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Being a mindful clinical teacher: Can mindfulness enhance education in a clinical setting?

PATRICIA L. DOBKIN & VINCENT LALIBERTÉ
McGill University, Canada

Abstract

Mindfulness may be viewed as a vehicle to promote the healer's role in medicine. This role addresses the way in which a medical practitioner interacts with patients. The aim of this article is to highlight how mindful qualities may also enhance teaching in clinical settings. Challenges to being a mindful clinical teacher are presented along with creative ways to accommodate them. Residents play an important role in training medical students. Examples of how mindfulness influenced a psychiatric resident's teaching experiences are presented to illustrate the concepts discussed herein. The dimension of "being" in medicine, based on the humanist philosophy of Dr Karl Jaspers, is provided as a framework for this article.

Introduction

> "*The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires.*" — William Arthur Ward

According to psychiatrist and philosopher Karl Jaspers our conception of medicine once rested on two pillars: scientific knowledge and expertise on one side, and a humane ethos on the other (Jaspers 1963). Yet, the expansion of the first is such that it may have impeded the other: "The discoveries which have been made in medicine and in the natural sciences have endowed us with unprecedented skills; yet for the bulk of the sick it seems harder and harder to find the right physician for any individual. One might think that the steady growth of scientific skill had made good doctors rarer." (Jaspers 1963, p. 159) "Humanism" in medicine and the "healer role" refer to the pillar of medicine where human beings are viewed as whole (McNamara & Boudreau 2011). This is essential not only to the physician–patient relationship, but to the practitioner–apprentice relationship as well. The finding that medical training can have adverse effects on the psychological, social and spiritual development of the learner may reflect this imbalance (Allen et al. 2008) as is evident from high levels of distress and burnout reported by medical students (Shanafelt et al. 2003; Dyrbye et al. 2006).

Mindfulness has emerged in medicine precisely because it is one means of regaining equilibrium between the two pillars of curing and healing. This article addresses how mindfulness may also enhance the teacher–student relationship to the benefit of both the clinician and the learner. We first examine how it supports excellent teaching in clinical settings. Then we discuss the challenges and potential solutions to being a mindful clinical teacher. Our main goal is to describe how medical teachers can be effective and inspiring by incorporating mindfulness in the way they interact with students.

Practice points

- Being a good clinical teacher and being a mindful teacher share many characteristics
- Mindfulness qualities may enhance teaching in a medical setting by emphasizing the healer's role in medicine
- Residents play an important part in the training of medical students, and mindfulness may enlarge the scope of this teaching role

Mindfulness in medicine

Mindfulness is a *way of being* in which an individual maintains *attitudes* such as, openness, curiosity, patience, and acceptance while focusing attention on a situation as it unfolds. Mindfulness is influenced by one's *intention*, for example to act with kindness, and *attention*, i.e. being aware of what is occurring in the present moment. It is an innate universal human capacity that can be cultivated with specific practices (e.g. meditation, journaling); it both fosters and is fostered by insight, presence, and reflection. Thus, mindfulness is congruent with the overarching goal in medical practice to cure disease when possible and meet suffering in a compassionate manner (Hutchinson et al., 2009). Epstein and his colleagues at the University of Rochester School of Medicine and

Correspondence: Dr Vincent Laliberté, Department of Psychiatry, McGill University, Ludmer Research & Training Building, 1033 Pine Avenue West, Montreal, Quebec, Canada H3A 1A1. Tel: 514-880-5942; Fax: 514-398-4370; E-mail: vincent.laliberte@mail.mcgill.ca

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Dentistry have published numerous articles describing mindful clinical practice including how it may be taught to medical students, residents, and physicians (Epstein, 2003a,b; Epstein et al. 2008; Krasner & Epstein, 2010). Epstein (2003a) adapted the core aspects of mindfulness to clinical practice and described the "four habits of mind" of the mindful practitioner. First, s/he engages in attentive observation of the self, the patient, and the problem. This awareness includes one's own perceptual biases and filtering processes. The second habit is curiosity. For example, the clinician would wonder why certain "facts" do not add up. The third habit has been referred to as the "beginner's mind", i.e. the ability to see things as if for the first time. The fourth habit is termed presence; by being fully with the patient one's work can be guided by insight and compassion. Research has shown that in the context of medical practice, mindfulness has the potential to decrease burnout and enhance health care professionals' well-being, job satisfaction and empathy (Krasner et al. 2009; Martin-Asuero & García-Banda 2010; Beckam et al. 2012; Goodman& Schorling 2012) and foster patient healing (Dobkin 2009). What we examine herein is the notion that mindfulness also has the potential to enhance medical teaching. We start with a brief look at the literature pertaining to the characteristics of an exemplary clinical teacher.

Characteristics of a clinical teacher

A clinical teacher is distinct from other types of instructors because what is being imparted has implications for quality of care. S/he needs to possess several types of explicit (opposed to tacit) knowledge – of medical science; of how to listen and care for patients; of the context in which s/he practices and teaches; of learners; and of principles of teaching. Also essential to this setting are communication skills and knowledge of the curriculum (Irby 1994). Of course, an excellent teacher is also a role model. Jochemsen-van der Leeuw et al. (2013) reviewed 17 articles and divided the attributes of clinical role models into three categories: patient care qualities, teaching qualities, and personal qualities. Positive role models were most commonly described as being excellent, experienced clinicians who showed empathy towards patients, had positive interactions with others, were committed to the growth of their students and used a humanistic teaching style.

A good clinical teacher fosters these habits of mind in students (Epstein 2003b):

- experiencing novelty – the ability to perceive any stimuli as new and be able to describe it prior to interpreting it or using heuristics
- flexibility (use of the conditional) – prevents premature foreclosure (e.g. this patient *could have* X/diagnosis rather than, this patient *has* X/diagnosis)
- seeing a situation from various perspectives
- suspending categorization and judgment
- self-questioning, self-monitoring (reflection in action)

S/he does so by being cognizant of *how* s/he is relating to the student as much as what is being taught. Petrozzi (1995) describes the gifted clinical teacher as one who listens carefully, observes intently, asks well-crafted questions, waits patiently for responses, and is always attentive to non-verbal messages.

Residents play an important role in the development of medical students and may have an influence on their career choices (Wright et al. 1997; Butani et al. 2013). Butani et al. (2013) proposed a list of qualities valued in resident's teaching. Professional skills such as accountability, respect, and humanism should be displayed. Residents are responsible for providing a safe environment as well as having an empowering teaching style. They should be "showing enthusiasm, providing clear expectations, directing observation of learners, demonstrating problem solving, providing and asking for feedback" (Butani et al. 2013, p. e1056). Their leadership skills, which include a balance between supervision and autonomy, are also seen as important.

The mindful clinical teacher

It is striking how characteristics of the excellent clinical teacher and the attitudes and attention to the present moment that enable a mindful clinician to relate well to patients are similar. Hence it is logical that qualities promoted with mindfulness could be transferred to the way a clinical teacher instructs the medical student or resident. For example, the student is less likely to experience the dehumanizing aspects of clerkship if the teacher is fully present to the student and shows passion for her/his profession.

Just as the physician–patient relationship is central to quality patient care, the teacher–student relationship is vital to excellent teaching. Haidet & Stein (2006) note that the "interpersonal context" that fosters learning is often overlooked when content delivery is viewed as central to teaching. The relationship between the teacher and learner, when characterized by respect, collaboration, emotional investment, and acknowledgment of its inherent reciprocal nature will affect the student's development of her/his professional identity. When a teacher is mindful, s/he is aware of the self (e.g. feeling overworked), the other (e.g. the learner's level of experience), and the context (e.g. oncology ward). S/he uses this awareness to respond rather than react to a situation and to guide the learner with a student-centered orientation.

One of our students wrote:

> "The ward culture is completely different from what we imagined. The notion of fostering empathy is hardly evident in the day-to-day hospital experience. My supervisor wrote this comment during my first clerkship rotation, "*Caring and competent, but needs to work on separating his emotional involvement with patient predicaments from necessary objective decision making.*" We were asked to be more *objective* and to dissociate our feelings from the physician-patient relationship in order to respond efficiently with evidence-based information to the patient's needs. Yet, we wonder, what is the place of subjectivity in patient care? Perhaps the answer is not by "*separating [our] emotional involvement*" if we want to deliver comprehensive patient care. The physician-patient relationship – whether deep

> or insincere, nurtured or ignored – has some form of mutuality inherent in it. We can learn through these sentiments, allowing for a better understanding of our patients and ourselves."(Garneau et al. 2013)

What had his clinical teacher done? Was s/he aware of this student's concerns and caring for the patient? Did s/he role model the humanistic aspect of medicine? We think not.

Challenges to being a mindful clinical teacher

While many would agree that it is ideal to be mindful while working with students, we queried those amongst us about what gets in the way of teaching in this way. They listed the following challenges:

- Needing to attend to the learner and patient at the same time
- Number of trainees/learners
- Other faculty present with different "agendas"
- Conflict and confrontation between professionals
- Distractions (e.g. cell phones)
- Goals may differ between teachers and learners
- Use of technology (e.g. viewing screens rather than people)
- Structure of the health care system
- Multi-tasking
- Conflict between different clinical roles
- Rapid turnover of students
- Many different working contexts

While we do not present solutions to all of these challenges, we will illustrate ways to overcome some of them based on our teaching experiences.

- Needing to attend to the learner and patient at the same time

The second author (V.L.), a psychiatric resident, relates how mindfulness informed his teaching when faced with the challenge of attending to the patient and learners simultaneously during an evening shift in the emergency department (ER) where he was accompanied by two medical students.

Earlier that day, a situation occurred when a young man entered a woman's apartment and refused to leave even though he was not welcome. Two police officers escorted him to the ER and remained all day to guard him. Because the patient refused to inform us about what happened at the woman's house and why he was there, it was impossible to determine if he was suffering from a psychiatric condition or not. The young man straddled two systems: the law and health care services. Our job was rendered even more difficult when he alleviated his bladder on the wall as this prevented us from doing a routine drug screen.

While walking toward the seclusion room, passing by the visibly bored police officers, I indicated to the two medical students that were accompanying me that we needed to build an alliance with the patient so that he would open up to us. With one hand bound in a handcuff, the patient was staring at the wall while lying on his stretcher, looking very detached from the whole situation. The spotlight being on me, I did not share his apparent equanimity, and not surprisingly the alliance that I was hoping to build remained solely in my imagination. A few minutes into the interview that was going nowhere, one of the medical students took the initiative by exchanging a few words with the patient, simply expressing interest, without attempting to extract factual information.

I realized that my desire to be judged as a good doctor hampered the therapeutic alliance, and was a poor teaching example. The patient had resisted all day the questions being asked. He only opened up to the kind words provided by this medical student. Following a quick glance of the medical student signaling me to take back the lead of the interview, I tried to obtain an answer to one simple question: "Why did you enter this apartment?" After pausing a few moments, he said: "There are too many people here, I won't answer." This provided us with an opening. My reply was, "Fair enough, choose one of us, and the two others will leave." As I expected, he pointed toward the third year medical student who just spoke with him. I, along with the other student, exited the room.

Returning 20 minutes later, the student was clearly proud. I listened intently as he related the story. I asked some questions pertaining to the facts as well as the relational aspects, "Why do you think the patient chose you?" I asked. Perhaps due to modesty, he did not compare our two approaches and responded that it may have been by chance. I suggested that he had treated him as another human being instead of as an obstacle, and with that simple act of kindness the tension in the room dissipated. The patient revealed the required information: he had been using amphetamines daily. It is likely that it had induced a psychotic state.

The resident learned at this point that instead of trying to be both a teacher and clinician at the same time, it would have been preferable to give his full care and attention to the patient, and then do the same while teaching the students. However, by staying anchored in the moment and taking into consideration the context, he found a creative way to transform the situation so that it became beneficial to everyone.

- Distractions

Another clinical situation occurred while the resident (V.L.) was on call in the ER.

This was crisis situation that required my entire attention. A patient was in an acute psychotic state and was escalating with the nursing staff who were about to have the patient restrained and sedated. I approached the patient using a very calm voice and felt that I was having an appeasing effect on him. However, suddenly I received three successive text messages accompanied by a little symphony that both annoyed me and the patient. He started to feel paranoid about the sounds which he believed might be directed against him. In the end, a "code white" was called, and to my dismay, I realized that the text messages were completely unrelated to my job.

Working on a busy medical ward includes dealing with vast amounts of information and stimuli coming from patients and their family members, co-workers, students, as well as the environment (e.g. noise, cramped quarters). When compounded by internal stimuli one may feel overloaded.

Staying mindful in such a context is a challenge but is worthwhile. Given that it is not possible for the human mind to attend to two things at once, it is important that the mindful teacher attend to each event sequentially. For example, not responding to e-mails on one's smart phone while working with students.

- Conflicts between different roles

Another challenge faced by both staff and residents is of being mindful – which includes a nonjudgmental stance – in the context of an ongoing and necessary process of student evaluation. Hence there seems to be a conflict there between two roles: teacher and evaluator. Making the distinction between judging the person from evaluating behaviours/skills is one way to go about this. For instance, one can give feedback without blaming or offending the student. One can ask the student first to reflect upon her/his own work and then acknowledge strengths as well as weaknesses. Conscious use of language that does not belittle or humiliate is important. Given that medical training occurs within a hierarchy because some have more experience and responsibilities than others, the teacher's attitude matters. For instance, the supervisor has an opportunity to set the tone for a team; when s/he is caring towards the patient and enjoys his/her work, this is felt by all involved. While an authoritarian stance may be detrimental to the development of the healing capacities in students, the master-apprentice model can be invaluable for the learning process. This model, as old as humanity itself, may create a sense of fulfillment for the teacher and the student. Even a negative evaluation may be seen as a valuable opportunity for growth, when provided with tact and kindness.

- Adapting to the context

Adapting the teaching to different types of students and situations can also be challenging. When working with peers it is important to tap into the skills and strengths they already have. Allowing them to find solutions not only shows respect but enriches the teacher too. For example, in our Mindfulness-Based Medical Practice program (Irving et al. 2014), when we teach communication skills via role plays participants first enact a situation in which they feel perplexed or they may present a problem from the clinic that was left unresolved. They, with guidance from one of the instructors, are encouraged to find another means of communicating that is more empathetic and effective. Group members can add to the learning experience during the debriefing as they often have had similar issues and may have other means of approaching the situation. Thus, a context is created in which pedagogical encounters occur based on shared experiences and understanding. In contrast, the climate of competition and rivalry often present on the ward (e.g. students feeling the need to have all the answers, be the best, etc.) is less likely to engender learning.

Overcoming challenges to being a mindful clinical teacher

Mindfulness, while not a panacea for these difficulties, can influence our approach toward them. For example, finding external excuses for an unfavorable situation is a habit of mind; an alternative is to notice the habit, not act on it, and see the circumstance with more clarity and then respond accordingly. It is possible to consider difficulties as an opportunity to overcome overlearned reactions. Epstein (2003b) created a "method for mindfulness in medicine" meant to guide the clinical teacher in how to help students become mindful clinicians; this includes eight aspects. It can also be used as a guide on how to become a mindful clinical teacher.

- Priming – Set an expectation for self-observation

The medical teacher can notice how s/he prepares to see the student(s); does s/he have a list of goals? Does s/he tune in to the present moment? Has s/he set the intention to be attentive of cognition, emotion, as well as the body, while engaged in the teaching process? For instance a practitioner may notice a tendency to show less interest in the progress of the students compared to that of the patients. Perhaps the former is viewed as the "real job" whereas the latter as a burdensome addition to the workload. Noticing this thought while working is essential. Furthermore, meditation practice may provide the teacher with a broader understanding of the way events unfold (i.e. how they are interconnected).

- Availability – Creating physical and mental space for exchange

The teacher needs to be available to her/himself first. Again, this quality can be cultivated by activities where a mental space is purposively explored outside of the working environment, such as by journaling or by setting aside time to be in nature. Another possibility is to organize reflection groups among teachers to share their experiences. These exchanges would sustain improvement of didactic skills while emphasizing the value of teaching in medicine. Most importantly, being available means to be fully present during the unfolding of process of teaching, be it formal or spontaneous. Humility which implies not adding unnecessary authority to the teacher–apprentice relationship may enhance learning as well because it involves relinquishing the notion that one has all the answers (Harden & Crosby 2000).

- Asking reflective questions – Invite curiosity

A traditional teacher-centered orientation of medical education may not tap into the merit of "thinking outside the box". However, this ability may be essential in the constantly evolving health care system which requires new ways of dealing with difficult situations. In medical teaching, critical thinking skills and the use of self-reflection have been seen as important ways to enhance learning both for students and teachers because it encourages meta-cognition in which the learner becomes more attuned to the self and to the situation (Azer et al. 2013). Ambiguity and doubts occurring in a given situation can also stimulate self-questioning thereby encouraging teachers and students to adopt new ways of thinking. Finally, the teacher may also direct curiosity and self-questioning to the teaching process, for example by wondering in what precise way s/he is influencing it.

- Active engagement

Students learn by doing and the teacher's role is to guide them in the knowledge gained through these experiences. Clearly factual and technical knowledge are indispensable, but to only consider objective data gathered during the clinical encounter implicitly transmits the idea that the healing aspect of medicine is less important. Such a message was given to

the student previously described (Garneau et al. 2013). However, the opposite can be transmitted by accompanying the student while s/he is performing the art of medicine and by providing feedback specifically directed toward the relational aspects of it. Core values of medicine would be taught at the same time. This might also bring student's awareness to his/her way of relating to the patient that s/he overlooked.

- Modeling while "thinking out loud"

By making mental processes transparent, the teacher invites the student to become aware of his or her own mental processes that are leading to a particular diagnosis, for example. It may help students identify certain detrimental ways of thinking that were not perceived as such. Since teachers are enhancing learning in students who will become teachers, or in residents who share both roles, thinking out loud teaching may be useful. Concretely, it may clarify which components of medical teaching are being stressed; knowledge transmission, imparting skills, or sharing professional values (Cooke et al. 2006). It could also render explicit when curing or healing is being addressed, a distinction rarely made in medicine (Hutchinson et al. 2009). Referring explicitly to this core distinction can counteract the implicit assumption that *being* and relationship skills are of lesser value and can be taken for granted.

- Practice presence – *Being* may be more than doing

Practice in this context means to work toward developing and cultivating the qualities of mindfulness such as attentiveness, curiosity, flexibility and presence, characteristics crucial to the teaching process. It is helpful to model these while teaching. For example, one can maintain the intention to be present and be attentive to what the student is saying or experiencing. Developing these qualities will give the teacher the opportunity to choose how s/he will respond to the student's need, instead of reacting automatically.

- Praxis – Consolidation of learning processes

Praxis is the logical step that follows rigorous practice. In praxis, the teacher does not need to think about practicing anything. Embodying mindfulness qualities, s/he will spontaneously know how to act simply by being available to a situation as it unfolds. For example, the teacher will have the flexibility to change instructions based on a given situation, instead of imposing it. S/he will be able to take advantage of the multitude of learning occasions that does not consist of formal teaching, that some have called the "hidden curriculum". The teacher will also be aware of the consolidation of the learning processes in students.

- Assessment and confirmation

Teachers can assess their own ways of interacting with students to see if they are fostering learning in a safe environment. The view of other teachers might also provide important insights.

Butani et al. (2013) points out that there is a dearth of tools to assess resident's teaching skills, despite the importance of their teaching activities. More than simply being assessed by the quantity of knowledge transmitted by quizzing medical students, attributes expressed by their professional skills and attitudes should be appreciated. Confirmation refers to creating an environment where teaching is promoted and highly regarded. Too often medical teaching is viewed as secondary to research (Cooke et al. 2006). Incentives, such as having an humanism award, may convey the message that ethics in medicine can promote career advancement (Hafler et al. 2011).

Conclusion

Jaspers referred elegantly to the spontaneity that characterizes the transmission of the second pillar of medicine – what he calls medical humanism: "Medical science is handed on by instruction, explicitly and on the broadest scope. Medical humanity, on the other hand, is imperceptibly handed on at every turn by the medical personality – in the manner of speaking and acting, in the spirit of the hospital, in the calm, unspoken, ever-present atmosphere of medical propriety. The instruction can be planned. It keeps growing clearer and more didactic. Scientific research, augmenting knowledge and skills, keeps growing more critical and methodical. But humanity cannot be planned. It makes no general progress but unfolds anew in every doctor, at every hospital, by the human reality of the medical man." (Jaspers 1963, p. 154)

The teaching experiences involving the resident were selected to broaden the scope of what can be considered to be teaching in a clinical setting. Of course medical knowledge and skills are required, but cultivating humanistic values is equally as important. Mindfulness offers an explicit way of transmitting the importance of "being" in the clinical setting, and how it can promote both healing and teaching.

Our goal in writing this article was to show that mindfulness applies equally to how we relate to patients and students. Basically the qualities that promote both healing and learning are the same. As stated by Jaspers, "The presence of a personality whose zeal to help will – for the moment, at least – let it exist entirely for the patient is not only infinitely soothing; in the sick as in anyone else, the existence of a rational person with a strong mind and the convincing effects of unqualified kindness will release incalculable forces of trust, of wanting to live, of truthfulness, without a word being spoken. We cannot grasp all that one man can be to another." (Jaspers 1963, p. 166).

Glossary

Mindfulness: is a way of being in which an individual maintains attitudes such as, openness, curiosity, patience, and acceptance while focusing attention on a situation as it unfolds. Thus, mindfulness is congruent with the overarching goal in medical practice to cure disease when possible and meet suffering in a compassionate manner

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Notes on contributors

DR PATRICIA L. DOBKIN, PhD, is an Associate Professor in the Department of Medicine at McGill University and teaches mindfulness programs in the McGill Programs of Whole Person Care.

DR VINCENT LALIBERTÉ, MD, MSc, is a Psychiatry Resident in the Department of Psychiatry at McGill University Health Center.

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