

ticipate in journaling, and follow individuals who were advocates for homeless individuals. It is possible that including residents in a clinic experience without the additional experiences may have fostered less positive attitude change, since the patients were often complex and lacked adherence with medical regimens. Attitudes might change more noticeably in the positive direction if we expanded the clinic experience to include more didactics and personal experiences with the homeless population. Nonetheless, we believe that a homeless clinic experience is an important addition to a primary care residency to enhance health care advocacy efforts and volunteerism. We encourage other residencies to develop such experiences and share efforts at measuring learning outcomes.

Erin L. Woodhead, MS

Jeannie A. Sperry, PhD

Emily H. Bower, MS

Karen M. Fitzpatrick, MD

West Virginia University

Acknowledgments: Financial support for the Homeless Care Clinic described in this manuscript was provided by DHHS, HRSA, Bureau of Health Professions, D58-HP05144 for Residency Training in Primary Care, PI: George Fredrick.

Portions of this manuscript were presented at the 2007 Society of Teachers of Family Medicine Annual Spring Conference in Chicago and the 2007 Forum for Behavioral Science in Family Medicine in Chicago.

The Institutional Review Board of West Virginia University approved the research presented in this paper.

Corresponding Author: Address correspondence to Dr Sperry, West Virginia University, Department of Family Medicine, PO Box 9152, Morgantown, WV 26506-9152. 304-598-6900. Fax: 304-598-6905. sperryj@wvu.com.

REFERENCES

1. Forrest CB. Strengthening primary care to bolster the health care safety net. *JAMA* 2006;295(9):1062-4.
2. Kingree JB, Daves WF. Preliminary validation of the attitudes toward homelessness inventory. *J Community Psychol* 1997; 25(3):265-88.
3. Buck DS, Monteiro FM, Kneuper S, et al. Design and validation of the health professionals' attitudes toward the homeless inventory. *BMC Med Educ* 2005;5(1):2.
4. Buchanan D, Rohr L, Kehoe L, Glick SB, Jain S. Changing attitudes toward homeless people: a curriculum evaluation. *J Gen Intern Med* 2004;19(2):566-8.

5. Buchanan D, Rohr L, Stevak L, Sai T. Documenting attitude changes toward homeless people: comparing two standardized surveys. *Med Educ* 2007;41:346-8.

Comment

Dealing With Loss in the Journey of Mentoring

To the Editor:

Pamela, a first-year resident, presented a case to me (ASW) as part of a reflective learning session. Cases are selected by residents sometime after regular staffing. These sessions are designed for the residents to think about, reflect, and discuss with the mentor their emotional experiences during the patient encounter in order to utilize them in a more mindful manner in patient-centered care. She presented a young woman who had a miscarriage about a month ago and she was seeing her for an acute care appointment.

Pamela related that she was troubled by this woman's loss but gave reassurance that this feeling did not interfere with her workup or care. I asked her to tell me about her interview, her workup, and how she detailed the experience of the management plan. Reviewing the whole encounter gave her the opportunity to think about and reflect on the situation in a deeper way than a more-routine preceptor encounter.

Pamela indicated that she had assessed the patient's coping with the miscarriage, including using the Beck Depression Scale, and discussed both the woman's support system and her partner's ongoing adaptation to the loss.

When I asked Pamela if she would share what it was like for her to see this woman, she became teary eyed. She told me that as a student, she saw a woman who lost a baby at birth, and her advisor told her then that the sadness she felt was unnecessary. "Pamela, this is not your pain. It is the patient's loss and the patient's pain, not yours!"

She then said that she has continued to struggle, often unsuccessfully, with her own sense of loss and pain as her patients who suffer with loss and pain. She wondered if she was meant to be a physician if she had such problems with her own feelings and emotional responses.

As faculty and medical educators, we frequently miss helping a troubled learner. The desire to be helpful, understanding, and wise is a commendable and expected value. However, this miss begins with the perception that the learner is "troubled" and the response is to offer "help." Assumptions are made and the resulting conversation can interfere in a learner's ability to cope successfully with the emotional trials of being a physician. The ability to cope in medicine may be about many things, but certainly it is about seeking balance, focus, and "sense making" to one's experiences. The medical student advisor meant well but in reality hampered the coping strategies of this learner. It truly was Pamela's pain. It was her emotional response to a patient's loss; they traveled the same road of experience. Trying to make people deny their human responses to others is not only inappropriate, it is confusing and can lead to the questions Pamela posed about her ability to be a competent and effective physician.

There is yet no closure to this situation with Pamela. I asked her to reflect on why the advisor's words meant so much to her, had such an influential impact on her thoughts and self concept, and why she hasn't made an effort to struggle with what was said. Pamela's answers came out as I expected. Earlier school experiences outside of medicine in which she was "called out for sharing the pain and loss of others" had found a new credibility in her training.

Pamela and I created an action plan. Pamela was instructed to use guided imagery to place these earlier messages into a box and close

the cover for now. They can reappear later when her self-judgment is easier on herself and viewed through new and more enlightened rules. She was to seek more reflective sessions with faculty of her choice to create a more nonjudgmental assessment of her skills in being empathic but with legitimate boundaries and propriety,

There is much work to do. There must be the reframing of her experiences in caring for patients, some who will most likely lose and suffer. She will travel many of these same roads by caring for them. Pamela, and all of us as learners, must seek the opportunity and skills to explore and understand who we are and how we can care best for others

and ourselves at the same time. We need to remember that empathy is not about the loss of personal and professional boundaries. It is about everything that makes for compassionate human beings and healing physicians.

And yet, I wonder what other clues I should have followed? Could I have been clearer, more confident, and more capable? Have I muddied the waters for her?

We believe that Pamela is not the exception. How many physicians in training and practice suffer quietly from their past and have it potentially impede their care without us being there to begin a healing process? I shared some of Pamela's struggles with our son, who designs

programs that help people struggle with understanding themselves and others in a frequently painful and conflicted world. Together, we suggest that these essential skills, and the ability to be a mindful thinker in this work, do not come easily. They develop through hard work, discipline, and caring support of colleagues and mentors. Residents travel with their patients as we travel with our residents, a journey of mentoring worth taking.

*Alan S. Wolkenstein, MSW, LCSW
Aurora University of Wisconsin
Medical Education Group
Milwaukee, Wisc*

*M. Evan Wolkenstein, MA
Jewish Community High School
of the Bay
San Francisco*