

R.E.A.P.

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Following the completion of the reading assignments, you will prepare a one page paper (max 1500 words), describing your reaction to the reading and your discussion with Dr. Hardt or Dr. Bucciarelli (if this occurred). This is to be a paper reflecting thought, not a research paper; the intent is for you to concisely, and in an organized manner, present your *analysis* of your *reactions* to the readings and to the discussion *for possible implications for patient care*. A summary of the material or a description of this reaction is insufficient.

The goal of this activity is the development of your ability to systematically analyze issues arising in the clinical context. This includes refinement of observation and listening skills, the former being of self, as well as of other, and the application of the skills in a systematic manner. Inasmuch as reasoning is directed by the expectations (which include values), experience and emotional reactions that structure thought, systematic analysis of any situation begins with recognizing relevant personal expectations, experience and emotional reactions, to identify one's perspective on the situation. Factoring these elements into the reasoning that leads to the choice of approach to a clinical problem may be particularly difficult, insofar as it may require the translation of what is experienced in emotional terms into the cognitive terms necessary for them to be used in any rational analysis. These steps are critically important to the clinical approach because the failure of physicians to appreciate how their personal attitudes and expectations affect their thinking and judgment has been found to be at the root of their poor performance in the evaluation and treatment of conditions as diverse as chronic pain, child abuse, sexual issues and alcohol abuse.

The format of the paper, referred to as REAP, breaks out the analysis into its component parts and is analogous to the now standard format for entries in medical records, the "SOAP note";*

- Reactions:** (1) *Reactions to the topic and to issues raised by the handout and by discussion*
(2) *The specific event (what you read or what you heard) that triggered the reactions described.*
- Expansion:** *Life experiences, beliefs, and values and their sources, identified as relevant to the topic and to the triggers of the reactions described.*
- Assessment:** (1) *An analysis of the reactions and their sources as expanded upon for what it reveals about the perspective brought to the topic.*
(2) *The potential consequences, both salutary and detrimental, of that perspective for patient care.*
- Plan:** (1) *What will be done to prevent the detrimental consequences and facilitate the salubrious ones;*
(2) *How the success of these efforts will be determined.*

Reactions:

(1) Reactions to the topic and to issues raised by the handout and by the panel.

These should consist of 1 or 2 word descriptors of each specific reaction, feelings and thought elicited by the issue generally and by the points made in the essays and by the panelists.

(Some find it useful to jot down these reactions as they occur) It may sound simple, but it isn't. It isn't, because in many situations, our "gut" reactions aren't exactly what we would like them to be. Those reactions are often less kindly, meaner, more selfish, even vindictive and punitive, than would be expected of the pure, caring, generous, altruistic-even virtuous-individuals that we like to think we are. The incongruity of such reactions with the "take charge" and "in control" self-image we may feel is appropriate for us to have as physician often leads to the reactions going unrecognized, despite their demonstrated value in assessing the patient's situation (as illustrated in the footnote on p.2) no less than in their influence on our decisions and actions in the clinical encounter.

It is in this component of identifying personal reactions and their significance that observation in the clinical context is a profoundly different process than observation in the biological sciences as it is commonly understood. *Observation in the clinical situation includes self-observation as an integral element, as important as detailed observations of the patient and the patient's environment.* With rare exceptions, the fully successful clinical encounter depends on the effective integration of the data from the self-observation with what is seen and heard from the patient and with what is known of the pathophysiology of the disease. Engaging in this process can lead to a questioning of your understanding, even your perceptions; this opportunity to reevaluate your understanding is most clearly presented when the patient is reacting to their situation in a manner other than how you might react if in what seems to be a similar situation. This self-questioning and self-doubt that may go to the root of how a person sees the world, is not at all something people are practiced in doing in their daily lives.

(2) The specific event (what you read or what you heard) that triggered the reactions described.

These should consist of a 1 or 2 sentence statement of the triggers for each, whether to the idea of the topic, to points made in the readings, to statements of the panelists or to aspects of the experience of the first day exercise; discussion of what underlies the reaction is inappropriate here.

Essential here is the meticulous observation and attentiveness to precisely *What* is being said (or written), to *How* it is being said (or written) and not infrequently, more important, to what is *Not* being said (or written), for what is triggering the reaction. Such precise observation is central to the work of the physician and is the first step in the ongoing process of integrating what you see and hear into what you already know about this person, about the human condition, and about yourself-your own expectations and experience, your emotional reactions. *The paper must be specific about what was observed that elicited the reaction.*

Rebutting a statement from the discussion or in the handout, rather than simply identifying the reaction to rebut, is a common error in this step of the analysis. When such a reaction occurs, self observation entails identifying in the Assessment section your perspective on the issue and

recognizing what prompted the need to argue/defend it, and its implications for patient care. *Insofar as whatever was said or written reflects no more than a different perspective on the issue being addressed, any rebuttal is irrelevant to the analysis.*

Expansion:

*Life experiences, beliefs, and values and their sources, identified as relevant to the topic and to the triggers of the reactions described.

Insofar as the reactions elicited to the presentations are typically triggered by the dissonance between the data with which you are being presented and your beliefs and values—though it may be an affirmation of those beliefs and values—these are the elements warranting elaboration in the expansion. This includes consideration of relevant experiences in your family and in the various communities with which you are to have been affiliated that have contributed to the development of those beliefs and values. It also includes consideration of whether those beliefs and values stem entirely from personal experience (which includes instruction) or are based in part on scientifically validated data. This is important insofar as the conduct of your personal life is appropriately dictated by those beliefs and values developed over the course of your life, and may be entirely independent of the data of science, whereas in your professional life, it is inappropriate to introduce personal beliefs and values in making recommendations to patients; the physician's license is to practice allopathic medicine, requiring you to base recommendations on scientifically validated data. *In the absence of this recognition, you are at serious risk of innocently assuming your perspective on an issue for a patient to be based on accepted scientific data, when it is, in fact, entirely a matter of personal preference.* It is important to recognize that relevant experiences are not only those clearly related to the issue being considered, but can also be the *absence* of clearly related experiences.

The second section would then consist of an expanded discussion of these reactions and their triggers, locating them in the context of your relevant life experiences in your family and in the various communities with which you have been affiliated, and the beliefs and values you have developed; these might be thought of as the factors contributing to the reactions. While the sources of some of the reactions identified may be implicitly appreciated from the expansion, it is prudent to be explicitly identify them in the discussion.

Assessment:

This section is an analysis of the reactions and the identified relevant life experiences, beliefs and values for their implications for patient care, both positive and negative. It consists of 2 steps:

(1)An analysis of the reactions and their source for what they reveal about the perspective brought to the topic:

This initial step in the assessment consists of analyzing your reactions in light of the contextual elements, personal and professional in which they were embedded in order to identify the perspective from which you see the situation. It can be thought of as a kind of triangulation. This

analysis becomes particularly important when you experience unexpected reactions to situations or to patients, or when your reactions indicate an attitude inconsistent with positions expressed in the scientific literature or inconsistent with the reactions of a patient. In those situations, an examination of personal experience and its attendant beliefs and values for the perspective from which you may be looking at the situation, may reveal the source of the inconsistency.

(2) The potential consequences both salutary and detrimental, of that perspective for patient care.

Identifying the implications of your perspective for patient care requires “stepping outside yourself” and recognizing how your reactions—both positive and negative—may affect how clinical situations are perceived, and consequently, the clinical judgments that may be made in those situations. The operative word here (and elsewhere in this introduction) is “may”; these reactions merely suggest risks that can be reduced and become less likely to be realized when adequately addressed. (In the case of salutary consequences, they may be similarly increased.) It may feel awkward and embarrassing, even painful to acknowledge in specific situations, but in the abstract, it can easily be appreciated how reactions such as disliking a patient or being particularly repelled by their condition or disturbed by their reaction to it, or feeling particularly helpless in dealing with it, places you at risk for thinking of good reasons for not doing what may be clinically indicated for patients and providing them less than optimal care; common, is the “He/she is resting; there’s no need to disturb him/her” justification for bypassing terminally ill patients while seeing patients in the hospital, when the “rest” may be a consequence of over sedation or poor pain control. While less apparent, a patient simply reacting differently to a situation than you might react in a similar situation, can also place you at risk for providing less than optimal care; typical is the stoic patient whose complaint of pain is inadequately evaluated because the intensity with which it is expressed does not meet the physician’s threshold for significance. Even more difficult to recognize, may be how liking a patient, or feeling particularly moved by their situation, entails equivalent risks; the physician will go the “extra mile” for the patient that they like without even thinking about it, but that can also lead to justifying inappropriate, and even futile interventions.

Plan:

(1) What will be done to prevent the detrimental consequences and facilitate the salubrious ones:

This consists of specific steps to be taken in response to a personal reaction and the perspective it reflects, when caring for a patient, if any seem warranted; in this context, “hope” is not a plan. This can be difficult, insofar as these reactions often arise in complex ethical and moral situations, and any plan must remain within the constraints of your beliefs and values. This is the critical step in the entire analytic process, because it’s not the reactions themselves that are important; it’s what you do about them that matters. It doesn’t matter whether the reaction to a patient is compassion, anger, or even erotic stirrings, whether the reaction is of wanting to care for them, to kill them or to make love to them, --all, and everything in between, are reactions that experienced,

outstanding physicians have described. *What matters is how you deal with that reaction, how you will respond to the patient so that care is facilitated, rather than impeded.*

Given that the issues raised in the course can as readily be manifest in daily life as in a clinical encounter, and that most students lack the experience in the clinical context that could provide them with a broad basis for developing a plan, when you have identified a risk (or potential benefit), consequences to your reactions, **your plan should address what you might do now when encountering these issues in your daily life.** Requiring such thought as a conclusion to the sequence of ideas initiated by a reaction is a step toward mitigating an undesired response or maintaining a desired one under the stress of clinical activity.

(2)How the success of these efforts will be determined

Implementing your plan in the present in daily life situations analogous to those encountered in a clinical situation can provide immediate feedback about the effectiveness of your proposed approach. What observations, both now and later, when caring for patients, will enable you to recognize that a goal has been achieved?

Appendix IV shows the required format in outline form. Appendix V is a “sample” paper illustrating the analytic process described; it is prefaced by an explanatory background note.

REACTIONS:

- Reaction#1 (1 or 2 words). Trigger (1 or 2 sentences).
 - Reaction#2 (1 or 2 words). Trigger (1 or 2 sentences).
 - Reaction#3 (1 or 2 words). Trigger (1 or 2 sentences).
- Etc.

EXPANSION:

Sources of those reactions in your life experiences, beliefs and values and other specific relevant areas identified in the cover note; the basis for events described or statements being experiences as triggers.

ASSESSMENT:

- (1) Your analysis of your reactions triggers and sources for what they reveal about your perspective on the topic.
- (2) The potential consequences, both salutary and detrimental, of that perspective both in your present daily life and in your future patient care.

PLAN:

- (1) What you will do in your daily life in the present, and in your patient encounters in the future, to facilitate the salubrious consequences of that perspective, and prevent the detrimental ones.
- (2) How you will determine your success in these efforts.

In discussing their papers with me over the years, individual students have commented on how “foreign” the analytic process the course requires was to their way of thinking, and while most eventually learned it, several suggested that it would have facilitated their learning had I provided a “model” reaction paper to assist them in grasping the concept. While I have serious questions about the idea of a “model” for a task such as this, the idea of a sample paper seemed reasonable. I considered it inappropriate to use a student paper for such a purpose, but as reflected on it, it occurred to me that before adopting the laboratory exercise that now opens the course, I thought it necessary to experiences it myself to best appreciate what I might be asking of the students, and I could honestly provide such a sample paper with my own reactions to the exercise, which have remained vivid over the years. My paper follows below.

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Reaction:

Anxious: 1) Not having any idea of what to expect when we started.
2) Making a mistake and getting kicked out.

Sympathy: For visitors who made mistakes and were kicked out.

Frustrated: For not being able to help the visitors.

Abused: By the Betan who ignored my Alpha greeting and just looked at my cards and took 2 and walked away.

Expansion:

I’m an “outsider”. Have been since my critical early socialization years when I was the only Orthodox Jewish kid in a predominantly Christian/Catholic community about which I know nothing, in second grade reported by a classmate to the teacher for not reciting the Lord’s Prayer(I didn’t even know what it was), with others in class after the Bible reading (They still did that in those days; the teacher, sensibly, did nothing about it), and a year later, steered into a trap by two ostensible friends who joined a group of others in attacking me, calling me “Christ Killer” (I had no idea what they were talking about) from which I escaped injury only by putting my head down and pushing through them and running off (I was small and fast and they couldn’t keep up). I’ve felt the outsider ever since. To some degree, this was probably reinforced in the self-contained Orthodox Jewish community where my parents moved shortly after I was attacked, where mistrust of non-Jews prevailed (this was WWII and the era of the death camps); and even there, as a potentially challenging, bright, non-Hebrew speaker coming into an established social hierarchy in 5th grade in a Hebrew speaking parochial school, I was an outsider. Over time (and repeated social bruising) I became very cautious in unfamiliar situations. With experience, I eventually learned to recognize the nuances of relating and began to rely on observation and questioning to guide my actions. This enabled me to become “attached” to different communities, even as I continued to feel an outsider; as an outsider though, those “attachments” were tenuous and vulnerable-as I saw it, I was being suffered for what I might have to offer and would be taken advantage of whenever the opportunity presented. Despite this vulnerability, I gradually became more comfortable with my outsider state and the questioning perspective that accompanied it, and as I did so I realized

that I also seemed able to identify others who were feeling that ways and gravitated toward them to help.

In contrast to my experience in school and neighborhood, my immediate and extended family (the latter initially living 90+ minutes away and seen only irregularly) related in a warm, openly affectionate and supportive manner (natural Alphas!) and invited and encourage engagement. They also conveyed a strong sense of social responsibility; my father, by nature decidedly not a gregarious person, was nevertheless for many years the president of the synagogue.

The convergence of these two lines of experience led to my becoming very cautious in relating to groups/communities. Yet very forward in engaging others individually, especially those that I perceived as being victimized.

Assessment:

With that early experience, it's no surprise that I see everyone as a different, even to thinking that we use language differently, and I'm very cautious in feeling my way into relationships until I am confident about how accepting of my differentness in how I think and how I feel about whatever is on the table, and how open of their differentness the other is willing to be. It's also no surprise that with differentness always in the forefront of my awareness, I feel most comfortable in an inclusive atmosphere that focuses on commonalities and "building bridges", that I would want to learn as much as I could about the unfamiliar so that I could know where the bridge is "anchored" on the other side before I would engage in anything significance with the other. I ask a lot of questions.

The most important implication of this for patient care is that everyone is a stranger and I begin by reaching out to them. I do this by trying to build a bridge with them by asking what I can do for them. Because I assume no commonality with them, even before I develop a working hypothesis of what might be wrong, I try to get a sense of "who they are", by asking questions about their lives. This would work well for those who want to feel that connection with me, but would annoy those who think of the visit as no different than a visit to an auto mechanic, as the soldier who just wants to get back to their unit, especially in combat. It also might lead to my missing an opportunity to engage by being overly tentative with those who are prepared to engage but see doing so primarily in terms of a shared task and want to "get down to business" right away. What I have identified as prudent caution at times may be better characterized as mistrustful tentativeness.

Plan:

To work on the latter issue, I will note situations where I find myself inclined to "hold back" and examine them for what might be "inclining" me that way. When I cannot find a solid reason for it, although I'm generally disposed to trusting my instincts, I'll at least "put a toe in the water" and reach out more than I might otherwise, and see what develops. Although I don't expect all of those efforts to bear fruit—my initial hesitancy is usually well grounded, even if I can't account for it- if I find myself encountering fewer situations where I'm inclined to hold back. Indirectly, I'll know that I've been successful.