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# Mindful Practice in Action (II): Cultivating Habits of Mind

RONALD M. EPSTEIN, M.D.

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*Habits of mind, such as attentiveness, curiosity, and presence, are fundamental to effective medical practice and physician well-being. In this second of two articles about mindfulness, I propose an 8-fold method for promoting mindful practice in medicine: (a) Priming—setting the expectation of self-observation, (b) Availability—creating physical and mental space for exchange, (c) Reflective questions to open up possibilities and invite curiosity, (d) Active engagement—direct observation and exchange, (e) Modeling while “thinking out loud” to make mental processes more transparent, (f) Practicing attentiveness, curiosity, and presence, (g) Praxis—consolidation of learning by experience, and (h) Assessment and confirmation. I include examples from medicine, music, and meditation.*

*Fam Sys & Health 21: 11-17, 2003*

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Ronald M. Epstein, M.D., Departments of Family Medicine and Psychiatry, University of Rochester School of Medicine and Dentistry

Correspondence concerning this article should be addressed to Ronald M. Epstein, M.D., University of Rochester School of Medicine and Dentistry, Departments of Family Medicine and Psychiatry, Family Medicine Center, 885 South Avenue, Rochester, NY 14620 E-mail: Ronald\_Epstein@URMC.rochester.edu

In the first article of this series, I demonstrated how mindfulness is fundamental to effective medical practice and helps the clinician face novel and ambiguous situations. The ability to make prudent choices in situations where data are insufficient or contradictory is a characteristic of expert clinicians. In contrast, much of professional education involves training at the technician level by emphasizing rules and formulas to manage clear-cut diagnostic entities. This leaves the student on his or her own to deal with those common situations that do not conform to the rules. Also, adopting a biopsychosocial model of care and an evidence-based framework for decision-making expands the educational challenge by incorporating new skills and knowledge.

In trying to define the characteristics of clinical expertise, Fraser and Greenhalgh (2001, p. 799) distinguish between competence and capability. They define competence as “what individuals know or are able to do in terms of knowledge, skills, attitude,” whereas capability is “the extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance.” In this second of two articles about mindful practice in medicine, I suggest an 8-fold teaching method to improve the capabilities of health professionals by fostering four key habits of mind: attentive observation,

critical curiosity, informed flexibility, and presence.

### A METHOD FOR MINDFULNESS IN MEDICINE

Table  
Fostering Mindful Practice

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Priming
Availability
Asking reflective questions
Active engagement
Modeling while “thinking out loud”
Practice
Praxis
Assessment and Confirmation

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*Priming.* Priming involves setting the expectation that students will report on their own mental processes. For example, before seeing a patient, I instruct students to report not only on the clinical findings, but also on their own thoughts and feelings during the visit. I frequently ask students and residents to observe what they do to prepare themselves for each patient visit. Do they stop for a moment? Do they complete the previous patient’s chart? Do they develop a mental list of tasks? Do they take a deep breath? And, I might ask, “How might your prior clinical experience affect your decision-making in this case?” Other priming activities take place outside of the clinical setting. Reading poetry can invite and intensify focus on the present moment (Connelly, 1999), as can courses in mindfulness meditation for clinicians (Kabat-Zinn, 1994).

*Being available.* This may involve creating quiet, uninterrupted spaces on a regular basis for rehearsal (such as a seminar, reflection group, or retreat) as well as moments of contact during chaotic real-life contexts. Balint groups (Balint, 1964; Balint & Norell, 1973; Botelho,

McDaniel, & Jones, 1990), or other types of reflection groups (Novack, Epstein, & Paulsen, 1999) in clinical training, help trainees to gain insight into the effects of their actions on patients, and, in more psychotherapeutically oriented groups, motivation for their actions as well. In our training programs we use several formats. For students in a 4-week family medicine clerkship, we have a 3-session “reflection group” in which students discuss clinical situations that raised difficulties for them, e.g., difficult clinical decisions, ethical problems, and strong emotional reactions. Assessments of medical interviews include videotape for self-critique of technique and for examination of the physician’s emotions and biases (Femino & Dube, 1995; Westburg & Jason, 1993). Keeping a journal, meditation, and exercise are individual means to help focus the learner on the present. However, being available is more than creating small group contexts. More important may be the availability in the moment—during rather than after the clinical encounter. This kind of availability involves making others (and yourself) feel that each moment is limitless in attention, such that time appears to slow or stand still.

*Asking reflective questions.* This may help a teacher identify and seize opportunities for learning. Reflective questions are designed not to edify, but rather to invite doubt and ambiguity so that students can discover their own answers.<sup>1</sup> For example, clinical data gathering is commonly conditioned by the expected diagnosis. In meeting with a patient with fatigue, a resident might “forget” to ask a patient about sleep disturbances or feelings of worthlessness, expecting “somatization” or a “viral syndrome.” A question to students such as, “What are you assuming about

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<sup>1</sup> Much of this material was borrowed from workshops on “Questionology” presented by Richard Kennedy, M.D.

this patient that might not be true?" can provoke curiosity in an open-ended way, and may improve diagnostic thinking. These questions should promote critical curiosity, in contrast to "what am I thinking" questions. It is not the answer that is important. In fact, many reflective questions have no answers. Rather, the question should disrupt habitual and rigid patterns of thought and behavior to allow a familiar situation to be seen in a new way. In that sense, reflective questions share some qualities of Zen koans (e.g. "What is the sound of one hand clapping?").

Reflective questions are useful in teaching clinical ethics. The preceptor can comment on "tacit ethics of the moment" as reflected in small gestures that often go unnoticed in daily practice. Preceptors can ask students to note those small moral acts, such as how nods of the head convey interest or not, or how the clinician acknowledges an error to a patient.

Finally, reflective questions can improve the trainee's ability to listen and observe. Listening for the unexpected involves the ability to find surprise in the ordinary actions of daily work, and to listen to oneself and others without naming what is heard until it has been understood. Teachers should ask, "What did you observe?," "In what ways were you surprised?," "How did you respond to the feeling of surprise?," "What interfered with your observations?," and "If there were relevant data that you ignored, what might they be?" The goal is to help students internalize a habit of self-questioning.

*Active engagement.* In his essay, "What If They Taught Musicians The Way That Medical Students Are Trained?" Engel (Engel, 1982) created an imaginary scenario in which music students would never be observed actually playing their instruments. Rather, they would just report to the teacher what they had done. We can laugh at the absurdity of this, but most of the time medical training is not done much

differently. In musical training, similar to medicine, teachers talk about the need to know theory and develop good technique, and also be emotionally expressive. The making of a musician, though, is the ability to make technique sufficiently automatic so that he or she does not have to think about every individual muscle movement, while maintaining enough subsidiary awareness to be able to recognize when technique needs more focused attention. Similarly, musicians bring awareness to the harmonic structure at key transitional moments, but then let it inform the interpretation in a more tacit way at other times. A good musician knows how to be emotionally expressive and to listen from the perspective of the audience at the same time.

In contrast, medical education is structured as if the most difficult skills balancing focal and subsidiary awareness of complex tasks are learned without critique or mentoring. By focusing only on theories, principles, and details, i.e., the "facts," physicians are trained to limit their potential learning and self-correction. Further, musical education is based on frequent, sustained contact between teacher and learner, something that is painfully lacking in medical education now (Ludmerer, 1999). Active engagement means being physically and mentally present to observe students in action, and to be observed in action. The financial and structural barriers to active engagement in medical education currently are formidable, but the consequences of neglect may be even more worrisome.

*Modeling.* "Thinking out loud" and encouraging the student to do the same, can make the tacit explicit. This can occur while teaching about communication, clinical reasoning, or even technical skills. For example, Caurough, Martin and Martin (1999) describe an elaborate method of "thinking out loud" coupled with split-screen video feedback on hand movements to train surgical residents to

manipulate instruments more efficiently while performing an inguinal hernia repair. Thinking out loud makes it apparent that good medical practice requires the constant effort of recognizing and correcting for errors, rather than merely the linear pursuit of protocol.

*Practice.* Medicine, music, and meditation are all considered practices. Practice consists of disciplined repetition in controlled settings. Among performing artists, a common saying is, "In discipline is freedom." Practice requires an object, real or imagined, external or internal. The object of meditation is one's own thought processes, of music it is sound and the audience, and of medicine it is the patient and the learner. Availability, active engagement, listening deeply (especially to those things that we'd rather not hear), generosity, and "beginner's mind" can be practiced. "Unexpected" is another aspect of practice. It refers to training the mind to recognize one's expectations, then imagining another outcome. In the next paragraphs, I will describe some ways of practicing attentiveness, curiosity, and presence.

A lesson in practicing attentiveness and "unexpected" can be learned from John Cage, one of the most influential musical composers of the 20th century. He pioneered the use of small objects such as screws, cloth, and aluminum foil placed on the piano strings to make unusual sounds. A later piece consisted of 12 radios all turned on, but tuned to different stations. In 1952, he wrote a piece that has come to be called 4 minutes and 33 seconds. It is one of a series of pieces that he wrote named only for their its length. The unique thing about the piece is that there are no notes written on the page, just the word "Tacet" (silent). The performer indicates with a gesture the beginning and end of each of the three movements, but does not produce any intentional sound. Most people, hearing the description of the piece, have expectations of what they will, or will not, hear. Some

people even wonder if it is music at all. Listeners discover, though, that there are always sounds. In this case, they are random sounds not specified by the composer, and never the silence that one might think was implied by the absence of notes on the page. The first time it was performed, it created quite a stir. People were outraged not by what they didn't hear, but rather by what they heard! It is an exercise in listening to one's process of listening and, by eliminating any coherent signal, recognizing the external and internal noise with which we live. People react to this piece strongly now, even when they know the score.

Curiosity can be practiced. Consider an exercise called "Three Days of Red" (Maue, 1979). As originally conceived, participants are asked to record in writing the names of all red things that they see for 3 days. With medical audiences, I do a 30-minute or even a 5-minute version of this. Typically, performers go through an interesting evolution—first excitement, then boredom, then curiosity. They often report that they begin to see the world as two categories: red things, which are of interest, and non-red things, which are ignored. Then, most people at some point wonder, "How red does something have to be to be considered 'red'?" Is this reddish-orange object more red than orange, or more orange than red? Is pink a type of red? And on and on. There are multiple parallel situations in medical diagnostics. The clinician, encountering a set of symptoms, may not question the categories to which the symptoms are assigned (influenza, depression, "something serious") unless attention is brought to them.

McPhee (1997) emphasizes the importance of practicing presence by developing a "habit of reflection." This should include some time each day in complete silence and stillness. There are different types and contexts of stillness. Stillness apart from daily life might include doing meditation at home or at a retreat. Stillness-in-action is a tool

that performing musicians use—an inner stillness in order to project energy to the audience. And, finally, there are the small moments of inaction between actions—those precious moments of repose during a busy day. The visceral learning from practicing stillness allows the practitioner to experience that stillness when he or she needs to call upon it e.g., to clear the mind before seeing the next patient, performing a delicate procedure, or listening more deeply to a disturbing story. There is nothing “new age” or mystical about this process. It is just practice.

*Praxis.* Friere (1998) argues that, to some extent, something is not “known” until it becomes incorporated into action in the world. Building on this idea, Dreyfus (2001) notes that higher levels of expertise are characterized by embodied knowledge. By this he means that there is significant emotional valence to knowledge; that when we don’t know something, we feel bad. From yet another perspective, Damasio’s somatic marker hypothesis (1994) notes that emotions are stored as physical memories; feelings evoke the sensations, thoughts and actions. Friere’s concept of praxis describes this neurocognitive link between knowing and doing.

In musical performance, praxis may be easier to describe than in a cognitive discipline. Non-musicians often assume that musicians play notes on an instrument, and thus hear the music. However, the reverse happens as well. A mature performer “hears” the music before any sound is produced, maintains a moment-to-moment awareness of the musical structure, and compares the sound produced with the sound intended. Perhaps the most difficult thing about learning to play an instrument, and medical practice, is maintaining awareness of the disparity between intention and action, and between the imagined effect and the effect produced.

Several years ago, an opportunity for fostering mindfulness arose in a challenging

exercise in which students conduct a series of role-plays with a standardized patient, beginning with testing for HIV, then delivering the positive test result, and, finally, negotiating a treatment plan with a complex antiretroviral regimen. A bright student was about to begin the interview with the standardized patient, with his fellow students and me observing. Before beginning though, he asked a seemingly simple question, whether I wanted a “regular” interview or a “biopsychosocial” interview. The student knew the difference between two approaches to communication, but did not know *what* to do with things he knew *how* to do. His espoused theory and his theory-in-action were transparent but contradictory. His “knowledge” was unconnected to the clinical context, and was not embodied in action. Rather, he was to responding to the imagined demands of those who would be evaluating his performance.

By asking the student to put his knowledge into action while at the same time observing himself in action, he found the interview more difficult than he had imagined. Debriefing afterwards, he was able to articulate what he did and why, something he had not been able to do before his attention was focused on his own actions. Although he had previously “learned” how to conduct a patient interview, in one sense, it only became “knowledge” once he was able to use it in practice. He not only learned a skill, but was personally transformed from the role of student to the role of novice practitioner (Benner, 1984; Dreyfus, 2001).

*Assessment and confirmation.* Mindfulness in some circumstances might be assessed, albeit indirectly (Epstein & Hundert, 2002). Our preliminary data, using a new questionnaire, suggest that patients can assess “presence,” and undistracted attention. Openness to experience and tolerance of uncertainty can be assessed using personality

questionnaires. Preceptors can judge evidence of curiosity by the use of reflective questions and “thinking out loud.” Explicit expectations that students will be assessed on their ability to be curious can then open further dialogue about becoming mindful in action. One can start a teaching session by saying, “Not only will I be looking at how you solve the clinical problems that you face, and how you relate to patients, but I also will be assessing how you reflect on your own performance.” Peer ratings and self-ratings can be helpful. A preceptor can confirm with the student (or a practitioner can confirm for herself) that something important has been learned, enabling the learner to re-enact the process of discovery in new situations. Without being pedantic, students can be asked to identify explicitly things that they have learned about medicine, or themselves, after each session.

#### TRANSMISSION OF MINDFULNESS

Transmission of mindfulness might be considered in two situations: from experienced teacher to an apprentice, and among peers. Experienced clinicians know that their professionally relevant knowledge is more than facts or skills, attitudes or values; it is the summation of years of living within their day-to-day tasks. It is critically informed action, some of which must be tacit, lest they be overwhelmed with every perceptual detail and every nuance of thought. Thus, there is always a dynamic tension when an experienced teacher tries to enter the world of the learner so as to be able to recognize mindfulness and nurture it. An “outsider’s view” can have enormous value by provoking curiosity about elements of clinical care that are either viewed as ordinary or are not observed at all. At its best, the “outsider” can be a “designated beginner’s mind.” The “outsider” encourages the student to assume new and multiple perspectives.

An “insider” such as a peer or someone closer in age and experience to the learner can “be with” the student in a different way. For example, an “outsider” might be able to empathize with the impact of a student’s experience after an unsuccessful resuscitation of a young patient who suffered a cardiac arrest. However, the immediacy of the situation—making quick decisions, smelling blood and vomit, doing technical procedures, and feeling the sinking disappointment when it becomes clear that the patient will not survive—is more intense for a peer who was actually there.

But, *how* is mindfulness transmitted? The arts also offer examples of the transmission of knowledge that is fundamentally tacit and personal. Mutual understanding, sustained contact, and patience are fundamental, but there is more.

Some 25 years ago, I had the opportunity to see a performance by Balasaraswati, a well-known classical Indian dancer whose family included several generations of dancers. As was tradition, her daughter, Lakshmi, danced the opening number before Bala was to come out on stage. But Bala was watching her from the sidelines. At the moment just before the dance started, their eyes met. Although no words were said, the communication was clear—it was the transmission of tradition that went beyond words. Earlier this year, I saw Lakshmi give a concert, and first to perform was her son. He was a wonderful dancer, full of energy, rhythm, and life. But the moment before he was to start, he and his mother exchanged a similar glance to the one that I had seen 25 years before.

This example captured my attention because it was nonverbal (or perhaps beyond words), in the context of a long-term caring relationship, and was in a setting where teacher and student had the opportunity to observe each other in action and participate in each other’s work.

## CONCLUSION

In addition to the eight steps outlined in this article, becoming mindful requires courage and motivation. Thus, the teacher's task, beyond asking reflective questions, is to provide a safe environment in which the learner can express fears and doubts. At the same time, the learner is encouraged to make hunches and seek new solutions to complex problems. Because habits of mind include the cognitive, emotional, and technical domains, group exercises that focus on emotionally difficult aspects of practice (such as Balint groups), while valuable, are only part of the process. Habits of mind can and should be cultivated in the operating room, the dermatology clinic, the radiology reading room, as well as in primary care and psychotherapy settings.

The activities described above must be coupled with time for reflection, whether it be designated time, or the brief opportunities between clinical tasks. "Sacred idleness,"<sup>2</sup> meditation, or just being alone are the "diastole" of clinical practice, in which suppleness and emptiness are more important than activity and focus.

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<sup>2</sup> "Certainly work is not always required of man. There is such a thing as a sacred idleness—the cultivation of which is now fearfully neglected" attributed to George MacDonald as quoted in *Poor Man's College Quotations*, 1994.

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## COMMENTARY

### Mindfulness in Medicine, Mindfulness in Life

PENELOPE R. WILLIAMSON, SC.D.

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In his two seminal articles on mindful practice in action (Epstein, 2003a; 2003b), Ronald Epstein presents a compelling explanation, useful model, and clear methods for cultivating and teaching reflective practice in all domains of medicine. In Part I, Epstein illustrates his points with examples from clinical practice, allowing the reader to track mindfulness-in-action and its positive impact on patient care. He also discusses the lack of mindfulness (delusion) and the negative consequences that result. By describing and unpacking the habits of thought and action in each case, the author articulates those capacities that lead to integral practice, on the one hand, and the mismatch of intention and outcome, on the other. He links these lessons to discussion of four teachable habits that apply across all domains of medicine: attentive observation, critical curiosity, beginner's mind, and "presence." In Part II, Epstein presents an eight-fold method

for promoting mindfulness, with examples and suggestions drawn from the practices of medicine, music, and meditation. He cites a wide range of relevant literature and mentions diverse practices that might be pursued individually or incorporated into medical education and practice.

In laying out this framework, Ron Epstein implicitly calls for further examination and practice of mindfulness in the cognitive, emotional, and technical aspects of medicine. He points out the applicability of this approach to evidence-based medicine, patient-centered care, technical skills, and ethical behavior. This is a compelling beginning. As Epstein says, mindfulness-in-practice is common among experienced practitioners, but has largely been tacit, hidden knowledge. It is time to make these practices manifest so that the ancient art of mindfulness may become a modern, lived practice in all aspects of 21st century medicine.

There are more compelling reasons for practicing mindfulness. When we are mindful in our work, we keep in touch with our essence, our place in the world. When we are reflective we bring more of our selves, unhidden, into the world. It takes courage to put oneself on the line in this way. As David Whyte points out "We are our gift to others and the world....In good work that is a heartfelt expression of ourselves, we necessarily put our very identities to

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Penelope Rose Williamson, Department of Medicine, Johns Hopkins University.

Correspondence concerning this article should be addressed to Penelope Rose Williamson, Sc.D., Johns Hopkins University School of Medicine, Department of Medicine, Bayview Medical Center, Baltimore, MD 21224. E-mail: penny.williamson@worldnet.att.net

hazard” (Whyte, 2001, p.13-14). The cost of not being mindful can be equally great. Again, quoting Whyte, “A work emboldens us for a while, and then, if we do not invigorate and reimagine our participation, it begins to enclose us and slowly starve our spirit. Good work done in the same way for too long, or done in the wrong way for any amount of time, eats away our sense of being right with the world” (Whyte, 2001, p. 76). Practicing mindfulness in work, then, is the continuing rediscovery of self. It is a re-engagement with what gives life, with one’s gifts and limits, with one’s unique capacities and vulnerabilities.

We don’t come to work in a vacuum. There are always other things going on, on the home front (illness or other important issues with oneself or a family member) or at work (overload of demands, uncertainties, unfinished business). Thus, each of us needs to have a way to prepare ourselves, to set the context, for being mindful in the work practices of the day. In other words, we need to be mindful for ourselves before we can bring our capacity for mindfulness to the service of others. As one colleague put it, recently, “there has to be room in your gifts for you.” I share a personal story to illustrate:

Last January, I faced the necessity of an operation to remove my thyroid gland because of possible cancer. In the 3 weeks leading to the surgery, I decided to enter this experience mindfully—wishing to hold the paradoxes of fear and trust, calm and agitation. Each morning, I lit a fire, meditated in front of it, and then wrote in a journal, often reflecting on the calm that regularly emerged after initial feelings of fear or agitation. Often the capacity to return to calm lasted for the day, allowing me a little space between anxiety and steadiness so that I could acknowledge the former, but live the latter. Thus I was able to work undistracted and with clear focus.

I went to the surgery with a similar peacefulness. Of course, knowing and

trusting the surgeon was part of this picture. Some years before, I had asked this physician what was most meaningful to him about his practice. He told me that his grandfather in Russia had been a tailor. As a boy, he remembered watching the meticulous stitches that he made. His own painstaking stitches as a surgeon connected him with pride to his lineage. The morning of my surgery I held the image of my surgeon’s care in his work.

One week post-surgery, I taught a group of physicians. The topic was “How We Work With the Fears in Our Life.” (Whether as clinician or patient, we must do our work; live our lives, sometimes in the face of daunting challenges. Too often we are alone with the struggles and successes borne from these times.) I shared the story of my recent experience as a way to invite recollections of how others had been able to work or live well in the face of fears. I found it took courage to do this. My thyroid cancer had been completely removed. The borders were clear. Nonetheless, the experience was still quite close. But I was determined to follow my “espoused beliefs” of teaching from lived experience, not simply talking about it. I was glad I did so, since it allowed others to follow suit. I will long remember many of the stories I heard that day and the lessons we learned from each other in the sharing.

It is important to say a word about limits. I (and many of my colleagues and friends) often aspire to achieve mindful practice in the midst of days crammed over-full with activities. This seems to be endemic to Western culture in general and to healthcare in particular. I believe in, but have to keep re-experiencing, the counter-intuitive wisdom that more work can in fact be accomplished, and at that, more effectively, by insuring time for “being” between times for “doing.” The following poem has been a teacher to me about this (Brown, 2002, p.27).

## Fire

What makes a fire burn  
is the space between the logs,  
a breathing space.

Too much of a good thing,  
too many logs  
packed in too tight  
can douse the flames  
almost as surely  
as a pail of water would.

So building fires  
requires attention  
to the spaces in between,  
as much as to the wood.  
When we are able to build

open spaces  
in the same way  
we have learned  
to pile on the logs,  
then we can come to see how  
it is fuel, and absence of the fuel  
together, that make fire possible.

Then we can watch the fire leap  
and play,  
burn down and then flame up  
in unexpected ways.

We only need to lay a log  
lightly from time to time.  
A fire  
grows  
simply because the space is there,  
with openings  
in which the flame  
that knows just how it wants to burn  
can find its way.

Judy Sorum Brown

A final reflection: I don't believe many of us ever "achieve" mindfulness, as if arriving at some wished-for-state. This seems a lifetime journey, and one that is often the harder to pursue with consistency because it runs counter to so much that is prized in our fast-paced, bottom-line culture. We take steps, some forward, some back. Our greatest gift may be to be appreciative of the process and patient with the pace.

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## COMMENTARY

### Omnipresent Mindfulness

JOSEPH E. SCHERGER, M.D., M.P.H.

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When Ron Epstein's article, "Mindful Practice," appeared in the *Journal of the American Medical Association* in 1999, I was very excited. Here was a new way of describing excellent medical practice. The backlash against managed care was in full force, and physicians in general seemed down in the dumps about time restraints getting in the way of caring for patients. Healing was not a commonly used term to describe medical practices during the 1990s. Rather, cost-effective care, clinical guidelines, and evidence-based medicine were the order of the day, and still are. These two articles by Ron Epstein on mindfulness in medical practice give tremendous depth to his construct. Rereading them gives me the sense that Epstein knows what it means to be a master clinician. Mindful practice would result in encounters that are frequently powerful and sometimes even magical. He gathers elements from

a variety of healing traditions to distill what it means to be effective. Diagnostic ability is only a small part of the process.

I have spent considerable time wondering how I might constructively add to these articles. I am humbled by the request. Ron Epstein is now my favorite deep-thinker about the physician-patient relationship. As a humanistic physician (philosophy minor in college), I am open to these ideas. We need modern-day George Engels, and Ron Epstein fits the bill. My 30 years in medicine have been successful, partly because I am a reasonably talented communicator. I went into family medicine and became a therapeutic pragmatist. While I think I have done a decent job at diagnosis and treatment, what has impressed me is that most of my patients value having a relationship with me that is far beyond my ability to help them with their problems. Patients find extraordinary comfort in having a personal physician that they know and trust, and someone who genuinely cares about them.

A big problem over the past few decades has been the barriers of access for patients to their personal physician. Appointment schedules, answering services, and my frequent travels have often removed me from my patients when they needed to communicate with me. Powerful encounters, even with Ron Epstein, can become attenuated in their effect by the time in between. If the

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Joseph E. Scherger, M.D., Department of Family Medicine & Rural Health, College of Medicine, Florida State University

Correspondence concerning this article should be addressed to Joseph E. Scherger, M.D., M.P.H., Professor, Department of Family Medicine & Rural Health, College of Medicine, Florida State University, Tallahassee, Florida 32306-4300. E-mail: scherger@med.fsu.edu

healer is not readily accessible, the healing power may not be available when it is needed most.

I had the privilege of serving on the Institute of Medicine (IOM) Committee on the Quality of Healthcare of America. In 2001, we released the report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. This report called for six qualities as goals to help improve care: safe, effective, timely, patient-centered, efficient, and equitable. Mindful practice would come out of being truly patient-centered, since the attentiveness to the patient is the only preoccupation of a clinician. The report went on to describe 10 simple rules for the 21st century healthcare system. The first rule applies to this discussion. It states that "care is based on continuous healing relationships." This rule replaces the current approach in which "care is based primarily on visits." Visit-based mindful practice may have powerful encounters, but it is episodic. What the IOM calls for is using all forms of communication to provide continuous access, resulting in continuous relationships. The new tool that allows this to happen is the internet. Patient encounters in face-to-face visit are still the most important means of care, and allow for sight, touch, and other elements of face-to-face presence. Epstein describes these visits at their best through mindful practice.

Can the elements of mindfulness be transmitted over the internet? Of course not completely, although people seem to be hooking up and even getting married as a result of communication over the internet. What I discovered in 1996, quite by accident, was that when I began giving my E-mail address to all my patients for their convenience in reaching me, avoiding a dreadful telephone system, I initiated an omnipresent sense of relationship. Electronic communication, or E-mail, allows a person to communicate with me any hour of the day from anywhere. I can receive this communication at my

convenience, at any hour of the day, from anywhere. The patient can spend as much time as he or she wants constructing the message and can even revise it before sending it. I have the ability to reflect on the message as long as I want, and even add attachments to my reply. This is a different type of mindfulness, and is much like thoughtful correspondence by mail that has been the hallmark of many great relationships. Knowing that the personal physician is "out there" in cyberspace, always available to connect with, is enormously powerful in enhancing the physician-patient relationship. E-mail communication is far from perfect, and subtle communication usually fails. Miscommunications are common and often have to be cleared up. But despite these limitations, the availability and sense of continuous direct access far exceeds these limitations.

The increased privacy policies coming from the HIPAA legislation may prevent the use of "open" E-mail communication. Vendors are available that offer secure web portals for communication that can be accessed from internet Web sites, and soon most medical practices will have these.

E-mail, like telephone communication, does not reimburse well in a fee-for-service environment. When care is capitated or contracted in advance, E-mail is a low cost means of communication and may even reduce the expenses of care by preventing some visits.

When I started practice right out of residency in 1978, I had all the time I needed with patients. I even had time to call patients on the phone the next day to find out if they were better. Most of these patients from my early days of practice became exceptionally dedicated to me as their personal physician because of this extraordinary reaching out to them. Continuous open access to E-mail communication has brought back that feeling, and it is a two-way street this time.

So, my contribution to Ron Epstein's exposition of mindful practice is that we should apply this in an omnipresent relationship. A next level of description could be omnipresent mindfulness, including the elements of using cyberspace to extend the power of masterful healing.

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# COMMENTARY

## Reflective Practice

KURT C. STANGE, M.D., PH.D.  
KAREN M. PIEGORSH, PH.D., MSIE, PT  
WILLIAM L. MILLER, M.D., MA

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In his book published earlier this year, (Dalai Lama, 2002) Dalai Lama illustrates *How to Practice: The Way to a Meaningful Life*. In two articles published in this issue of *Families, Systems and Health* (Epstein, 2003a, 2003b) Ron Epstein adapts insights from the same tradition to demonstrate how to practice medicine in a manner that increases its effectiveness and satisfaction for both the practitioner and the patient. These articles show us how to cultivate the habits that result in mindful practice. By naming and exploring the process, Epstein helps us to be explicitly reflective and thus to improve our awareness, attentiveness, and effectiveness in clinical practice.

Epstein has defined one of the core processes at the heart and soul of the practice of medicine. In the article on cultivating habits of mind, (Epstein, 2003b) Epstein proposes an 8-fold method that draws upon his experiences in practicing medicine, performing music, and meditating. These steps, which parallel other reflective approaches to enlightenment, (Bhagavadgita, 1985; Boldt, 1999; Briggs & Peat, 1999; Catford & Ray, 1991; Dalai Lama, 2002; Easwaran, 1991, 1997; Gelb, 1998; Huxley, 1945; Kabat-Zinn, 1994; Myren & Madison, 1993; Ramakrishna, 1988) are immediately applicable to medical practice. The skills require years to refine and necessitate practice in areas of a clinician's life outside of medicine.

The article on technical competence, evidence-based medicine, and relationship-centered care (Epstein, 2003a) shows how tacit and personal knowledge can be made explicit and used to inform and improve the quality of medical care. The four habits of mindfulness—presence, beginner's mind, critical curiosity, and attentive observation—make the patient more available to the clinician and vice versa. The four habits are partially analogous to the four steps of the Kolb learning cycle: concrete experience, reflection, abstraction, and active experimentation (Kolb, 1985; Whitman, 1996). Successful teaching and learning requires that all four stages in

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Kurt C. Stange, M.D., Ph.D., Department of Family Medicine, Case Western Reserve University; Karen M. Piegorsch, Ph.D., Department of Environmental Health Sciences, University of South Carolina; William L. Miller, M.D., Chair of Family Practice, Lehigh Valley Hospital.

This work is supported in part by a Family Practice Research Center Grant from the American Academy of Family Physicians.

Correspondence concerning this article should be addressed to Kurt C. Stange, M.D., Ph.D., Professor of Family Medicine, Epidemiology & Biostatistics, Sociology and Oncology, Case Western Reserve University, Center for Research in Family Practice and Primary Care, 10900 Euclid Avenue, Cleveland, Ohio 44106

Kolb's cycle be experienced, just as caring and healing are enhanced if all four habits of mindfulness are practiced.

Multiple ways of knowing are required for effective medical practice. The generalist craft involves integrating (a) self-reflective practice by clinicians, (b) understanding and involving the patient voice, (c) being aware of the systems affecting health and healthcare, and (d) understanding disease phenomena and treatment effects in patients over time (Stange, Miller, & McWhinney, 2001). Epstein's articles furnish the tools for self-reflective practice. These tools are important for all practitioners. However, they are *essential* to the primary care clinician attempting to realize the prioritizing, integrating, and relationship-centered function of generalist practice (Stange, 2001; Stange et al., 2001; Stange, Jaén, Flocke, et al., 1998).

Mindfulness is a powerful antidote to the potentially depersonalizing effects of current productivity pressures and technically oriented, rule-based, quality improvement initiatives (Stange, 2001). Many current efforts to improve the quality of practice operate as if the provision of medical care is independent of the personal characteristics of the practitioner (Stange, 2001). Recognition and reflection on individual differences in practitioners and patients through mindfulness may help to increase the desirable variation in practice that results from adapting evidence from groups to the specifics of individual patient-clinician partnerships (Miller, McDaniel, Crabtree, & Stange, 2001). Mindfulness also provides a powerful perspective that, if consistently practiced, is likely to increase the satisfaction of an increasingly disgruntled and disempowered healthcare workforce (Huby, Gerry, McKinstry, et al., 2002; Kassirer, 1998; Leigh, Kravitz, Schembri, et al., 2002). A mindful approach, in addition to helping clinicians buffer the effects of a dysfunctional healthcare system on their patients and themselves (Flocke,

Orzano, Selinger, et al., 1999), may also provide a source of insight and strength to confront and change the system.

Epstein also shows us how mindfulness can be at least a partial solution for the crisis in medical errors. Current approaches to reducing medical errors appropriately focus on systems solutions (Kohn, Corrigan, & Donaldson, 2000). This has the very desirable effect of overcoming the blame, shame, and punishment cycle that has caused us to sweep errors under the table for so long. However, a focus on systems solutions often minimizes the personal contribution to errors. The mindfulness approach provides a mechanism for understanding and valuing individual contributions to variation in medical practice (Miller et al., 2001) and for developing the insights and flexible application necessary to optimize practice. "...good medical practice requires the constant effort of recognizing and correcting for errors, rather than merely the linear pursuit of protocol." (Epstein, 2002b, p. 13) Mindfully working within complexity (Miller, Crabtree, McDaniel, & Stange, 1998; Miller et al., 2001), rather than trying to control every aspect of the healthcare process, is more likely to result in care that meets both group standards for quality and individual needs for personalization.

The understanding and approach to mindfulness elucidated by Epstein offer a powerful means for effectively integrating evidence-based medicine, the clinical particulars and context, and the patient's values, expectations, and preferences (Haynes, 2002). It is the clinician, in partnership with the patient, who must integrate these multiple sources and kinds of clinical knowing (Stange et al., 2001). Mindful practice is an explicit way to both enact and learn this core task through shared narratives and personal reflection (Borkan, Reis, & Medalie, 2001; Miller, 2001).

The mindful practice approach that Epstein outlines is familiar. It resonates

with our best self when we are most aware, most connected, most thoughtful, and most effective. It is worth daily effort to achieve—both as individuals and in community. Even clinicians who practice in different traditions (Easwaran, 1991, 1997) or who do not explicitly practice mindfulness will recognize themselves in the approach. What is recognized often will be parts of ourselves that have been subdued by other pressures and neglected, to the detriment of ourselves, our patients, our families, and society.

We take these articles as a call to action. First, action within—beginning with the long process of nurturing mindfulness in ourselves. Through this self-transformation, we will increase our ability to serve, and may implicitly influence others to be more reflective and connected. More formally, we plan to incorporate Epstein's articles into teaching students and residents. A journal club on mindful practice, and then conjoint practice by learners/teachers will help to create a learning community. In addition, mindfulness techniques are a legitimate and important avenue for professional development and continuing medical education for practitioners. Creativity and persistence will be needed to develop teaching methods for learners at all levels (Schön, 1990). Mindfulness is especially needed in the arenas of quality improvement and error reduction in order to overcome tendencies toward linear thinking and approaches that do not recognize the complexity and personal aspects of improving the quality of healthcare. Finally, practice of mindfulness in the generation of new knowledge will help to create a research community that integrates different ways of knowing, and shares new knowledge in ways that include mindful practice in the formulation of questions, the conduct of research, and the interpretation and sharing of findings.

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### *Corrections to Winter 2002 Issue*

Page 333—Don R. Lipsitt, M.D., 1999 Cummings PSYCHE Awardee

Page 338—Donald A. Bloch, author of “Dr. Biomedicine and Dr. Psychosocial: The Dual Optic II. Why Referral (Mostly) Does Not Work.”