before examinations.

- Primary care physicians who participated in an educational program that included an emphasis on mindful communication reported improvement in personal well-being, emotional exhaustion, empathy and attitudes associated with patient-centered care, according to a study in the September 23/30 issue of JAMA, a theme issue on medical education.

- Improved self-awareness is also perceived by educators to help students and practitioners shed light on their own belief systems (personal perspective and cultural influences), minimize bias in making clinical decisions, and reduce counter-transference reactions in dealing with patients who have diverse beliefs, values, and preferences, thus enhancing cultural competence.

- A report on a study of reflection on professionalism observed that reflection "transforms experience into understanding, promoting higher levels of learning."

- A review of the research on levels of attentiveness showed, as expected, that reacting mindlessly "leads to failures in task performance."

- A qualitative study on the results of a faculty development program found that self-awareness aids effective patient care, that it should theoretically prevent errors in clinical practice, help maintain professional standards, and help prevent "ethical drift" and was proven to improve clinical teaching.

**HOW?**

**A. Approaches to Enhance Self-Awareness**

**Teaching Content**

Teaching program of self-awareness for physicians, consisting of four topics concerning:

1. beliefs and attitudes
2. feelings and emotional responses to patient care
3. coping with challenging clinical situations (e.g., medical errors, angry patients, patients with a terminal illness)
4. self-care (e.g., stress management, prevention of burnout).

**Teaching interventions: direct and indirect approaches**

**Direct approaches: teaching programs** focusing on students' feelings and emotional difficulties that arise in response to various clinical situations

**Objectives:**
- To help them recognize how:
  - their feelings shape their behavior
  - this behavior affects patients and colleagues
  - doctors' values, needs, motives, and attitudes influence their practice of medicine.
- To enhance students' private self-awareness

**Forms of direct approaches**

1. **Classroom discussions of emotionally challenging clinical situations**
The program consists of classroom demonstrations of patient interviews by senior clinical instructors. These are followed by discussions with psychiatrists of possible emotional responses by the doctor who conducted the interview with the patient, and of the degree to which these responses may affect the doctor's behavior and decisions. An attempt is made to convey the message that all doctors have feelings and impulses that result from their personal experiences with patients, and that these feelings can interfere with optimal professional judgment. The main weakness of classroom discussions such as those described above is that they cast the students in the role of passive recipients of knowledge, which probably limits the effectiveness of this type of teaching.

2. **Small-group discussions in which the participants share personal experiences** (Balint groups, Small-group discussions for medical students). In all types of small-group discussions, the main task of the tutor is to encourage the participants to express their own thoughts and feelings about what they have heard, protect group members from unwelcome intrusions on their privacy, and ensure that the presenting participant group members are not unduly hurt by criticism.

3. **Counseling of individual students**
This approach consists of personal feedback after an instructor observes a live or a videotaped student encounter with a patient. An attempt is made to analyze the student's feelings and help him or her become aware of attitudes that interfere with the patient interview.

**Indirect approaches**

**Objectives:** To draw students' attention:
- to the shortcomings of the medical profession in general
- to discrepancies between the optimum treatment given to some patients but not
to others
- to how students' performance is assessed by themselves and their instructors.

Forms of Indirect approaches

4. Analysis of common patient complaints
Examples given by students about poor patient-doctor communication (The doctor
was in a hurry, ...did not listen, ...did not understand), inadequate doctor’s response
to patient's needs for information (The doctor did not explain, ...did not let me ask
questions, ...expected complete obedience), limited insight into the patient's state of
mind (The doctor embarrassed me, ...appeared not to believe me, ...changed the
subject when I spoke about my troubles) or bad manners or prejudice (The doctor did
not greet me, ...did not apologize for being late, ...shouted at me, ...discriminated
against me because I am...).
After listing these complaints, the instructor quotes published data indicating that the
complaints can indeed be traced to doctors' behavior. For example, complaints such
as The doctor did not listen to me are consistent with the observation that the average
time interval between the onset of patients' narratives and their being interrupted by
the doctor was only 18 seconds.24 Complaints of prejudice are consistent with
evidence of doctors’ tendencies to discriminate against poor and elderly patients, and
patients belonging to ethnic minorities.4,5 Complaints such as The doctor did not
explain are consistent with the finding that doctors attach a lesser importance than
their patients to sharing health-related information with them.25 As the discussion
proceeds, the students agree that patients' complaints articulate a problem that
cannot be dismissed as rare or trivial. They recognize that some physicians are indeed
arrogant and impatient and even discriminate against some of their patients.
Students are then asked to trace this behavior to doctors' feelings, personal life
problems, and attitudes that may affect the quality of their relations with patients.

5. Analysis of the variability in doctors' counseling of different patients
about their illnesses
This approach has been used previously in teaching counseling skills during the
clinical clerkship part of the curriculum17 and is also well suited for teaching self-
awareness. It consists of a simulated meeting between a patient and his or her
attending physician before discharge of the real patient from the hospital. For
example, a young student who has been following the real patient closely in the
hospital and who is familiar with the patient's case, assumes the role of the attending
physician, while the instructor, who is also familiar with the patient, plays the role of
the patient. During the simulation, it is assumed that the instructor has the same
disease as the real patient. However, the instructor is obviously different from the
real patient (e.g., has a medical background, a good rapport with the students, and is
respected by them). The fact that the instructor assumes the real patient’s role
motivates the students to do their best in order to meet the instructor's expectations
for information. The medical background of the physician-instructor makes sharing
of information easy because, unlike what might be the case with real patients, in the
case of a physician, there are no cultural or language barriers.
In such ideal circumstances, the student cannot but respond well to the simulated patient's needs for information and preferences regarding future management, adapt the patient's management to his lifestyle and provide optimal counseling. As the simulation proceeds, the students who are observing the simulation realize that the real patient was almost always not optimally counseled in a similar manner. This opens the door to discussions of possible reasons for the detected discrepancies concerning the extent to which the real and simulated patients were listened to and encouraged to ask questions, the amount of information they were given, and the patient's involvement in making clinical decisions. Students realize that the simulated patient's prerogative for information and respect for her preferences are accepted as obvious when her role is played by a person with the same professional and cultural background as the students. However, real patients are only rarely given the same consideration, even though their needs are similar. This double standard makes the students aware that they are not free of prejudice and that stereotyping of patients, whether done consciously or subconsciously, might affect patient counseling.

6. Training students to assess their own performance

Approaches that have been described for improving students' self-assessment skills consist of asking each student to, first, evaluate his or her own performance; second, compare this self-assessment with the instructors' evaluation of the student's performance; third, reflect on the causes of possible differences between these assessments; and, last, make a judgment regarding needs for improvement.

Some studies have shown that learners often had difficulties in understanding the purpose of the requirement to assess their own performance.31-34 Other difficulties were the requirements for a clear definition of the learning objectives of the teaching program, and of the criteria for the evaluation of students' performance, and the requirements for a large number of teachers for repeated self-assessments and feedback sessions, to reconcile the students' and teachers assessments.

B. Training mindfulness

Through observation of physical sensations, thoughts and feelings, participants learn that they are more than these components of their experience, -- and that they can respond rather than react to life’s circumstances --by cultivating a quality of awareness that allows for more discernment in their appraisal of these circumstances.

Objectives:
- To understand the principles and applications of mindfulness and mindful practice
- To explore the role of mindfulness training for self-care in medical curricula.
- To discuss the potential application of mindful practice to participants’ educational programs.
- To foster patient safety, caring attitudes and professionalism by enhancing mindful practice in residents and students when encountering challenging situations in clinical medicine.
- To foster elements of mindful practice (attentive observation, critical curiosity, informed flexibility and presence) in trainees at multiple levels.
WHO?

- medical students, physicians, health professionals, patients

WHEN?

- During clerkship for medical students
- During residency training period for medical residents
- Postgraduate Training courses for physicians

Haifa Israel Experience

Teaching medical students:

At the first 3 years of medical school the students experience and work with a tutor in small groups on psycho-social and ethical subjects. The course which is called "being a doctor" - is done by working in small groups dealing with medical issues as well as the personal experience and group processes.

At the first year, the students learn and experience the basic concepts of communication and interview patients, physicians and families. Small group discussions (dealing with personal and organizational obstacles and the group dynamics as well) and written narratives are the first self-awareness tools.

At the second year the main issue is medicine in the community (primary care and issues as addiction, violence in families, etc..). They learn communication skills, with role plays and real patients-the small group discussions emphasize self reflection. They also meet and talk with prisoners, battered women, drug users and discuss their own feelings' and thoughts.

At the third year the main communication skills are cross cultural and dealing with ethical issues.

The main self awareness tools are: Small group discussions of your own culture and beliefs, meeting the others in the group, interviewing patients from different backgrounds and eliciting their explanatory model. Writing reflective diaries and sharing them with the tutor.

Separately from this course which is obligatory and evolve in 3 years there is an elective course on Literature and Medicine. Through reading stories and poems discussing them and narrating one's experience we facilitate compassion. Empathy self reflection and self awareness

Sixth year students participate in a communication course of breaking bad news. Part of the course deals with the students fears and difficulties dealing with anger and loss. It is done by small groups discussions role play and inspecting others.

Family practice residents methods and courses used to facilitate self awareness:

- Preceptorship(mentoring)
- Balint Groups
- Medicine and literature course.
- Using music, art, literature, cinema in teaching
• Narrative medicine course. (based on writing narrating and close reading)
• Family of origin course
• Small groups learning of communication which evolve self reflection, group and personal process. Using videos (with real patients) role play of real situations that are brought in.
• Communication in Palliative care. (hands on).
• Death grief and bereavement in our life and work

Primary care physicians (mostly specialist):
• Balint groups (only family Physicians)
• Challenging cases (small groups discussion)
• Videotapes- Medical situations with actors (small groups)
• Using narrative and working in couples to discuss critical incidents moment
• Learning from positive experience

What about literature resources?


Wegner BS, Hartmann AM, Geist CR. Effect of exposure to photographs of thin models on self-consciousness in female college students. Psychol Rep. 2000;86:1149-

Mindfulness training: student self-care and clinical practice, ppt Presentation, Craig Hassed MD, Monash University, Melbourne, Australia, Ron Epstein MD, University of Rochester, New York, USA