

Statio: The Time in Between

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US medical students have been losing interest in family medicine since 1997. The number of residency positions has fallen by 15%—from 3,262 in 1997 to 2,761 in 2005, with the number of US medical school seniors entering our specialty dropping by 52% from 2,340 to 1,117 during the same period.

Having practiced family medicine and been involved in the education of students and residents for 20 years, I am still struck by the marvelous complexity of my daily work and the joy and honor it is to serve my patients. While there are many justifiable reasons to point fingers at those who we believe are undermining interest in our specialty, there still ought to be room for some introspection. In that light, why then have I not been more successful in sharing the importance and rewards of being a family physician with students and others? In searching for answers, I rediscovered an old practice that helps to see the meaning of experience in our intertwined lives.

My journey to find better ways to show learners the value of family medicine began with a novel. *All the Names*, by Jose Saramago,¹ chronicles the quest of Senhor Jose, a clerk in the registry of births and

deaths in an unnamed city, as he endeavors to retrace the path of a recently deceased woman. While initially somewhat morose, the story is ultimately an exquisite tale of interwoven lives. Appropriately, I read it with the rest of a couple's book club in which my wife and I participate each month. Husbands and wives alternate in selecting the next book that we all read and discuss, so we cover wide territory and come to know each other better in the process.

As Senhor Jose followed the life of this previously obscure woman, I could not help thinking about the stories of two patients I had the privilege to know and care for.

Ingrid was a crusty Scandinavian who I first met more than 15 years earlier when she was in her late 60s. She was already legally blind from macular degeneration, and yet she worked productively until her retirement as a desk clerk in a Milwaukee "fleabag" hotel. Most of her medical problems were those of aging: arthritis, hypertension, and an occasional flare of eczema. She had a biting and affectionately sarcastic wit, a well-developed sense of humor, and not an ounce of patience for fools. She had no children but was much loved by a niece who lived in a suburb of Chicago, where she spent most of her holidays. She seemed on track for a long life until she began to lose weight rapidly. A CT scan showed a retroperitoneal mass in her abdomen. The verdict on biopsy was pancreatic cancer. When I presented the rather lim-

ited options for treatment, she said the hell with it and died at peace, with her niece at her side, about 3 months later.

My other patient, Genevieve, was of a more conventional nature. She had lived well as the wife of Ed for the past 67 years. A wisp of a woman, she ascribed her long life to her daily morning regimen of sit-ups capped off by an afternoon martini with her husband. The day I first met her some 15 years ago, she had been climbing one of the trees in her back yard to prune its branches. During a subsequent office visit, I asked whether she and Ed had any children, to which she gave her stock answer: "We never did have any children, but we sure had a lot of fun trying!" Her heart was the root of her medical problems, which were egged on by the late onset of diabetes and hypothyroidism. Remarkably active even with an ejection fraction of 20%, she finally submitted to congestive heart failure and died peacefully within hours of being transferred to the hospice unit, surrounded by those who loved her.

As much as a physician can love his patients, I too loved these women and personally grieved their passing. I realized that there is a cumulative knowing that builds while caring for people over time. In the context of the doctor-patient relationship, this kind of knowing can be surprisingly intimate and deep. Until the specter of death cast its shadow, I had not been adequately able to articulate the affection that I

(Fam Med 2006;38(3):211-2.)

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felt for these women—not to them, to myself, or to the many learners who had been transient participants in the care that I had rendered.

The depth of feeling that develops over time, often only with the chronically ill, is something I have only been able to appreciate as I and my relationships with my patients have matured. But, while I try to encapsulate the richness of the human condition for medical students rotating through family medicine, I wonder if what they see is more like a few frames of a full-length motion picture. A few segments only give you fragments of action, not the entire story. Perhaps I am failing by not providing learners with more background to show the rich substance of these seemingly brief encounters.

Like most of us, I have an RVU (relative value unit) target with incentives to increase productivity and penalties when I fall below the required threshold. As a consequence, my pace in the office can be frenetic. As I looked at my practice setting, I could see how I might be unintentionally dissuading students from their interest in family medicine and simultaneously failing to give voice to the experience of caring for people such as these two remarkable women. I began to realize the need to slow the action down so that the uninitiated might see what I intuitively see, so that I might reveal the depth of the substance of caring for people over time. Sometimes, I just need to hit the “pause” button.

Although I would like to claim this as my original thought, I soon learned that some monks have long used a discipline that incorporates a similar contemplation into their daily lives. Rather than moving rapidly and seamlessly from one task to another, they engage in

“statio,” a brief reflective moment to punctuate the point of disengagement from one activity to prepare for engagement in another. Statio originally was a military term for a garrison alert and in a state of readiness. In the Christian community, it came to mean a period of preparation and waiting, often associated with fasting. In writing about Benedictine spirituality, Joan Chittister wrote:

The practice of statio is meant to center us and make us conscious of what we're about to do . . . Statio is the desire to do consciously what I might otherwise do mechanically. Statio is the virtue of presence.²

In medical practice, we call statio “reflection.” This has long been identified, but perhaps not enough engaged, as essential to the practice and scholarship of teaching and learning. In Boyer’s *Scholarship Reconsidered: Priorities of the Professoriate*,³ this kind of practice reveals the subtle intricacies of teaching:

. . . positioned as a highly complex activity involving a deep understanding of the subject on the part of the teacher; a dynamic, shifting relationship between the learner and the teacher, a professorial practice needing *constant reflection and review* . . . (emphasis mine)

I have since been making an effort to introduce statio in my own practice, using transition times to center and reframe experiences. What I find is a new sense of composure upon entering the examining room and a more-attentive approach to my patients. In the quiet moments during the

interview process, I find that people are more likely to fill those spaces with pertinent clinical information that is often useful beyond the depth of my queries. In the context of a busy office, a break of as little as 30 to 60 seconds may be enough to reflect with a student, reconsider my medical decision making, and prepare for the next patient. This is not wasted time but an opportunity to be alert and ready—to still my mind, to breathe, to experience a wholeness and context that is invisible in the middle of action, and to focus and bring the learner along with me. The practice often comes into full flower at the end of life, where retrospection is necessary to appreciate the full measure of what has transpired, as Senhor Jose shows us.

Taking a moment to reflect in the midst of our caregiving may provide a space to let a student see more clearly what we are doing, how it helps those for whom we care, how it affects us, and why we value it so. Maybe it will help them to do the same, regardless of the specialty they choose.

Acknowledgment: I would like to acknowledge the valuable input and editing assistance of Ms Chris A. McLaughlin, writer, Department of Family and Community Medicine, Medical College of Wisconsin.

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