EXPLORING GROUP-BASED LIFE REVIEW WITH FAMILY PHYSICIANS: CONSTRUCTING NARRATIVES OF EXPERIENCE AND MEANING

by

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ABSTRACT

This narrative research study was inspired by a desire to expand professional development opportunities for family physicians in Canada. Research points to increasing numbers of physicians who are unable or unwilling to continue practicing because of the overwhelming stress experienced in their work. Self-care, disclosure of personal difficulties, collegiality and help-seeking have not traditionally been fostered in medical culture and difficulties are often denied or go unnoticed until they reach a critical point. Recognizing that the current medical practice environment places the morale and sustainability of many physicians in jeopardy has underscored the importance of developing a range of initiatives to support physicians in their work and reduce professional isolation.

Group-based life review is a semi-structured process designed to combine individual reflection and writing about one's experiences with sharing life stories in a small group context. It has the potential to promote self-awareness, interpersonal learning and a sense of connection and mutual support among group members.

The purpose of this inquiry was to create an understanding of the multiple meanings that six family physicians made about their participation in a seven-week professional development program grounded in group-based life review. The goal of the inquiry was to gain an understanding from the participants diverse perspectives that could shed light on the viability of using group-based life review with family doctors as a means to enhance well-being and sustainability and illuminate the potential benefits and drawbacks of this approach within the context of their personal experiences and professional culture.

A reflexive collaborative narrative research methodology combined with participant inquiry was used to investigate the research question and to co-construct an in-depth understanding of how each of the participants experienced joining with colleagues in the life review program. The six narratives presented in this document provide a multi-focal perspective of the experience of participating in the program and contribute to understanding the viability and effectiveness of life review as one possible means to promote well-being, collegiality and sustainability among family doctors. The doctor's stories also illuminate some of the ways in which current medical discourses impact professional development opportunities for family physicians and raise issues and questions that merit further attention by both practitioners and researchers who are seeking to develop effective initiatives to support family doctors.

The narratives and thematic results that were generated in this exploratory inquiry indicate that the life review program was experienced as an effective way to promote self-care, mutual support, a sense of community and enhanced sustainability among family physicians.

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CHAPTER 1

Introduction

This narrative research study was inspired by a desire to expand professional development opportunities for family physicians in Canada and contribute to the future development of initiatives that can effectively enhance well-being, collegiality and sustainability among family doctors. Many authors who have conducted research on family practice medicine have drawn attention to the importance of enhancing the sustainability of family doctors (Cassell, 1997; Hale & Hudson, 1999; Sotile & Sotile, 2002; West, 2001). They report problems with recruitment in family practice medicine and increasing numbers of doctors who are unable or unwilling to continue practicing because of the overwhelming stress experienced in their work (Hale & Hudson, 1999; Holland, 1995; Myers, 2003; West, 2001). Based upon my experiences of working with family doctors prior to this study, evidence about the need to expand the range of resources available to support physicians in their work, and my familiarity with group-based life review, I decided that there was definite merit to exploring the efficacy and viability of using a group-based life review model (which I describe in detail in Chapter 3) as one possible way to enhance sustainability and collegiality among family physicians. As part of this study, a life review program for family doctors was designed and piloted with six physicians. By engaging in a collaborative research relationship with the participants in this study I sought to create a rich, in-depth understanding of the unique and complex meanings that the doctors constructed about their experiences in the life review program.

In the context of an identified need to expand professional development opportunities for family physicians, the results of this collaborative narrative inquiry offer a multi-focal understanding of the experience of participating in the life review program and provide insightful contributions about the viability of using this approach to enhance personal well-being and mutual support among family doctors. The doctors' stories also illuminate some of ways in which current medical discourses impact professional development opportunities for family physicians and raise issues and questions that merit further attention by both practitioners and researchers who are seeking to develop effective initiatives to support family doctors.

In this chapter I provide the rationale for this inquiry and the purpose of the study. I then briefly outline my approach to engaging in this narrative inquiry and describe two initiatives that led me to want to explore the process of group-based life review with family doctors and construct an understanding of how they experienced being in a life review program.

Rationale for the Inquiry

Researchers underline the importance of self-awareness, social support and the ability to talk about distressing events for people who, like physicians, work in professions where they are called upon to witness suffering in other's lives (Arvay, 1998; Catherall, 1999; Figley, 1999; Levine, 1997). Unfortunately, self-disclosure, self-care, and collegiality have not traditionally been

fostered in the medical culture and relatively little literature exists on the subject of the internal stress experienced by doctors (Cassell, 1997; Frank, 1995; Hale & Hudson, 1999; Sinclair, 1997; West, 2001). Traditional medical training, attitudes and expectations all too often result in a professional stance of coping alone, maintaining interpersonal distance, and isolation. Many doctors remain legitimately cautious about disclosing personal distress in this professional climate for fear of being judged weak or incompetent and stigmatized for needing support. In such circumstances, "the professional environment is a good place to become and remain ill" (Kaufmann, as cited in Sullivan, 2004b, p. 1). Difficulties are often denied or go unnoticed until problems reach a critical point (Montgomery Hunter, 1991; Myers, 2003; Sotile & Sotile, 2002). Without opportunities for collegial connection, doctors also miss out on occasions to proactively revitalize themselves by sharing the satisfactions, frustrations, personal meaning, anxieties and joys that they experience in their work (Remen, 2000, 2001).

In the editorial report of the Canadian Medical Association (CMA) Guide to Physician Health and Well-Being (2003) Dr. Michael Myers calls for sweeping reform of the culture of medical practice. This, he says, is needed to reduce suffering, isolation, lost productivity due to illness, and to counteract the traditional stigma attached to seeking help. He describes this stigma as reinforcing denial of symptoms, delaying help-seeking, driving self-medicating and noncompliance with treatment, augmenting suffering and exclusion, and killing doctors through self-neglect and suicide.

There is evidence that the current medical practice environment is exacerbating what is already a critical situation and places the health, well-being, and sustainability of physicians and their families at even greater risk. A large scale survey carried out by the CMA reported a serious decline in physician morale (Sullivan & Buske, 1998) and almost half of the respondents (46%) to the CMA's 2003 Physician Resource Questionnaire reported that they were experiencing an advanced stage of burnout. Remen (2001) suggests that people who are interested in the well-being of physicians need to expand their concerns about the care of impaired physicians to the care of all physicians, given the unprecedented numbers of doctors who are dropping out or seeking early retirement. The initial report of the National Physician Survey (Sullivan, 2004b) confirms the difficulties that many Canadians are experiencing in obtaining access to family doctors and medical specialists and indicates that 60% of family physicians in Canada are currently either having to limit the number of new patients they see or are not accepting new patients at all.

In recognition of these concerns the CMA has launched a number of initiatives such as the National Centre for Physician Health and Well-being, the Canadian Physician Health Network and the CMA Guide to Physician Health and Well-being. Despite such initiatives, Myers (2004) draws attention to a current lack of available resources to sustain physicians in their work and the need to develop a broad range of preventative and remedial interventions that can respond to the

varied needs of doctors and their families and mitigate the traditional avoidance of seeking support.

The reasons for conducting this study are grounded in this documented need to expand resources to support physicians in their work and explore ways to proactively promote their well-being and sustainability. My review of the literature revealed that there is currently a shortage of group-based programs designed to enhance self-awareness, provide family doctors with an opportunity to share both the joys and burdens of being general practitioners, and encourage a climate of mutual support.

As I shall discuss in Chapter 3, a considerable body of literature in the field of adult education and group counselling points to the value of biographical learning and the potential for transformative interpersonal learning that can occur when people are given opportunities for authentic self-reflection and re-storying in the safety of a cohesive group climate. Group-based life review is designed to combine individual reflection and writing about one's experiences with sharing life stories in a group context. It has the potential to promote individual self-awareness, interpersonal learning and intimate connection among group members. At the same time, it is a semi-structured process that allows participants to self-disclose at their own pace and retain a high degree of personal choice and control over their level of engagement. Sotile and Sotile (2002) contend that many physicians would welcome opportunities for informal counselling and workshops "that are respectful of the medical culture" (p. xix). Based on my familiarity with using a group-based life review model and previous opportunities to work with family doctors I decided to explore the viability of this approach as a possible means to enhance well-being and collegiality among family physicians.

Previous research studies on life review (Birren & Deutchman, 1991; Kuhl, 2002; McClean, 2001; Shaw, 1999; Silver, 1995; Westwood, Black & McClean, 2002; Westwood & Kuhl, 2002) indicate that the model appears to have natural therapeutic and integrative potential. To date, no research has been published to understand how family physicians would experience participating in a group-based life review program.

The Purpose of the Study

Given the rationale presented for this study that highlights the levels of stress among doctors, the isolation and reluctance of physicians to seek help and the lack of resources available to support physicians in their work, the research question being asked in this study is the following: What meanings do family physicians construct about their participation in a group-based life review program? The purpose of the study was to create an understanding of the multiple meanings that six family physicians made about their participation in a seven-week professional development program grounded in the life review method. Through a reflexive narrative research process and presence as a participant-inquirer during the program, I engaged in a collaborative relationship with the participants in this study so that we could co-create an in-

depth and multi-focal understanding of the meanings they constructed about the experience of joining with colleagues in life review.

The goal of the inquiry was not to draw conclusive truths about the value of life review or in a traditional sense to generalize the findings to family doctors as a whole. It was to gain an understanding from the participant's diverse perspectives that could shed light on the viability of using group-based life review with family doctors as a means to enhance well-being and sustainability, illuminate the potential benefits and drawbacks of this approach within the context of their personal experiences and professional culture, and contribute insights and new questions to ongoing discourses about how to effectively enhance well-being, collegiality, and sustainability among family physicians.

Locating the Researcher

We all, novice and experienced researchers alike, come to inquiry with views, attitudes, and ways of thinking about inquiry. These histories, these personal narratives of inquiry, may coincide with or cross a boundary to varying degrees with the actual inquiries we undertake. Almost all of us – it is almost unimaginable that we could not – come to narrative inquiries with various versions of formalistic and reductionistic histories of inquiry. To the extent that this is true, we are forever struggling with personal tensions as we pursue narrative inquiry. ...narrative inquirers need to reconstruct their own narrative of inquiry histories and to be alert to possible tensions between those narrative histories and the narrative research they undertake. (Clandinin & Connelly, 2000, p. 46)

I did not come to this research from a naive or a neutral stance. As a counselling psychology professional I have intentionally sought to be entrusted with and intertwined in other people's life stories. As we co-create and re-member their personal experiences in the quest for new, fulfilling or at least bearable stories, my own story is inevitably changed and re-membered. Influenced as I am by the epistemologies of constructivism, social constructionism and narrative, I embrace a relational, contextual, dynamic, and narratively co-constructed view of selves.

During my initial training and work as a counsellor, I specialized in working with women from a feminist perspective. This illuminated the need for me to consider how power dynamics and current social and cultural discourses can constrain or expand both the relative opportunities we have for telling our stories, and the ways in which we tell them. In following years, I pursued additional theoretical and clinical training and experience in couples, family and group counselling. This work, together with my experiences in the community college system where I meet many new immigrants to Canada and people from a broad diversity of cultural backgrounds, has sensitized me further to the fact that the stories we tell others (and that we tell ourselves about our selves) are inevitably constructed and re-constructed according to the audiences and

contexts in which we find ourselves. The relative degrees of safety, freedom and acceptance that we experience in any situated interpersonal encounter will undoubtedly affect what we choose (both consciously and unconsciously) to reveal of our complex selves and reciprocally how others receive and interpret what we tell or show them. Our constructions and representations of "selves" are interpersonally co-created, negotiated and dynamically re-constructed according to our purposes at any particular time, the audiences we are addressing (including our own internal audience) and the discourses that are available to us.

Charmaz and Mitchell (1997) note that researchers rarely tell beginning tales about the uncertainty or awkwardness that is often the starting point of any meaningful investigation:

> Beginnings are reconstructed at the end, in appendices and footnotes. In
> retrospect, what we did becomes what we should have done. Our temperate
> voices tell measured tales of just means and ordered findings. No false starts are
> in these stories – no confusion, trepidation, quandary, infatuation, or terror. (p.
> 209)

However, from the perspective of constructivist and narrative inquiry, the self of the researcher cannot be disengaged from the research process. Authors are called upon to be both adequately self-aware and adequately self-exposing to allow readers to understand the writer's interpretive positioning (Arvay, 1998, 2003; Clandinin & Connelly, 2000; Reinharz, 1997; Richardson, 1997, 2000).

Steier (1991) challenges researchers to allow processes of self-reflexivity to enter into research activities and to consider "how can we create ways of relating research stories that allow the tellers (us) and our constructing processes not to be eliminated from the tale?" (p. 167). Based on the belief that I need to include myself in the research in a sufficiently transparent way, I will risk telling a beginning tale. I therefore begin by revealing some of the trepidation and passion that infused my desire to engage in this research study and describe two initiatives that informed my desire to explore group-based life review with family doctors.

Developing Interest in Researching with Family Doctors

Seven or eight years ago, I was part of a team from the Counselling Psychology Department at my university who were involved in helping residents[1] in Psychiatry to learn about using a client-centered counselling model in their practice. During our work together, the students talked about the difficulty they were having "switching gears." Their years of medical training had underlined the importance of rapid assessment and intervention. If they took too long diagnosing a medical problem or became distracted by generalities, they were negatively evaluated. The residents reflected on the struggles they had initially had with this approach and their desire, as beginning medical students, to connect with their patients and spend time talking with them. Now,

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[1] Doctors who undergo a period of advanced training in a medical specialty after graduation from medical school and licensing to practice medicine.

ironically, when they were very accustomed to the fast paced diagnose-prescribe model, they were being asked to suspend problem solving, build a therapeutic relationship and focus more holistically on the experiences of their client.

For myself our work together brought into focus what Kenyon and Randall (1997) point out: In any given educational program we are schooled in particular principles, theories and methods, "we are literally discipline-d into a particular way of interpreting both our world and ourselves" (p. 108).

After several years of medical training, the residents I worked with had been discipline-d toward an ethics of intervention just as I, as a counselling psychology student, had been discipline-d toward an ethics of relationship. The ability to cross boundaries and integrate perspectives in a way that is personally and professionally meaningful is not necessarily easy. As Weston (2001) notes:

> The task of isolating a biomedical cause of a patient's suffering is worlds apart
> from the task of understanding a patient's experience of being ill. The first
> demands the ability to sift through the patient's personal story of illness, discard
> all that makes the patient's narrative unique, find what is universal, and discover
> the disease. The second requires physicians to "steep" themselves in the
> experiences of their patients in a very personal way, to understand their patients'
> feelings and individual frames of reference. (p. 2)

I became increasingly conscious of the importance of the degree to which doctors could both diagnose the disease and simultaneously steep themselves in the experiences of their patients over the next several years as I accompanied my aging parents through various health crises. I knew the comfort that Berger and Mohr (1967) refer to in telling an ailing parent that the doctor was coming, implying that all would be well, or at least better, with the reassurance of his presence. We may be feeling panicky but he would not. Throughout my father's last illness and death I experienced how much his sense of being seen, being truly witnessed, by the multiplicity of medical professionals he encountered meant to him and to myself, as his daughter. When he felt seen he was reassured, confident, at ease. When the encounters were distant, formal, impersonal, he became anxious and vulnerable, and so did I.

I noticed the toll on my Dad's caregivers. Early one morning, a young resident came to take my father for yet another test but he kept addressing him by the wrong name. I insisted on checking with him several times about the name, concerned that Dad would unnecessarily go through a test destined for another patient. The resident was finally able to reassure me that he did have the right person (my father). He was simply exhausted after more than 24 hours of being on call. It had been a busy night with multiple crises. He apologized for seeming muddled and appearing rushed.

As I journeyed with my Dad through his illness, I reflected on my experiences of working with faculty and students in Health Sciences programs at the Community College where I am a counsellor. Through my involvement in co-teaching communication skills training for students and co-leading some professional development workshops for faculty, I had gained some knowledge about health care culture and I had developed a profound respect for the demands involved in combining care and cure. At times I stood in awe of the challenges presented to students as they embarked on careers in health care. They were expected to rapidly and effectively learn a whole range of communications skills competencies alongside the medical procedures required by their chosen professions. Many students sensed that after graduating, the challenges they would face in the world of work would be no less. How would they find ways to provide deeply empathic care at the fast pace demanded by our current systems? How would they find ways to prevent themselves from burning out, or from becoming disillusioned if workloads and time pressures prevented them from truly connecting with patients?

Both my father and mother had been hospitalized previously. However, my Dad's final illness was the first time that I became deeply aware of the complexities of health care in a large teaching hospital. As we navigated our way through the comings and goings, I was grateful for knowing that our family doctor was only a phone call away. He was one source of stability and constancy in a shifting sea of changing caregivers. One person who knew my father as more than just a patient, a disease, or a dis-eased elderly man. Inevitably, the family doctor was our first port of call when a problem arose and just as frequently the last. The person we turned to for follow up and for help with pulling all the pieces together when things became confusing.

Although through marriage I had joined a family in which both my father-in-law and brother-in-law were family doctors, I began to realize how little I knew about what it was like to be a general practitioner. I knew they worked long hours, saw many different patients in a day and frequently had weekends and nights interrupted when they were on call. I knew that they bore witness to the whole range of traumas, joys, suffering, births and deaths that entered their patient's lives. More than this, I did not know. The ethics of patient confidentiality and what I have come to think of as the required stoicism of medical culture, left little room for them to speak about their felt experiencing of being a family doctor. And respecting the cultural norms that I had grown up with, both in general and in particular around doctors, I respected their privacy and did not ask.

What was it that drew me to want to learn more about the worlds of family doctors? The re-cognition of the central role that the doctor played in our lives during my father's illness, that our current family doctor continues to hold for us? What I have read, heard, and experienced about the crisis in health care in Canada? Conversations with family doctors as our paths intersected in various workshops and meetings? Perhaps some sense of social and professional responsibility to contribute to supporting colleagues in allied health care professions? Maybe it

was a greater awareness of my own vulnerability as I moved into a period in my life when I began to experience the deaths of friends and relations? Perhaps partly it was realizing that I, like many others, hold somewhat conflicted and shifting expectations of how I want doctors to be with me when I am in the role of patient: Warm, compassionate and human on the one hand, yet fast to pinpoint a solution to my various problems, calm in the face of tragedies and consistently available. Probably all of these threads (and others that I have yet to uncover) intertwined to draw me toward this research project.

In the last four or five years I have had a number of opportunities to engage with groups of family practice residents and family doctors in a variety of training and professional development initiatives. As I began to learn with them and to gain some insights into the world of doctoring, I became increasingly aware of the paradoxical dilemma between responsibility and response-ability that I was encountering. I realized, more than ever, the depth of responsibility that we, as individuals and as a society, ask our doctors to bear. As Arthur Frank (1995) says: "The weight modernity places on its heroes (being the beginning and end of all things – having to settle the task of the universe) – physicians feel this weight" (p. 153).

At the same time, as an outsider to their professional culture, I sensed that I was moving into a world that encouraged them (almost required them in many instances) to silence much of their felt experiencing of being doctors. I contrasted what I was learning about their professional training experiences and cultural norms with my own experiences of becoming and being a counsellor. Our perspectives on voicing personal experiences and actively seeking peer support had been shaped very differently.

In my work as a counselling professional over the last 17 years, I have personally learned about the joys and burdens of working in a caring profession and the risks that I, and others, run of experiencing vicarious traumatic stress. Research and practice stress that it is important for those who experience trauma and those who work with trauma to have opportunities to share their experiences and have them witnessed and validated. By the very nature of their work, physicians experience traumatic events, either directly or in witnessing the suffering of their patients. However, as Montgomery Hunter (1991) points out, although medicine is filled with stories, the untold stories of medical care are often those of the physicians.

Preparing to Re-search: Two Professional Development Initiatives

As part of preparing to engage in this research, I co-led two professional development initiatives which included elements of group-based life review. These were neither designed nor intended to be research studies, but rather to engage in learning with family doctors and familiarize myself somewhat with their culture. I will highlight what I learned from these initiatives while protecting the identities and individual experiences of the participants and co-leaders.

First initiative.

The first initiative involved working with members of an inner city, front line health care team. This group of professionals wanted to address the impacts of vicarious traumatic stress on their functioning as individuals and team members, enhance their resiliency and both celebrate and re-generate the joys of caring. The majority of the participants in the program were family doctors. In initial meetings to discuss the goals and viability of the program, we dialogued about what would be appropriate to share. How would the personal and professional connect as they engaged in collaborative group work? How could they be separated? How would the cultural and ethical norms about what could be voiced in medical care impact their level of engagement? Would they be comfortable, even able, to share experiences and self disclose when, for most of them, their medical training and work culture underscored the importance of confidentiality and coping alone? How would the group work affect their day-to-day working relationships, both among themselves and with other team members who would not be participating? These issues remained alive as we worked together to build and maintain a climate of safety and support that is necessary for effective group work and essential when working with trauma or vicarious traumatic stress.

Eight of the eleven people who had initially indicated an interest in the initiative participated in the program. One person was unable to continue after the first session because of prior commitments. Two others chose to discontinue after the first two months citing other priorities in their lives and preferring to pursue the self-care strategies they already had in place for themselves. We met as a group for 12 sessions, of approximately 3 to 4 hours each, over a period of 6 months. Anecdotal reports given at the evaluation meeting that was held two months after our last session, suggested that collaboratively re-storying and re-enacting critical life events had enhanced their ability to integrate traumatic experiences and given them an increased sense of resiliency and sustainability with regard to their professional work.

Several members spoke to becoming aware of the degree to which they had shut down their emotions prior to the group work. They talked of how their professional training and culture endorsed a stance of coping alone, maintaining composure ("detached concern"), and an appearance of being confidently in control. The cumulative impacts of bearing witness to multiple traumas in their work with an extremely vulnerable population of inner city patients were compounded by their expectations of handling things alone and a perceived sense of little support from health care administrators. The slide toward emotional numbing and withdrawal was not difficult in these circumstances.

Learning that others in the group shared similar feelings in the face of difficult encounters with patients or the death of a patient with whom they had built caring relationships normalized their experiences, led to a greater sense of collegiality and significantly reduced feelings of isolation. Collaboratively exploring practical ways to effectively handle challenging situations and

debriefing with colleagues in a time-efficient way both validated the depth of knowledge and skills that were present in the group and opened up new perspectives and novel ways of trying things in the future. Many reported that as a result of the group sharing they were reaching out for support in ways they had not previously thought possible.

A number of the participants spoke to an increased sense of aliveness and joy, both in their personal and professional lives. They felt that the sense of connection they had experienced in the group and the strategies they had developed (both for self-care and for supporting one another) were spilling over positively into the workplace as a whole and into their personal lives.

We discussed, as we had on a number of occasions during our work together, the relative benefits, challenges and disadvantages of engaging in this kind of collaborative re-storying with colleagues with whom one works on a daily basis. We looked at how the goals of building personal and professional resiliency and enhancing team cohesion can both intersect and be dissonant. For example, some participants expressed that because they had wanted as many colleagues as possible to join the group, they had initially put subtle pressure on people who were ambivalent to join or stay in the group. However through their own experiences of having members choose to leave the group, they realized how important it was to experience a sense of constancy and shared commitment to the group process.

Overwhelmingly, participants believed that the collaborative group work had a significantly positive effect on their goal of alleviating the impacts of vicarious traumatic stress and increased their resiliency and professional sustainability. They had two main recommendations with regard to future initiatives of this kind: First, to emphasize in initial meetings that the personal and professional are deeply interconnected and, in many ways, are inseparable when one engages in therapeutic group work. This, they felt, would allow people who are unaccustomed to self-disclosure to judge their readiness and commitment to this kind of process. Second, to make professional development opportunities of this kind more readily available to health care professionals. As I mentioned earlier, the majority of the participants were family doctors and several proposed that we consider offering groups for family physicians across the city.

For myself, being invited into their stories increased my knowledge and understanding of the health care culture and the complexities involved in working in this field. It was also an intensely emotional experience. I was inspired by their commitment to provide care for patients who are perhaps among the least advantaged and most desperate in our Canadian society. At times I was awe struck by their heartfelt desire to actively bear witness to the multiple traumas in their patient's lives and the humility and humanity with which they did this. At other times I feared for their well being as I recognized the systemic levels of trauma they were consistently exposed to and as I, in my turn, bore witness to their suffering and the suffering (through their stories) of their patients.

The period during which we worked together as a group was co- incidentally the period in which the disappearance of women from the down town eastside of Vancouver was becoming more prominent in the news. A number of these women were patients of the front line health care team we were working with. We struggled with the enormity of this tragedy and our sense of horror, disbelief, anger and helplessness. We sat together in a circle of profound grief, drew strength from the sacred space of human and spiritual connection that we had created among ourselves and, at the closing of one session, moved in a huddled group toward the elevators that would signal separating for the night and returning to our own lives outside of the group. At other times in the group, we shared laughter and learning and celebrated working in professions where we are privileged to witness healing moments and accompany people (including ourselves) on journeys of self-discovery and self-affirmation.

In addition to reflecting on what I was learning with them and on my practice as a group facilitator, I was naturally spiraled into reflecting more deeply on my own journey. To question how experiences of traumatic events in my own life, experiences of witnessing trauma in the lives of my clients, and choosing to work with professionals who experience vicarious traumatic stress impact me. To reflect on the extent to which I am personally practicing what I preach in terms of self-care and retaining personal and professional resiliency. The disappearance of so many women in the down town eastside, some of whom I came to k/now through our group work, impacted me deeply. Continual conversations and peer supervision with my co-leader, discussions with the supervisor of the initiative and my research supervisors, attending a memorial service with friends, and being encouraged to language my experiences in poetry in an inspiring class at the University (Appendix A) helped me to both sediment the learning I was engaged in and alleviate the potentials of experiencing not only secondary, but possibly tertiary traumatic stress reactions.

Second initiative.

In the second initiative, I worked as part of a team to enhance the abilities of family physicians to work with patients experiencing post-traumatic stress response (PTSR). The group program included both didactic and experiential elements. As part of the training, we introduced the concept of life review. Once there was a strong climate of safety and trust in the group, we invited the participants to share, in ways that felt comfortable for them, a significant branching point in their lives. We introduced this both as a way to enhance their own self-awareness and resiliency and as a means to further understand what it might be like for patients who were experiencing PTSR to share their stories.

The impact of listening to the doctors' stories was for myself, and others in the group, very moving. What follows are some of the words spoken by participants about the meanings of this collaborative re-storying for themselves:

Doctor W: "The group restored my faith in humanity. I feel better about seeing my patients"

Doctor X: "I was going to work. I had stopped connecting. I felt privileged to hear the stories. I've always felt, as a family doctor, the sense of being privileged to connect with people's lives, have patients share with me. I had lost the sense of being privileged – had gone to a place where I had closed off. I got reconnected."

Doctor Y: "The process allowed me to tell my own story and to know others. This is the first time with doctors that I've been able to get so low – so deep. Deep enough to know that I'm not alone. Always before I've felt that I was alone. I always thought I was the one who had the worst story. I reached a level where I shared my insecurities with others who were honest. I felt that you understood the deep anxiety I feel at times".

Doctor Z: " This allowed me to trust what I've always known about doctors – a feeling of deep respect and affection. Deep down, what I've felt doctors should be - we are. This will affect the way I worship at the church of medicine. Why can we not do this with each other? The religion of medicine is alienating. We need to have a forum. What is, or has been historically, the support system? My faith is being restored with regard to the system."

The Research Dilemma

Many authors have underscored the benefits that connection, peer relationships, supportive witnessing and small group member-to-member learning bring to healing trauma, preventing or ameliorating secondary traumatic stress reactions and enhancing well-being (Catherall, 1999; Flannery, 1990; Herman, 1997; McCann & Pearlman, 1990; Stamm, 1999; Yalom, 1985). My experiences as a co-leader in group-based life review and trauma repair work using group-based therapeutic enactment have shown me first hand the benefits of being able to share stories in the safety of a supportive group climate. What emerges frequently, in my experience, is a sense of healing and connection/re-connection that extends beyond any one individual in the group and often beyond the boundaries of the group into an increased sense of community. Herman (1997) speaks eloquently to this issue of connecting with a sense of human commonality:

> Traumatic events destroy the sustaining bonds between individual and
> community. Those who have survived learn that their sense of self, of worth, of
> humanity, depends upon a feeling of connection to others ... Trauma isolates;
> the group re-creates a sense of belonging. Trauma shames and stigmatizes; the
> group bears witness and affirms. Trauma degrades the victim; the group exalts
> her. Trauma dehumanizes the victim; the group restores her humanity.
> Repeatedly in the testimony of survivors there comes a moment when a sense of
> connection is restored by another person's unaffected display of generosity.
> Something in herself that the victim believes to be irretrievably destroyed – faith,

decency, courage – is reawakened by an example of common altruism. Mirrored in the actions of others, the survivor recognizes and reclaims a lost part of herself. At that moment, the survivor begins to rejoin the human commonality. (p. 214)

I resonated deeply with the words spoken by Dr. Z; "Why can we not do this with each other?" and re-cognized that the seeds of my research interests had sprouted into a passionate desire to puzzle through this question with family doctors. Why could they not do this with each other? The need to do this was palpable in the two groups that I had co-facilitated and I had a beginning sense of both the difficulties and significance of sharing stories among colleagues. Could other family doctors share stories with each other? If they did, which ones would they share? How would they tell their stories? Would sharing stories among doctors be restor(y)ative, as it seemed to be in the case of Dr. Z, or might it be discomforting and cause angst? How would doctors experience participation in a structured group program of self-reflection and collaborative re-storying about various themes in their personal and professional lives? How would they voice the meanings of such an experience? How would I be able to adequately co-construct with them the experience of our co-participation in a life review program? How could I adequately re-present the meanings of their/my/our experiences?

Anecdotal evidence and my experiences in the two groups led me to believe that group-based life review could be one way in which family doctors could engage in self-reflection, share stories, create spaces for collegial support and in doing so, potentially enhance their personal and professional sustainability. And yet, I remained cautious. I was very conscious that self-disclosure has not been traditionally fostered in medical culture and that as West (2001) says, "Medicine is a profession where it can be safer to pretend that all is well, even when palpably it is not" (p. 204).

McWhinney (1996) stresses the importance of self-knowledge if doctors are to be healers as well as competent technologists. However, he notes that "self-knowledge is neglected in medical education, perhaps because the path to this knowledge is so long and hard" (p. 436). He wonders whether it is preposterous to ever imagine that medicine could become a self-reflective discipline.

Was it preposterous for me to think that family doctors would join with me in this research project? Literature in the field of adult education emphasized the value of self-reflection and biographical learning (Brady, 1990; Birren & Cochran, 2001; Kenyon & Randall, 1997; Mezirow, 1991). Previous research studies on group-based life review indicated a number of potential benefits that participants may experience in the life review process. However, group-based life review had not previously been researched with groups of family doctors, or to the best of my knowledge with any homogenous groups of physicians.

I dwelled among self doubt, trepidation and passion for several months, wondering if my desires were off base, wandering into exploring other avenues of researching, alternately sitting

on and falling off a knife edge of anxiety. Each time I turned away from my questions, I felt a need to re-turn and listen to the whisperings of my heart. Thankfully, as the process unfolded, my research committee supported me as wise companions and challenged me to pay attention to my passions. I returned to reading the word of James Hollis (2001): "When something is *of* us, it is *for* us, it sets off a tuning fork inside us ... The resonance within us cannot be willed; it happens. No amount of willing will make it happen. But resonance is the surest guide to finding our own right path" (p. 61).

It was time to start the research journey that is storied in the pages of this text and risk asking the questions.

CHAPTER 2

Review of Relevant Literature

Introduction to the Literature Review

Group-based life review was originally conceived within the discipline of adult education. I therefore start by reviewing the place of self-reflection and biographical learning in the context of recent developments in the theory and practice of adult education. In doing so, I have chosen to focus on the theoretical propositions of Mezirow and Randall that I find helpful in informing my understanding of life review processes. I then highlight issues from counselling theory and practice relevant to creating climates that facilitate sharing stories. I also describe in detail the approach to group-based life review that formed the foundation for the personal and professional development program for family doctors that is the focus of this research study.

Following this I concentrate on three main content areas related to medical practice: (a) an exploration of the impacts that exposure to suffering and professional expectations can have on physicians in the context of literature on secondary traumatic stress, burnout and distress among physicians; (b) the literature on the context of family medicine and family physicians; and (c) I conclude by considering the degree to which three existing group-based models address opportunities for collegial support among family doctors.

Self-reflection and Biographical Learning in Adult Education

Sokol and Cranton (1998) note that Habermas's (1971) delineation of three kinds of knowledge (namely, instrumental, communicative and emancipatory knowledge) has become a common framework for understanding learning. Instrumental knowledge is concerned with causal laws, technical knowledge and hypothesis testing. Communicative knowledge includes our practical interests, understanding of others and the social norms of the world we live in. Emancipatory knowledge is the freedom and sense of empowerment that comes from critical self-reflection which engenders greater self-awareness and ability to integrate our experiences.

Much formal education has traditionally focused on instrumental knowledge and reflected what Friere (1970) described as a "banking model" of teaching (instructors deposit information into the supposedly empty vaults of student' minds) or Ortony (1979) referred to as a "conduit model" (pre-packaged knowledge is transmitted from experts via teachers to students who are subsequently tested in various ways to demonstrate that they have learned the preordained information). Mezirow (1994) noted that most adult education has been devoted to descriptions of how to facilitate instrumental learning and similarly, professional development programs, particularly in fields where there is rapid technological change, tend to focus on instrumental learning. Given this context, it is not so surprising to learn that self knowledge and self-reflexivity have been neglected in medical education (McWhinney, 1996).

The conviction that storytelling can be intrinsically empowering has been advanced by both feminism and popular education movements. This has had a significant influence on present-day adult education and has led to the development of a number of "story-ing" approaches that are currently used within adult education and other disciplines (Randall, 1995). Increasingly in the last two decades authors in the field of adult education have underscored the value of what Alheit (1992) terms "biographical learning" – the potential for an increased sense of authenticity, aliveness and agency that comes from reflection on our own lived experiences (Atkinson, 1995; Brady, 1990; Howard, 1989; Kenyon & Randall, 1997, Mezirow, 1978, 1991). There is now wide acknowledgement of narrative as a primary way in which human beings make sense of their experience and of the emancipatory potential of reflecting on and sharing the stories of our lives. As Brady (1990) says:

> Is this not our destiny as human beings to learn, to grow, to come to know ourselves and the meanings of our life in the deepest, richest, most textured way possible? If we do not know the self, what can we know? If we cannot learn from reflection upon our own lived experiences, from what can we learn? (p. 51)

Similarly, Newman (1994) notes that reflection has been given increasing importance in the field of adult education "and a lot of us in adult education have come to see one of our major roles as that of helping learners reflect on and learn from their experiences" (p. 236). Newman (1994) charts the changing meanings given to reflection over the years and the relationships between reflection and action in various models. I will briefly summarize his review:

- In the liberal education tradition reflection really meant the same as pondering. Learners would listen to a teacher, or read, and then find time to think things over hoping to reach deeper understandings or finer appreciations. Reflection happened in repose. Action, as a result of such reflection, may take place later.

- In the 1960's, a whole range of psychotherapeutic techniques that encouraged self-disclosure were incorporated into adult education. Reflection became a more emotionally charged and less orderly activity as a result.

- In the early 1970's Paulo Friere politicized reflection. Reflection and action are inseparable; both are contained in praxis. Learners act both on themselves and their worlds, changing their own consciousness and the ways they engage with other people and institutions.

- In the 1970's and 1980's Donald Schon was interested in practitioners who could think on their feet and adjust their practice accordingly. He named this process reflection-in-action. Action and reflection coincide but remain separate concepts. Reflection is a way of monitoring and adjusting action.

- In 1985, Boud, Keogh and Walker developed a model which suggested a chronological sequence of experience, reflection, then outcomes. Later on, Boud and Walker (1992)

revised the model to give greater emphasis to the roles of reflection both prior to and during learning experiences. However they view reflection as by definition detached from experiencing. We cannot, they conclude, be fully immersed in an experience and at the same time be reflecting on our actions.

- In the 1990's models of reflection tend to focus on linking reflection with reasoning. Reflection becomes more a set of mental activities to be performed or part of a definition of the competencies required to be successful in the workforce.

Newman views the move to seeing reflection as a competency based in reasoning as stripping away other important elements of reflection such as reverie, flights of fancy, insight and intuition. He views Mezirow's (1991, 1994) transformative learning model as significant in preventing a domestication of the potentially emancipatory activity of reflection:

> Mezirow's perspective transformation contains within it a form of reflection that is of another order altogether. Perspective transformation involves achieving a form of meta-reflection in which, if successful, we do not only see the world and ourselves more clearly, we *see ourselves seeing the world*. We perceive our perceptions. We are aware of awareness. (Newman, 1994, p. 239)

Mezirow: Transformative Learning

Mezirow (1991, 1994) framed his theory of transformative or emancipatory learning within Habermas's (1984) writings on communicative action and views transformative learning as central to adult education. At the core of transformative learning is a process of critical self-reflection, which allows us to see how our present is enveloped by our past and possibly shapes our future.

> In emancipatory learning we come to see our reality more inclusively, to understand it more closely, and to integrate our experiences better. Dramatic personal and social change becomes possible when we become aware of the way that both our psychological and our cultural assumptions have created or contributed to our dependence on outside forces that we have regarded as unchangeable (Mezirow, 1991, p. 88).

The underlying assumptions of Transformative Learning Theory (1991, 1994) are constructivist. The theory is based on the premise that we all have perspectives derived from our experiences, expectations, assumptions and values. We create meaning (and therefore learning) out of what has happened in our lives. According to Mezirow (1994) our meaning structures (or frames of reference) are two-dimensional. Meaning perspectives or habits of mind are "broad sets of predispositions resulting from psychocultural assumptions which determine the horizons of our expectations" (p. 223). Such habits of mind include intentions, emotions and cognitions and act as filters through which we interpret the meanings of experiences. Meaning perspectives include sociolinguistic codes (e.g. social norms, cultural principles or rules and language games),

psychological codes (e.g. personality traits, repressed parental prohibitions and emotional response patterns), epistemic codes (e.g. learning styles and sensory learning preferences) and moral codes (conscience and moral norms). Meaning schemes "are specific manifestations of our meaning perspectives" (Mezirow, 1994, p. 223) and are comprised of things such as beliefs, opinions, judgments and feelings which are related to a specific interpretation.

Transformative learners reflect upon and question their perspectives; they open up new ways of looking at and integrating their experience and act based on new perspectives. Mezirow (1991) contends that the most significant learning (transformation of meaning perspectives) can occur suddenly as the result of a major life event or may occur in increments as the result of changes in meaning schemes. Engaging in critical reflection and discourse will not always result in transformative learning and individual or social action. Mezirow (1994) identifies four processes of intentional adult learning: 1) refining or elaborating meaning schemes; 2) learning new meaning schemes; 3) transforming meaning schemes; and 4) transforming meaning perspectives. He outlines eleven phases that can contribute to perspective transformation:

1. A disorienting dilemma
2. Self-examination with feelings of fear, anger, guilt or shame
3. A critical assessment of assumptions
4. Recognition that one's discontent and the process of transformation are shared and others have negotiated a similar change
5. Exploration of options for new roles, relationships and actions
6. Planning a course of action
7. Acquiring knowledge and skills for implementing one's plans
8. Provisionally trying out new roles
9. Renegotiating relationships and negotiating new relationships
10. Building competence and self-confidence in new roles and relationships
11. A reintegration into one's life on the basis of conditions dictated by one's new perspective.

Mezirow (1997) notes that establishing a sense of solidarity among participants is essential to effective discourse and educators must pay attention to establishing democratic, safe and collaborative learning climates.

> The implementation of these ideal conditions within the context of adult education
> implies a conscious effort by the educator to establish and enforce norms in the
> learning situation which neutralize or significantly reduce the influence of power,
> the win-lose dialogue, and the hegemony of instrumental rationality found
> elsewhere in society ... The educator is seen as a collaborative learner, and tries
> to work his or herself out of the job of facilitator to become a collaborative
> learner, contributing her experience to arriving at a best consensual judgment.

Ideally (and this is characteristic of *adult* education), the relation of educator to learner is one of subject-to-subject, a peer relationship, rather than one of subject-to-object, not uncommon in the education of children. (p. 171)

Shaw (1999) draws attention to four issues that were raised at the first national conference on transformative learning that took place in 1998:

- A need to pay more attention to power structures and how these impact dialogue, communication and the process of emancipatory learning.
- A need to consider more fully to how different cultural contexts affect transformative learning processes.
- A need to recognize different ways of learning and knowing such as intuitive, emotional and spiritual knowing and possible gender differences in learning styles.
- A need to consider the issue of whether transformational learning emphasizes individual rather than societal transformation and how this relates to issues of social action.

Notwithstanding some of the criticisms that can be made of transformative learning theory (or indeed any attempt to create a comprehensive model of adult learning), Mezirow's model is a valuable lens through which to consider life review because it does contextualize the act of reflection (Newman, 1994). Mezirow (1996, 1998) points out that there is significant diversity in the ways various cultures delimit who has a voice, the forms that discourse and learning may take, how the validity of beliefs are claimed and maintained and the extent to which individuals and groups are allowed to act on critically reflective insights. He notes that in attempting to develop an evolving and comprehensive model of adult learning, his aim is not to engage in specific cultural critiques, but to provide a framework for studying learning in different cultures and understanding how different cultural contexts affect how adults learn within them.

Randall: Life-As-Story

Randall (1995) explores the metaphor of life-as-story and the expansion of this metaphor to include the possibility that we author ourselves into being, making sense of the events of our lives to the extent that we incorporate them into our unfolding novel. Randall (1995) contends that any examination of the life-as-story metaphor is coincidentally an examination of the mysteries of learning, "that entire active process whereby consciously or otherwise, we are forever trying to 'make meaning' out of our existence and 'make something' out of our lives" (p. 8). He notes that while much has been written about learning from psychological, sociological, economic and political perspectives, little has been written about the poetics of learning.

Randall draws attention to three issues related to adult education and adult learning that merit an inquiry into the poetics of self-creation and learning. First, in adult education and other fields there has been a significant increase in various approaches rooted in the story model. The conviction that storytelling is intrinsically empowering, which was put forward initially by feminist and popular education movements, has become well entrenched in many circles and has led to a

proliferation of storytelling. In this context, evaluation of what story and storying is can at minimum alleviate "the fuzzying effects of the enthusiasm with which talk of story is so often accompanied" (p. 5). Second, it is imperative to consider the construction of people's stories, stories which are not only about the past, but the present and future as well, given what we know through research about the impacts of past experiences, personal baggage and self concept on how, what and why adults learn. Additionally, the type of qualitative method often used in adult education research requires particular attention to critical reflection on the part of researchers. Third, there has been a shift away from predominantly psychodynamic models of personality toward a constructivist view which allows for an appreciation of peoples' active participation in the process of their own becoming and draws attention to the complex hermeneutical processes by which they are continually reconstructing their worlds and themselves.

If it is a question of not only *having* a story but *being* a story, then Randall wonders among other things what the implications are for seeing the self at once as the main *character* in one's story, the principal *reader* of that story and the story *teller*? Questions such as these are not merely intriguing, Randall suggests, but potentially of vital importance in understanding more about the art of living and what can be inferred about the art of telling – and living our stories. "The way we story our lives directly affects the way we understand ourselves; the way we understand ourselves directly affects the way we act; and the way we act directly affects the way the world is" (p. 9).

Randall (1995) provides a thought provoking and very wide ranging perspective on the art of living. I will not attempt to provide a summation of his work but rather point to two models (Figures 1 & 2) that I found useful in considering the complexity of the process of storying and re-storying our lives. He proposes viewing the concept of life-as-story in relation to one or another or combinations among four possible levels of self-awareness: existence, experience, expression, and impression.

"Existence – the outside story": In objective terms, the outside story encompasses all the minutiae of our existence in time and space. It is the level of what actually "happened" in the past, the sum total of everything we have done, said, thought or·felt in all the various dimensions of our lives; verbal, emotional, intellectual, interpersonal, conscious, unconscious, behavioural, physical, biochemical, and molecular. Where our whole story begins is a matter of debate because in some ways it is inseparable from the whole story of the cosmos: in temporal terms, our stories were underway in the bodies and minds of our parents before our birth; the physical boundaries between ourselves and everyone and everything else are difficult to delineate; we breath in and out, we eat and excrete as we regenerate the molecules of our bodies; in socio-psychological terms we are a part of all that we have met. The whole story is never available to us in its entirety because of its multi-dimensionality and vastness and because we are inside it; asleep,

unconscious, unaware for probably a third of it. We can only apprehend this outside story partially and imperfectly through theories, senses, memories, and imagination.

"Experience – the inside story": The inside story is what we make of our outside story. It is what we create in our hearts, minds and bodies about our experiences in the sense of everything we have somehow or another taken inside and constructed meaning from. The inside story is selective. Although it is based in the outside story, it is not a representation of it. It is our individual, unique interpretation and re-interpretation of what we know, think, feel, remember, believe and hope about ourselves. Multi-directional and many-leveled, it is not simply a storying of the past or present, but is also filled with projections about the future. As Randall (1995) says, "if the inside story is our experience, it is also our expectation; if it takes in our learning, it takes in our yearning as well. It is what we 'make up' about the past and future both" (p. 53).

"Expression – the inside-out story": The inside-out story is what we present or project to the world. It is what we communicate both in telling and showing ourselves to others be that through words, expressions, possessions, actions or involvements. Our inside-out stories are ambiguously and problematically related to the inside stories. What we tell or show of ourselves by one means of expression (our words for example) may be belied by another (our facial expression). How we perform our inside-out stories is shaped by the contexts, relationships and cultures within which we move and the variety of inside-out stories we perform are continually interacting and evolving. Even the act of attempting to express our inside story will change it as we move from felt experiencing to voicing or writing the inside-out story.

"Impression – the outside-in story": The outside-in story is what is made of us by others – what is "told" of us, or "read" into our lives by people who encounter us in any way. These outside-in stories are not static snapshots of who we are at some point in time. Inevitably they include hypotheses about where we have come from, who we have "been" in the past, and where we are going in the future. Sometimes people may seem to be able to "read" us better than we can ourselves. Often, the "readings" others make of us will feel very different from our own versions of ourselves, and seem to be simplified or skewed sketches of who we experience ourselves to be. "Rather than detailed narrative portraits, they are the un-filled-in outlines; "storyotypes", we might say; like stereotypes, only more historical, more tensed, and more inventive, for they entail reading into our lives not merely a hypothetical present but also a possible future and past" (p. 57). The storyotypes people create (whether positive or negative) will directly determine how they treat us, indirectly affect the opportunities provided to us, and will strongly impact the story we tell ourselves.

In diagramming this theoretical proposition (Figure 1), Randall emphasizes that there are no precise boundaries between the levels of existence, experience, expression and impression. They are inextricably entwined and the interplay among them is what constitutes the mystery of being and complexity of interpersonal relationships. "Somehow, woven together in one web,

swirling about me as one world, all of them *are* 'my life', all of them *are* 'my self', and all of them *are* 'my story' " (Randall, 1995, p. 61)

Figure 1

The Story of My Life
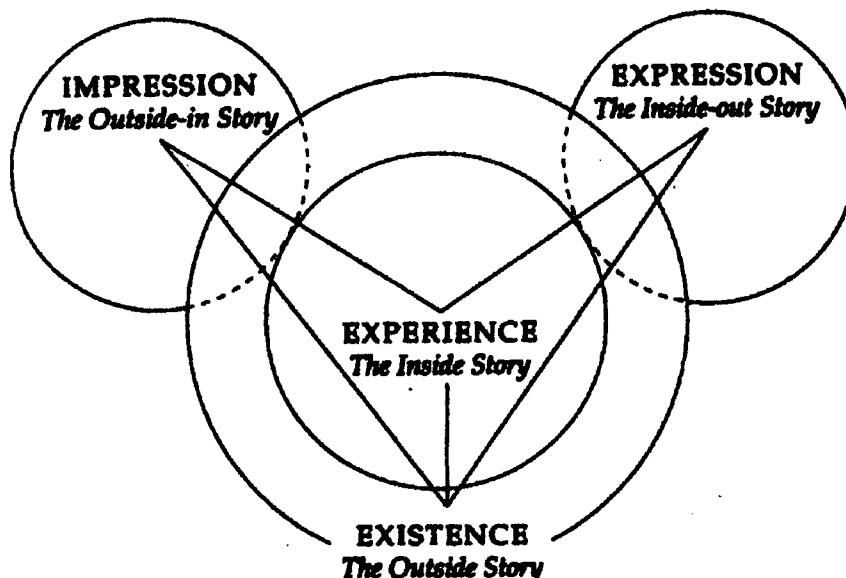
Adopting three of the main perspectives at work in the telling of literary stories (the narrator, the protagonist and the reader) Randall proposes a tentative schema for considering the complexities and subtleties involved in researching storying styles and the process of self-storying (Figure 2). In making distinctions between these three modes of being (basically talking, doing and thinking), Randall's goal is not to categorize people or suggest that in life these modes are either neatly contained or separate. He offers the schema as a beginning way of playing with possibilities and exploring questions.

Although visually limited to a circle in the diagram, Randall envisages a spiraling cycle of self-storying: one in which we move from a primarily protagonist mode, immersed in the doing of our life-story; to a primarily narrator mode, voicing the story of our lives to others and to ourselves; to a primarily reader mode, where we ask what kind of story it is and consider it in the light of the larger stories around us that have co-constructed our own. Re-entering the protagonist mode, we would then do so in a more self-aware way. We would, Randall suggests, have bridged the gap between "having" and "being" our story. Reading our story and questioning its composition in a critically reflective way allows us in effect to re-story it: "Thus, we have come out on the other side of it, ready not only to live it in a new and more author-itative manner, but also to take it and read it at a whole new level: one on which we might be open to re-storying our souls all over again" (Randall, 1995, p. 321).

Figure 2

Storying Life Cycle

PROTAGONIST
Doing/Being
Outside Story
Level of Existence

NARRATOR
Talking/Telling
Inside-out Story
Level of Expression

READER
Analysing/Thinking
Inside Story
Level of Experience
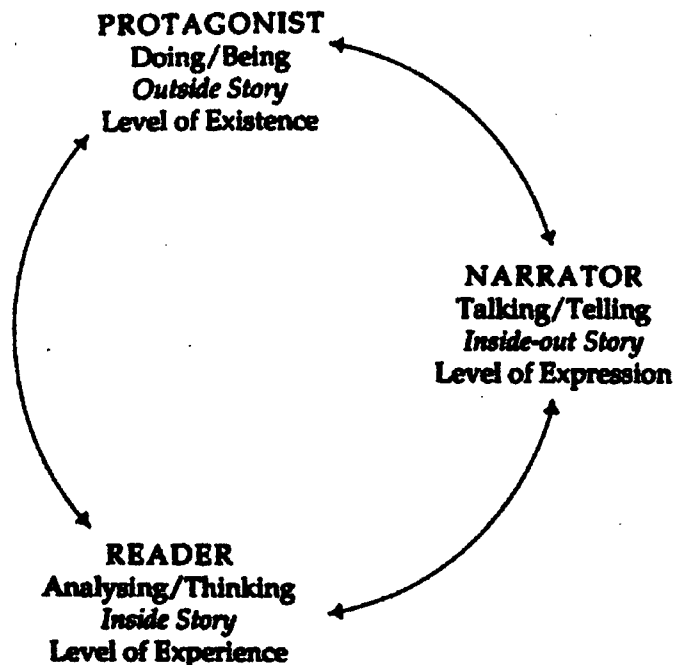
Of course, the cycle described above is idealized. Many factors can disrupt or interrupt our self-storying, prevent us from voicing our stories or disallow the space and means for critical reflection and re-storying. Retelling and re-constructing our lives on several levels at once is more easily said than done and the resistance to doing so may come not just from others but also from ourselves (Kenyon & Randall, 1997; Mahoney, 2003). As Mahoney (2003) points out:

> We are neither prisoners of our pasts nor free to choose any future. We are, however, vigilant protectors of what we hold "close to" our hearts – our view of reality, our sense of ourselves, our values, and our sense of control. When we are asked to change these, as we often are in our development, the challenge to change may feel overwhelming (p. 3).

Eakin (1999) describes a theoretical modeling of the self provided by Neisser (1988). Neisser's five selves include the ecological self; the interpersonal self; the extended self; the private self, and the conceptual self. Eakin expresses being drawn to this model because it avoids the traditional and restricting mind/body split; it presents the possibility of a plurality of selves, none of which are privileged; it acknowledges the formative role of conceptual models (social roles, personal traits, theories about body and mind, self and subject) in the development of individuals' self-concepts, and it extends the developmental history of selfhood to pre-linguistic and pre-symbolic registers rather than assuming, as many have, that selfhood begins with the acquisition of language. I am drawn to Randall's modeling for very similar reasons and

experienced it as a useful lens through which I could reflect on the process of group-based life review and the complexities of inviting, co-constructing and re-presenting the doctors' stories of their experiences in the life review program.

Randall (1995) proposes that the calling of educators, those interested in the drawing out (e-ducing) and nurturing (edu-care) of fellow human beings is to create spaces for the mutual birthing of stories:

> It is to provide each other a safe, hospitable space in which we can tell ourselves and read ourselves as much as we need. It is to help us re-story ourselves in such a way that the one story will more integrally embrace the many; that we will be able to tell, at least to ourselves, more of the stories we have hitherto left untold (especially those of the self-sabotaging kind); that we will be able to identify, to critique, and to discern among the many master-stories that vie for our allegiance in the world at large; and that we will be allowed a more self-conscious defense against the 'storyotyping' of both others and ourselves. (pp. 353-354)

Creating Safe Spaces for Sharing Stories

How can we meet the challenges of being present to stories and creating safe places to invite collaborative re-storying? I reflect on Moore's (1996) words:

> The people who come to me, like myself in my own life, are wobbling, and I know it will do no good for me to loose my grip and wobble with them... I can't presume to know how to help anyone. What I have learned as a therapist, something I didn't know before I began this work, is that each person is a mystery never to be fully understood. The so-called problems people bring to therapy aren't problems at all; they're mysteries, and the response to a mystery should be entirely different from that to a problem. A mystery is something not to be solved, but only to be honored, appreciated, contemplated, and revered. (pp. 181-182)

I have found that part of the answer to the challenge of creating at least relatively unwobbly spaces where we can begin to unfold the mysteries (and perhaps the missed-stories) of our own and other's lives resides in the words of Carl Rogers: "So if a theory is to be held at all it seems to me that it should be held tentatively, lightly, flexibly in a way which is freely open to change, and should be laid aside in the moment of encounter itself" (Rogers & Stevens, 1967, p. 187). What I have taken from these words into my own work as a counsellor is the challenge to enter into the ambiguous, unfolding, liminal spaces between theory and practice, self and other. It would be ethically unconscionable for me to invite others to share their stories and their struggles with me without having a solid grounding in theories that inform my professional practice and enhance my ability to co-create ethical and hospitable climates. Equally, in encountering others in therapeutic settings, I need to be reflexive and ensure that my theoretical perspectives are not limiting my openness to the uniqueness of their lives. Having knowledge about various theoretical

perspectives and integrating these within a constructive perspective (Mahoney, 2003) allows me to be both grounded and spontaneously responsive to the needs of clients and the nuances of the relationship we are creating together.

Like existential theories, a constructive approach emphasizes the importance of human relatedness and sees therapy as a collaborative and evolving journey between the client and the therapist (Mahoney, 2003; Yalom, 2002). The goal is to offer an authentic human relationship, remain open to how our own ways of being will be touched and possibly transformed in the process, and create contexts in which clients can risk exploring their lives in personally meaningful ways and experiment with possibilities for living more fully (Mahoney, 2003). I find the words of Yalom (2002) inspiring as principles to inform my own practice:

> At its very core, the flow of therapy should be spontaneous, forever following
> unanticipated riverbeds ... Therapists must convey to the patient that their
> paramount task is to build a relationship together that will itself become the agent
> of change. Above all, the therapist must be prepared to go wherever the patient
> goes, do all that is necessary to continue building trust and safety in the
> relationship. I try to tailor the therapy for each patient, to find the best way to
> work, and I consider the process of shaping the therapy not the groundwork or
> prelude but the essence of the work ... One needs technique in learning to play
> the piano but eventually, if one wants to make music, one must transcend
> learned technique and trust one's spontaneous moves. (pp. 34-35)

Building a climate of interpersonal safety and trust becomes an even more complex, dynamic and multidimensional process when we engage in group work. Kline (2003) points out that theories designed for individual counselling do not adequately address the complexities for group interaction and how such interactions can be used to benefit group members. Much has been written on the theory and practice of group counselling and therapy (Corey, 2000; Edelson & Berg, 1999; Ormont, 1992; Yalom, 1985, 1998). My intention is not to attempt to provide a comprehensive review of this literature or to explain differences among the variety of theoretical approaches. My goal is simply to highlight several issues that I see as an important framework for effective work with groups.

Yalom (1985, 1998) has brought some clarity to understanding how group work can be helpful to clients. In his work, Yalom conducted a comprehensive investigation of many different approaches to group psychotherapy. His goal was to look beyond the form, techniques, and specialized language of various schools of group therapy to distill a framework for considering the basic healing factors that group therapy can offer. Yalom (1985, 1998) describes eleven factors that contribute to therapeutic change, while stressing that these factors are interdependent and do not occur or function separately. The therapeutic factors he proposes are the following: instillation of hope; universality; imparting information; altruism; corrective recapitulation of the

primary family group; development of socializing techniques; imitative behaviour; catharsis; existential factors; group cohesiveness; and interpersonal learning.

I agree with Yalom (1985) that in therapeutic group work, it is to a large extent the group that is the agent of change. The group therapist's job is to be actively engaged in the creation and maintenance of a supportive group climate:

> Who provides support, universality, advice, interpersonal feedback, testing,
> learning, opportunities for altruism, and hope? Obviously, the other members of
> the group! Thus to a large extent, *it is the group that is the agent of change...*
> Thus, if it is the group members who, in their interaction, set into motion the
> many therapeutic factors, then it is the group therapist's task to create a group
> culture maximally conducive to effective group interaction. (pp. 115-116)

Yalom (1998) contends that "group cohesiveness and interpersonal learning are of greater power and complexity than any of the other factors examined thus far" (p. 24). Of group cohesiveness, he says:

> It is essential to note that group cohesiveness is more than a potent therapeutic
> force in its own right. Perhaps even more important, it is a necessary
> precondition for the other therapeutic factors to function optimally. When, in
> individual therapy, we say that it is the relationship that heals, we do not mean
> that love or loving acceptance is enough; we mean that an ideal therapist-patient
> relationship creates conditions in which the necessary risk taking, catharsis, and
> intrapersonal and interpersonal exploration may unfold. It is the same for group
> therapy: cohesiveness is necessary for other group therapeutic factors to appear.
> (p. 27)

Yalom (1998) speaks of how difficult it has been to pin down a precise definition of a variable such as group cohesiveness. It involves overlapping dimensions; on the one hand it is the group phenomenon (the degree of "groupness" or "we-ness" that the members feel), on the other hand are the individual member's various and fluctuating degrees of attraction to the group. Broadly speaking, cohesiveness may be defined as all the shifting forces acting and interacting on all the members to remain in the group. It reflects the "condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by other members" (Yalom, 1998, p. 26).

I have found a useful framework for addressing the complexities of group cohesiveness in the model proposed by Schutz (1958) and pragmatically translated in the work of Borgen, Pollard, Amundson, and Westwood (1989). Schutz posited that group members have three basic personal needs: the need for inclusion; the need for control; and the need for intimacy/trust. Each of these must be met as they arise, co-mingle and evolve during the life of the group. Borgen et al. define these three basic needs in the following way:

"Inclusion" relates to group member's needs to have a sense of belonging to the group. Assessing what is expected of themselves and others and figuring out how much they want to invest in the group, how much they 'fit in', how they will perform in the group and what that will be like for them.

"Control" refers to the needs that individual members experience in terms of influencing the group. How much can they control what happens in the group and to what degree can the group influence what happens to them in this context?

"Intimacy/Trust" relates to individual member's needs to feel close to and in a secure, safe relationship with the other participants. To what degree are they accepted as unique individuals and freer to express themselves authentically? To what extent do they experience others in the same way?

Borgen et al. (1989) stress that these needs are not independent of each other and are not dealt with by the group or individual members in some kind of systematic or prescribed way. However, the authors provide a useful framework for considering how the needs of the group members evolve and re-cycle through various stages of group growth: In the "initial stage" of the group, members will be most concerned about issues of inclusion as they (often warily) feel their way into the group. In the "transition stage", members will often struggle with issues of control and decision making as they try to secure their position in the group. Interpersonal conflicts and struggles with the group facilitator often arise in this process. Groups that successfully navigate these struggles develop an adequate sense of shared control and shared responsibility and a sense of cohesiveness and accomplishment arises. In the "working stage" of group growth, the concerns and needs of the members centre on issues of developing intimacy and trust among themselves. Developing interpersonal trust allows for greater appreciation of individual difference and more authentic communication among the participants. Members feel secure and psychologically safe enough to self disclose and provide feedback to others. The productivity of the group increases, as do opportunities for significant interpersonal learning and creative spontaneity. Finally the group moves into the "termination stage." Group members may experience grief reactions as they think about losing the connections they have built among themselves, the support and challenge that the group has provided them. At this stage group facilitators need to provide adequate time for these emotions to be expressed so that members have an adequate sense of closure and readiness to make the transition out of the group.

There are, of course, many different types of groups; educational, psycho-educational, support, and therapeutic to name only a few, innumerable reasons why people engage in group work (voluntarily and involuntarily) and equally varied goals or purposes. As I shall subsequently describe, a life review group is most closely described as a semi-structured learning group that has a psycho-educational emphasis. Attention is given to the intra and inter-personal psychological needs of the group members to create a facilitative group climate for both individual

and interpersonal learning. Many authors have written about the qualities and skills that are needed to be an effective group facilitator. It is beyond the scope of this brief overview to provide details about these here, but clearly, responding adequately to the needs of group members at any point in time, deterring forces that threaten cohesiveness and fostering interpersonal learning requires a range of competencies, flexibility, spontaneity and reflexivity on the part of the facilitator. Every member in a group is a unique, mysterious individual and equally, each group is unique. The journeys we take with them as a "fellow traveler" (to adopt Yalom's 2002 term) are mysterious, challenging, sometimes daunting, often inspiring and inevitably fascinating.

Group-Based Life Review

The process of group-based life review is designed to provide a personal and interpersonal opportunity for reflecting on, re-storying, re-presenting, re-integrating and potentially re-authoring the meaning of one's life stories.

In its original form, Butler (1963) initiated life review as a way to allow people nearing the end of life to revisit memories and deal with conflicts in need of resolution. The original model did not involve group work or the suggestion of themes by a facilitator or therapist but relied more on free-flowing memories. The approach to life review that I am proposing to research with family doctors is a semi-structured, group-based model known as Guided Autobiography (Birren, 1987; Birren & Birren, 1996; Birren & Cochran, 2001; Birren & Deutchman, 1991). Guided Autobiography expands individual approaches to reviewing experiences and emotions over a life course by placing it within a group context and using a series of evocative themes to promote reflection. For the sake of simplicity, and because the term life review is, I believe, more readily understood by potential participants, I shall continue to use the terminology of "life review" or "group-based life review" when referring to the Guided Autobiography model.

This life review approach has been widely used and researched (Birren & Deutchman, 1991; Kenyon & Randall, 1997; Silver, 1995) and appears to have natural therapeutic and integrative potential. Birren and Deutchman (1991) summarize the benefits from twenty-two life review studies. Some of the positive outcomes of life review included a sense of increased personal power and importance; recognition of past adaptive strategies and application to current needs and problems; reconciliation with the past and resolution of past resentments and negative feelings; resurgence of interest in past activities or hobbies; development of friendships with other group members; greater sense of meaning and purpose in life; increased role clarity, self-esteem and self-understanding; and ability to face the nearing end of life with a feeling that one has contributed to the world.

The model was originally researched with older adults in residential care facilities and in more recent years has been successfully used with older adults facing job loss (Rife, 1998), veterans from WWII and the Korean war (Molinari & Williams, 1995), Canadian WWII and

Peacekeeping veterans (Gervais, 2001; Westwood et al., 2002), terminally ill patients (Kuhl, 2002; Westwood & Kuhl, 2002), and beginning counsellors (McLean, 2001).

The distinguishing feature of the process is the semi-structured format. A set of core themes and guiding questions are used to foster self exploration (through personal reflection and writing) and sharing (telling one's story and listening to others' stories) in small groups of five to eight people. The following nine core themes were chosen as reflecting key life and existential issues (de Vries, Birren & Deutchman, 1995): History of the major branching points in my life; family history; career or major life work; the role of money in my life; health and body image; loves and hates; sexual identity, sex roles, and sexual experience; experiences with and ideas about death and dying, and other losses; influences, beliefs and values that provide meaning in my life.

The opportunity to view one's life story through the perspectives of the various themes has been described by Birren and Deutchman (1991) as akin to shining a light through a nine-sided prism. Just as the light is refracted differently depending on the side of the prism it is shone into, so each theme provides a different angle for re-viewing one's life stories. Themes can be used flexibly to fit with the make-up and time frame of the group program, and specific themes may be developed to reflect the interests of group members. In keeping with the non-invasive ethic of the process, members may always choose not to address a particular theme (Kenyon & Randall, 1997).

Structured group activities can enhance a sense of psychological safety for group members because each structured situation provides a focus and a container for the level of activity that participants choose to engage in (Borgen et al., 1989). The way a group member chooses to be during any particular activity is bounded by the structure of that situation and does not have open-ended implications or consequences for the process as a whole. In life review, while the various themes are inextricably interwoven in the complexity of individual life stories, each theme/session is also an entity within itself. Group members are free to adjust their level of disclosure according to their degree of comfort with the theme and their personal sense of safety and interpersonal trust.

The life review process always begins with an introductory session to clarify the facilitator's role, group expectations and goals, and the structure of the process. This first session is geared towards reducing the natural anxieties that will often arise in meeting other members for the first time and entering into the process. Knowing about life review is different than actually beginning to experience it, question how interpersonally comfortable and accepted one will be in the group, and wonder about the level of personal disclosure and emotionality that may be evoked. Establishing group agreements, guidelines for giving and receiving feedback, and providing structured activities that allow members to begin to get to know each other and engage in non-threatening self-disclosure provides the foundation for building a safe and cohesive group climate.

Following the introductory session, participants are invited to spend time personally reflecting on the theme that has been selected for the subsequent meeting. They are asked to write about how the theme relates to their life and encouraged to do this in their own individual way. To increase a sense of being able to write freely and spontaneously, members are reminded that they are not required to show what they have written to any one else, will be invited to share only what they choose to disclose, and should plan to share up to a maximum of two typewritten or four handwritten pages with the group. The reflecting and writing time that participants engage in outside of the group meetings is an integral part of the process and serves a two-fold function. It not only provides an opportunity to enhance introspection, integration and personal meaning-making, it also increases the personal control that individuals have over what they will subsequently share. As participants review what they have written, they have time to quietly reflect on their personal comfort about disclosing parts of the story that may include affectively charged material and decide which parts of their writing they want to share with the group, and what they prefer to keep private.

Birren and Birren (2001) recommend increasing the flexibility of life review for use with populations who are less comfortable with writing. I have personally found that there are great benefits in encouraging participants to use whatever modalities are most conducive to their own styles of personal reflection and story telling. Allowing people to use multiple ways of language-ing their experiences (for example drawings, objects, photographs) not only ensures that writing is not experienced as a barrier to participating but also allows participants to create a personally resonant exploration and voicing of their stories.

Participants share their stories verbally in the group in a nonjudgmental atmosphere. At the end of telling their story, each participant can choose to hear from others in the group how listening to the story impacted them personally and, as noted earlier, guidelines are established to enhance the effectiveness of both giving and receiving feedback. Hearing from others can offer the speaker new perspectives on his or her experiences and enhance the realization of both unique and common experiences. However, as de Vries et al. (1995) emphasize, life review is distinct from group therapy and does not actively seek to promote change in individual member's emotional, cognitive, or behavioural responses. The purpose of life review is to provide a learning climate within which people can increase self-awareness, integrate and make meaning of their life experiences to date, and begin to think about future hopes and intentions.

Sharing life stories in a safe, small group context gives individuals the chance to recall events, and feeling about those events, that may have been forgotten or perhaps suppressed because they were experienced as unacceptable at the time. Being able to compare and contrast one's own experiences with those of the other group members can help participants to feel accepted, acceptable and self accepting (Birren & Deutchman, 1991; de Vries et al., 1995; Brown-Shaw, Westwood & de Vries, 1999). Sometimes an individual may join a life review group

carrying what they feel is a shameful secret, only to find that disclosure of the secret is met with acceptance, little surprise and similar revelations on the part of others (Birren & Cochran, 2001; Birren & Deutchman, 1991).

The process of critical reflection and interactive sharing may lead to new insights, the resolution of past issues, affirmation of the journey that is unfolding, or bring to light issues that merit further exploration. Brown-Shaw et al. (1999) noted that life review sometimes results in a deepened awareness of issues that remain unresolved and challenging. In this way, it can serve as a self-diagnostic tool that allows people to consider whether, or how, they wish to address difficulties that may be preventing them from living life as fully as they wish. According to Kenyon and Randall (1997), group-based life review can provide a means for engaging in transformative learning:

> The point in this first stage is not to analyze our lifestory, simply to express it as
> fully as we can. But even this is transformative. Getting ourselves out of
> ourselves, turning our inside text inside-out (on paper or in the ears of another),
> inevitably changes us. "We are simply more than we were before" (Winquist,
> 1980, p. 60). Going thus intentionally from experience to expression, we expand,
> we evolve. Like the chambered nautilus, we step outside of the same old story.
> No longer thus so stuck in particular interpretations of who we are, we open to
> the possibility that one life (our life) can have more than one version. We become
> – to ourselves – a different person, for the entire exercise both empties and fills.
> On the one hand, it begins to purge us, even exorcise us, of the more troubling,
> less looked-at corners of our lives, of the stories we have habitually left untold...
> Finally, it can increase our personal power, not the potential power of the story
> left untold, but the actual power that every story, once aired, injects into the
> world. (p. 128)

The group leader's role is to ensure that each group member receives equal time to express themselves and that no judgmental remarks or interpretations interfere with an atmosphere of mutual respect. From my own experience in being a participant and leader in life review groups, I have found that the therapeutic benefits of the process are enhanced significantly when group leaders have a solid theoretical foundation and expertise in group facilitation and can ensure that issues of inclusion, control and intimacy are maintained at optimal levels (Dimock, 1976; Borgen et al., 1989).

Life review welcomes the presence of the whole person, including the pain and suffering people have experienced as well as their joys and triumphs (Birren & Cochran, 2001). Leaders need to be aware that sometimes life review may involve a group member describing a traumatic event from their own life story. Given the prevalence of trauma in our society, it is not unlikely that life review may lead to remembering either direct exposure to violence and victimization, or to

witnessing the traumatic suffering of others. Recovery from trauma cannot occur in isolation. It requires safety, re-membering, mourning the losses, and the possibility of reconnecting to life and community (Herman, 1997). Working with people who have been traumatized requires specialized training and, as noted previously, life review is not group therapy. However, if leaders are prepared to handle the disclosure of traumatic memories during the process, life review can provide fertile ground in which participants can both share and integrate distressing memories into their broader lives. Westwood and McLean (in press) recommend that facilitators have an understanding of trauma recovery processes, the ability to act in preventative, and, if necessary, remedial ways to reduce the risk of re-traumatization, and knowledge about sources of referral to other helping professionals if extreme reactions to traumatic memories arise.

A therapeutic life review process is one in which there is a natural and incremental deepening of the level of disclosure among participants reflective of, and embedded within, an increasing sense of cohesion, mutual trust and personal safety (Birren & Cochran, 2001; Birren & Deutchman, 1991; Westwood & McLean, in press). When effectively facilitated, life review can confirm not only a sense of one's uniqueness and worth as an individual, it can also promote intimate connection with other people, an awareness of commonalities, and sense of community (Birren & Cochran, 2001).

In summary, there are two features of life review that make it a preferred method for helping family doctors to share their stories: First, life review is framed within an educational approach. Although it can have a naturally therapeutic and integrative potential and has increasingly been used in counselling psychology, it was not designed to be a formal group therapy (Birren & Birren, 1996). This, I believe, may make it accessible and acceptable to a broader audience of participants some of whom who may shy away from therapy models for fear of stigmatization or because they view therapy as solely focused on repair or problem solution. Second, the structured format of life review allows participants who may be un-used to disclosing personal feelings or distressing experiences to move into the process in a gentle way, a way that endorses a sense of personal control around self-disclosure and is respectful of the medical culture (Sotile & Sotile, 2002).

The Constructs of Vicarious Traumatic Stress and Burnout

Vicarious traumatization was first coined by McCann and Pearlman (1990) to describe a phenomenon experienced by trauma therapists working with survivors of traumatic life events. The term "vicarious trauma" may be applicable to this study because it describes experiences of being overwhelmed by witnessing the trauma of others. Doctors are not immune to the effects of witnessing the trauma of others, their patients. Pearlman and Saakvitne(1995) describe vicarious trauma among therapists or other health care providers as:

> A transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material. . . . These effects are

cumulative and permanent, and evident in both a therapist's professional and personal life. (p. 151)

Figley (1999) defines vicarious traumatic stress (which is alternately referred to as secondary traumatic stress or compassion fatigue) as "the natural, consequent behaviours and emotions resulting from *knowledge about* a traumatizing event experience by a significant other. It is the stress resulting from *helping or wanting to help* a traumatized or suffering person" (p. 10). All health care personnel who engage empathically with people who are in severe distress are vulnerable to experiencing secondary traumatic stress reactions (Figley, 1999; Herman, 1997; McCann & Pearlman, 1990).

In describing conceptual frameworks for understanding vicarious traumatic stress, Arvay (1998) notes that according to Pearlman and Saakvitne (1995) exposure to trauma can damage us on six levels:

- Disruptions in our central beliefs about the world and spirituality: We may start to question our beliefs that the world is a benign place, that justice and trustworthiness exist, that our life is meaningful, that hope is possible.

- Disruption in self-capacities: Our ability to maintain a positive sense of ourselves, modulate strong affect and maintain a sense of connectedness with others can be disturbed. The results of this can include a sense of isolation, disconnection, hypersensitivity and increased self-criticism.

- Disruption in interpersonal relationships: We may start to withdraw socially, feel alienated, become indifferent to activities we previously enjoyed and lose our ability to maintain intimate relationships.

- Disruption in ego resources: Meeting our own psychological needs and negotiating appropriate boundaries in our personal and professional lives may become impaired.

- Disruption in memory: We may start to experience intrusive thoughts or images, re-experiencing the traumatic material we have witnessed as if it were our own.

Burnout is a different concept from vicarious traumatization. The construct of burnout was explicated by Maslach (1976) and the Maslach Burnout Inventory (Maslach & Jackson, 1981) is currently the most widely used instrument to measure burnout. Burnout is a prolonged response to chronic emotional and interpersonal stresses at work and is defined as comprising emotional exhaustion, feelings of depersonalization, and a low sense of personal accomplishment at work. In their research on vicarious traumatic stress among mental health professionals, Pearlman and Saakvitne, (1995) concluded that vicarious trauma (VT) is a distinct phenomenon from the construct of burnout. In the experience of VT, they found that individuals were almost always experiencing burnout. However, individuals experiencing burnout do not necessarily have symptoms of vicarious trauma (e.g., intrusive imagery, avoidance behaviours, feelings of numbing

out, hypervigilance, and disruptions to core beliefs). Sotile and Sotile (2002) have further described burnout as:

> . . . a state of physical, emotional, and mental exhaustion that results from
> intense involvement with people over long periods of time in situations that are
> emotionally demanding . . . burnout tends to be job related and situation specific,
> rather than pervasive. Burnout is not the same as being generally overstressed,
> and it differs from depression in that it is the final stage in the breakdown of
> coping reserves *specifically relative to work*" (pp. 4-5).

While the two concepts are different, there is commonality in the symptoms people may experience. In reviewing the vast literature on burnout, Sotile and Sotile (2002) summarize seven symptom clusters that identify burnout: distressed affective states such as depressed mood and emotional exhaustion; poor concentration; more frequent physical symptoms of stress such as headaches or sleep disturbances; diminished work performance; loss of motivation for work; interpersonal distress in various forms such as irritability, dehumanization or indifference; organizational distress, low morale, job dissatisfaction, absenteeism or job turnover.

Distress Among Physicians.

Becoming a physician invites direct exposure to human suffering. Hale and Hudson (1999) say that in all fields of medicine "doctors are required to transform the shocking into the mundane; and, in doing so to contain the unacknowledged anxieties their patients project on to them" (p. 221). Scaer (2001) points out that accumulation of traumatic life experiences leads to a state of increasing vulnerability and decreased resiliency to further trauma exposure. During their professional career many doctors are at risk of experiencing vicarious traumatic stress reactions and burnout because of the consistency with which they are exposed to suffering. Despite this, medical schools provide little training in traumatic stress (Bills, 1999).

Reluctance to seek help or disclose personal distress.

Reaching out to others is considered to be an important element in both preventing and recovering from vicarious traumatic stress. However, the experience of trauma can often lead to a sense of isolation and many professionals who view themselves as caregivers are resistant to seeking help for themselves (Gentry, Baranowsky & Dunning, 2002).

Maoz, Rabinowitz, Herz and Katz (1992) note that doctors find it especially difficult to seek help for themselves. Sinclair (1997) suggests some possible reasons for this:

> Several features of the medical habitus may be at work to account for such high
> rates of many sorts of mental illness . . . among members of the profession that
> itself treats illness . . . the underlying importance of not complaining or "whinging"
> . . . the distaste for the low-status segment of Psychiatry; unwillingness to
> examine, or unawareness of, internal mental events ... perhaps the most

important feature ... is the great difficulty doctors have in reversing their medical status and becoming a patient. (p. 319)

Unfortunately, the stress and suffering experienced by individual doctors may go undetected, even by themselves, until it reaches a critical point. As Montgomery Hunter (1991) notes, doctors who are constantly either dulled by routine or assailed by death (and the sense of failure that this can lead to) "easily become hardened to suffering, not the least their own" (p. 141).

Hale and Hudson (1999) list seven self-protective defense mechanisms that doctors typically employ in trying to cope with the anxieties of repeated exposure to traumatic material: denial of unwelcome feelings such as anxiety; becoming workaholic; intellectualizing or 'medicalising' personal problems to make them seem controllable; becoming hypochondriacal; escaping into eroticized experiences to confirm being alive and vibrant in the face of depression and physical decay; using black humour to transform what is terrifying, disgusting or sad into hilarity; and acting out which can include becoming medically overactive (e.g. over prescribing), taking addictive drugs or using alcohol excessively, engaging in risky behaviours (e.g., driving too fast) or committing suicide.

While some of these defenses may provide a semblance, or perception of coping, they are disturbing when considered in terms of research on trauma and trauma recovery. Fighting against, hiding from or denying painful feelings generally makes things worse: "The more feelings need to be avoided, the more energy is spent on keeping them at bay – energy that should have been used for feeling alive and open to new experiences" (Scaer, 2001, p. xiv).

Vicarious traumatic stress and burnout have been linked to high rates of suicide, depression, alcoholism and substance abuse among physicians (Holland, 1995; Preven, 1981; Reiser & Rosen, 1984; West, 2001). Hale and Hudson (1999) note that doctors have high rates of suicide compared to other professionals. When doctors are unable to continue working in ways that are personally and professionally satisfying, effective and sustainable, the impacts of this are felt in their professional, personal and family relationships (Hilfiker, 1985; Holland, 1995; McBride & Metcalfe, 1995; Rout, 1996; Rout & Rout, 2000; Sotile & Sotile, 2002; West, 2001).

Self-disclosure has not been traditionally fostered in the profession (Becker, Geer, Hughes & Strauss, 1961; Hilfiker, 1985; Holland, 1995; Maoz et al., 1992). Frank (1995) notes that the culture of medicine has "little space for personal becoming" (p. 158). West (2001), among others, draws attention to the implicit value in the medical culture of getting on with the physical business of doctoring and pushing the subjective and the psychological to the margins. A culture of silence surrounds mental health issues in a professional culture "in which the private and the public have been kept firmly and unhealthily separate" (West, 2001, p. 206). The costs of living with this mask of professionalism can be significant for some physicians. As Reiser and Rosen (1984) note:

Our profession is littered with casualties: doctors who are addicted, alcoholic, and divorced or else deeply depressed, disillusioned, and alone. For rare individuals, the apparent opportunity to deny all emotion may seem a welcome relief, but it is a dangerous denial and one most of us do not welcome anyhow. For the vast majority of us, being in touch with our feelings and coming to peace with them is essential to our well-being. There is good evidence that patients are much more vulnerable to disease if they are not in touch with their feelings. We believe that doctors too are at greater risk and for the same reason. We cannot continue to treat ourselves, much less our patients, like insensate machines. (p. 85)

Cassell (1997) notes that "the medical environment is not very kind to its workers" (p. 181). Physicians are uncomfortable acknowledging emotional distress in either colleagues or residents. Those in need of help receive little support from their peers and little encouragement to seek psychotherapeutic assistance in a climate where emotion is traditionally unwelcome and systematically suppressed. In describing a service for doctors in need of psychological services in the United Kingdom (U.K.), Hale and Hudson (1999) draw attention to the added fears of stigmatization experienced by doctors who are referred to counselling services (usually by their consultant or clinical tutor) as compared to those who self refer:

The position of the referred doctor is rarely simple. One doctor may become the focus and scapegoat for a troubled unit or hospital. In effect, doctors may come for therapy on their own firm's behalf. Often it takes a crisis, sometimes a crisis with legal implications, for the need – whether individual or collective – to be recognized. For the doctors on whom such pressures play, there is the reasonable fear of being labeled sick, mad, or inadequate – the weak link in a macho team. Small wonder that many doctors, junior or senior, can regard seeking psychological help as tantamount to professional suicide. (p. 228)

Furthermore, Hale and Hudson (1999) note intercultural issues complicate help seeking behaviours. Doctors practicing in the U.K. but who were trained abroad are generally wary of seeking psychological help and those that were referred to their services were "seized with thoughts of fear and rejection" (p. 228). Both Sinclair (1997) and West (2001) speak of the gendered and racial constraints that have been persistent in the medical world and muddled with questions about standards.

Emotional and interpersonal disconnection.

Given physician's proclivity to hide or deny the extent of internal emotional stress it is not surprising, in view of recent research on trauma, to see how readily relationships with others and with their own sense of being a compassionate and caring person can be undermined in the work of doctoring. Reduced ability to sustain compassionate relationships has been linked to iatrogenic

suffering for patients (Kuhl, 1999, 2002), a loss of meaning and validation of their place as healers for the physicians (Bills, 1999; McBride & Metcalfe, 1995), more dissatisfying, fractious and draining encounters with patients (Hilfiker, 1985; Holland, 1995; Maoz et al., 1992; Sotile & Sotile, 2002), and as a primary ingredient in patients pursuing malpractice suits (Cassell, 1997).

After more than 30 years of studying stress and trauma, Levine in his book *Waking The Tiger* (1997) describes the importance of learning to move fluidly between instinct, emotion and rational thought to resolve and heal traumatic experiences and maintain a sense of connectedness in the world:

> Without a clear connection to our instincts and feelings we cannot feel our sense
> of connection and sense of belonging to this earth, to a family, to anything else.
> Herein lie the roots of trauma. Disconnection from our felt sense of belonging
> leaves our emotions floundering in a vacuum of loneliness. It leaves our rational
> minds to create fantasies based on disconnection rather than connection. These
> fantasies compel us to compete, make war, distrust one another, and undermine
> our natural respect for life. If we do not sense our connection with all things, then
> it is easier to destroy or ignore these things. Human beings are naturally
> cooperative and loving. We enjoy working together. However without fully
> integrated brains, we cannot know this about ourselves. (p. 266)

It is now recognized that trauma is a psychophysical experience that affects the entire body-mind-spirit of a person's being (Rothschild, 2000). Traumatic memories tend to be stored in an emotional or somatic context that traumatized individuals may not be able to readily access or place in a verbal context (Scaer, 2001). Trauma is not "talked" into us and cannot be talked out of us (Dayton, 1994). Nevertheless, while talking alone may not heal trauma, verbal therapies and interactions have an important place in initiating the process of healing and helping traumatized individuals to begin the vital process of integrating traumatic memories into an embodied narrative (Rothschild, 2000; Scaer, 2001):

> Integrated trauma therapy must consider, consist of, and utilize tools for
> identifying, understanding, and treating trauma's effects on both mind and body.
> Language is necessary for both. The somatic disturbances of trauma require
> language to make sense of them, comprehend their meaning, extract their
> message, and resolve their impact. When healing trauma, it is crucial to give
> attention to both body and mind; you can't have one without the other.
> (Rothschild, 2000, p. xiv)

Researchers have stressed that people who work in the field of trauma must have a solid professional support network and an ability to pay attention to their own evolving needs if they want to continue to provide care and lead productive lives (Catherall, 1995, 1999; Cerney, 1995; Munroe, 1999; Pearlman, 1999; Zinn, 1988). Research has shown that being able to verbally

express one's distress can have significantly positive effects on the functioning of the immune system (McFarlane & van der Kolk, 1996) and that gaining information and education about traumatic stress symptoms alters the body's stress response and promotes healing (Scaer, 2001).

An inability to express emotional concerns limits opportunities for intimacy and invites disconnection thus leaving doctors much more vulnerable to being "toppled into depression, alcohol and drug abuse, or suicide" (Holland, 1995, p. 29). Concurrently, the unwillingness of doctors to openly speak about the stress they are experiencing (and see this as a sign of strength rather than weakness), prevents them from receiving broader societal understanding and a more comprehensive realization of the needs for increased systemic support and human resources (Holland, 1995). However for doctors, disclosing feelings of uncertainty, experiences of helplessness in the face of unfixable suffering or sharing the fear of making mistakes all carry with them the anxiety of being judged as incompetent or accused of malpractice (Hilfiker, 1985; Holland, 1995; Sinclair, 1997).

Mistakes and moral decisions.

Sotile and Sotile (2002) report the metaphor that Leape (1994) used to describe the fear experienced by doctors of making mistakes; like test pilots, errors are seen as a failure of character, the result of negligence or not trying hard enough. They report from literature that approximately one third of physicians in the U.S.A are, in the course of their lives, subjected to a medical malpractice suit and that the support of colleagues which is so much needed at times like this is often not forthcoming. Clarke (1996) notes similar trends in Canada; malpractice suits tripled in the fifteen years prior to 1996 and the amount of award quadrupled; twice as many suits against doctors were successful compared to fifteen years earlier; and in 1994, doctors were on average spending $200 million annually on insurance for claims of injury alone. As Holland (1995) comments, for many doctors "the threat of litigation hangs like gathering clouds" (p. 24).

Uncertainty is a fundamental aspect of medical practice. In diagnosing (identifying or labeling the disease), making a prognosis (forecasting how the illness may unfold over time) and deciding on a course of treatment, doctors must continually make decisions in situations that lack clarity. In reviewing literature on the issue of medical mistakes and how they are variously handled both interpersonally and through formal mechanisms, Clarke (1996) concludes that medical practice is inevitable error-ridden. Medical work "inherently encapsulates a degree of uncertainty. Yet it usually results in, even requires action" (p. 297). Hilfiker (1985) points out that although mistakes are inevitable they are not well received in the culture of medicine or society at large; doctors suffer their mistakes in silence and the emotional consequences are significant:

> The medical profession seems to have no place for its mistakes. Indeed one
> would almost think that mistakes were sins. And if the medical profession has no
> place for mistakes, neither does society. The number of malpractice suits filed

each year is symptomatic of this. In what other profession are practitioners regularly sued for hundreds of thousands of dollars because of misjudgments? . . . . The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our culpability, and the professional denial that mistakes happen all work to create an intolerable dilemma for the physician. We see the horror of our mistakes, yet we cannot deal with their enormous emotional impact. Perhaps the only way to face our guilt is through confession, restitution and absolution. Yet within the structure of modern medicine there is no place for such spiritual healing . . . Little wonder that we are defensive about our judgments, that we blame the patient or the previous physician when things go wrong, that we yell at nurses for their mistakes, that we have such high rates of alcoholism, drug addiction and suicide. At some point, we must all bring medical mistakes out of the closet. This will be difficult as long as both the profession and society continue to project their desires for perfection onto the doctor. (1985, pp. 85-86)

Doctors, Clarke (1996) notes, are continually called upon to make moral decisions. Even the choice of a label for a particular dis-ease can be a moral act, such as choosing to see drug addiction as an illness rather than a weakness of character. Citing previous work, Clarke identifies eight types of situations where doctors are frequently called upon to make moral decisions among conflicting demands:

- Deciding between the needs of one patient versus a group of patients. For example adequate care of one patient may require the relative neglect of others or the use of experimental drugs may result in death for an individual patient but benefit others in advancing knowledge.
- Making choices about the allocation of time, resources and skills among individual patients.
- Choices between the present and future interests of patients.
- Meeting the expected needs of the patient versus the patient's family.
- The conflict of being unable to help a patient when one expects oneself to be a healer.
- Conflicts between service to the patient and service to the state or other organizations.
- Dilemmas in balancing the advancement of one's career with the interests of patients. For example deciding to stay in a rural practice because the community needs a doctor versus moving to a more lucrative urban setting.
- Conflicts between the doctor's role as doctor and other roles such as wife, husband, father, mother, religious person and so on.

Impact of the current health care system.

Sotile and Sotile (2002) point to the pressures of being a physician in this day and age. Medical professionals have always led busy, pressured lives, however, traditionally they enjoyed high levels of control, autonomy and prestige and typically, most doctors were men who had the support of a stay-at-home spouse. Based on their research, they note that the typical medical family today has changed dramatically in both its form and function. Doctors are currently faced with demands to work faster, take on excessive workloads, keep pace with rapidly developing technologies in their field skills and constantly adjust to changes that are out of their control.

In Canada, the current health care climate is unsettled and demoralizing for many working in the area. High workloads, lack of resources and for many, a sense of not feeling adequately valued or recompensed is further complicated by a less deferential and more litigious culture. A large-scale survey of 3,520 physicians carried out by the Canadian Medical Association (CMA) indicated a serious decline in physician morale (Sullivan & Buske, 1998): "Canada's physicians appear to be a stressed-out, fed-up and cranky lot as the close of the century approaches... Never have so many physicians worked so much for so little income and so little gratitude" (p. 525). The CMA report indicated that 62% experienced heavy workloads, 55% claimed to have difficulty balancing professional and personal lives, and 43% had concerns about decreases in income.

In addition to facing comprehensive technological, political and economic changes along with significant forces of bureaucratization and corporatization, the prestige of medicine has diminished and doctors are currently experiencing unprecedented levels of criticism (Halvorsen, 1999). As one of the respondent's to the CMA survey wrote:

> The answers to these questions do not convey my very real sense of despair and
> exhaustion. I believe that most physicians unconsciously contracted with society
> to pursue their profession to the utmost of their ability and energy, to keep up
> their skills and to do whatever was needed to promote patient care. In return, we
> expected respect, the equipment to do the job and freedom from financial
> anxieties. All 3 of these expectations have been abrogated, yet we continue to
> fulfill our side of the contract in confusion, disbelief and a sense of betrayal.
> (Sullivan & Buske, 1998, p. 528).

Murphy (1999) noted that the ongoing restructuring of health care has been designed to address management needs (e.g. increased efficiencies and cost containment) and has largely ignored human and organizational elements. The key factor of the well-being of workers is "conspicuous in its absence" (p. 159). Restructuring, Murphy says, generally focuses on "hardware issues" (e.g. length of patient stay, speed of admission) and health care workers have little input into the redesign; they are expected to fit in as best they can. In advocating for a change in this model, Murphy points to results of the largest ever patient satisfaction survey

which involved over a million patients across 545 hospitals and 44 states in the U.S.A. The 10 factors that correlated most highly with patient satisfaction had nothing to do with hardware issues, they were all interpersonal factors such as the friendliness of nurses, sensitivity and attention paid to personal needs, cheerfulness of the staff and demonstrated concern for privacy.

The dramatic changes that have occurred in the health care system and the perception of medicine in the broader culture leaves many young doctors feeling dispirited as they see what lies ahead of them:

> It must surely be significant that today's young doctors seem to qualify and leave their medical schools dispirited by what they have come to know about the conditions in which medicine is now practiced. The reduced numbers who elect to continue in their hospital jobs and so become fully registered doctors are often, quite frankly depressed by their work, by the relentless hours, by their sense of working in isolation (or with colleagues who never seem to stop running), by an increasing number of patients who seem to view their relationship with their doctor as something that the doctor offers and in which that they themselves play only a passive part, by a growing view that administrators and politicians seem to stand over and against them, rather than alongside, and by increasing restrictions on their freedom to speak out about any concerns they may have for the service they are striving to provide. Without doubt, bureaucratic restrictions are growing year by year, with little to show in the way of improved doctor/patient relationships (the heart of medicine), but rather in dissatisfaction and increasing pressure. (Holland, 1995, pp. 150-151)

Sotile and Sotile (2002) describe physicians as feeling "double-crossed" because the spoken and implied psychological contracts they had on entering medicine (e.g. esteem, autonomy, appropriate financial recompense, appreciation for their efforts, supportive dealings with colleagues and harmonious relationships with patients) have been violated. Experiencing being double-crossed, they argue, leads to lowered morale, increased stress and loss of trust for the physician and spills over into their relationships with others and frequently results in a virulent, negative emotional chain reaction:

> For many physicians, the strained relationships and loss of support that result from mismanagement of their emotions proves to be the final ingredient in a recipe for stress, dissatisfaction, and burnout. High demand/low control is bad enough; high demand/low control/low support can be deadly. (Sotile & Sotile, 2002, p. xv)

Doctor's narratives. In this climate of uncertainty, Montgomery Hunter (1991) speaks to the "psychic refreshment" and "moral encouragement" that narratives about the experience of being a doctor can offer to others in the profession:

... being a physician is hard work. These narratives about doctoring, especially in a time of change, are valuable for representing the subjective experience of physicians meeting difficult patients, puzzling or frightening patients, patients who may sue ... such reports "from the trenches" tell us something never included in the medical case history: the physician's thoughts and feelings about the medical encounter. (p. 163)

However, as Montgomery Hunter also points out, the untold stories of medical care are often those of the doctors and Holland (1995) comments that it is "remarkable how little literature there is on this subject of internal stress in doctors" (p. 29). While some biographical, autobiographical and fiction writing does speak to the experiences of being a doctor (Berger & Mohr, 1967; Hilfiker, 1985), in general, the opportunities that exist for doctors to either voice or read about the experiences of being a doctor are quite restricted. In reviewing studies of the experience of being a doctor, Kleinman (1988) concluded that the majority of them are principally external accounts. The voice of the healer, the story of what it is like to be a healer is often missing:

Practitioners often feel that these externalist academic accounts for all their analytical power, leave something out that is of vital salience for them: namely, the internal, felt experience of doctoring, the story of what it is like to be a healer. Physicians have turned to fiction and essay to convey this inner world of the clinician. . . . We know more about the patient than the healer. We do not possess an adequate scientific language to capture the essence of the doctor's experience. What the doctor feels is most at stake - what is most relevant to practice - often slips through our crude analytical grids. (p. 210)

The tension between what stories doctors can tell, what stories we can hear, and what remains unnamed is great. Slaby and Glickman (1987) pick up the same theme that Berger and Mohr (1967) bring to our attention in their evocative story of the life of John Sassall, a country doctor in England. How much do we want our doctors to be our equals? How much can we hear of their struggles?

We all want physicians to be sensitive, warm human beings. We also want them to be professional; they must function in spite of the realities of our tragedies. We cannot expect them to be both to their fullest. Professionalism is to a degree, a mask. In professionalism's finest form, physicians who don the mask are forever aware that they are wearing it. They may hold it with tremulous hands, but they know its necessity. They must weigh data objectively, make rapid decisions, and confront problems in a manner inspiring confidence during our most dreaded crises ... and even our moments of death. (p. 165)

Rudolph and Stamm (1999) suggest that enhancing the personal satisfaction and professional effectiveness of front line health care providers is fundamental to the well being of our society as a whole. Given what we currently know about preventing and alleviating the impacts of exposure to suffering and the extent of distress being experienced by significant numbers of physicians, it is troubling to learn how few opportunities doctors appear to have for sharing either the burdens or the joys they experience in their work. Doctors' stories and narratives about doctoring appear to be circumscribed by societal expectations of physicians, medical culture, and the ways in which we currently "story" medicine.

While the above factors relate to all health care workers but especially physicians, family doctors face a unique set of circumstances because of the nature of their practice. The following details the particular stresses on family physicians.

Family Physicians[2]

Characteristics of family practice and the importance of self-knowledge.

In underlining the importance of the patient-caregiver relationship, authors have highlighted the need for interdisciplinary models that can augment required training in medical science and technology with a human science perspective that focuses on understanding individual experience and the co-creation of meaning. The importance of developing such a "transformed clinical method" (McWhinney, 1975) is particularly relevant in family practice medicine.

As Cassell (1997) says, family practice medicine is "based on the centrality of the patient rather than on an organ system or disease, as in the case with specialism. It is addressed to both the sick and the well" (p. 4). One of the main differences between family medicine and other medical branches is the duration of the doctor-patient relationship over extended periods of time. Polliack (1992) comments that family doctors are involved in both treating disease and caring for people who are ill or dis-eased.

> The dividing lines between curing and caring, between medical and social issues
> and between problems of health and problems of living are never very clear.
> More than any other type of doctor, family physicians work at the undefined
> interfaces. Nor can they deny this role, for the core of family medicine lies not
> only in the technical competence of the doctor but also in a comprehensive
> approach to the needs and expectations of others. (1992, p. xii)

Family practice focuses on the human components of medicine and the therapeutic benefits of the doctor-patient relationship. The self of the doctor is seen as fundamental in

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[2] I will continue to use the terms family doctor, family physician and family practice medicine as they reflect the most commonly used terminology in Canada at this time. Equivalent terms in the literature are general practitioner (GP), general practice, primary care physician, primary care practice.

general practice (Cassell, 1997; McWhinney, 1996). In family medicine "it is the being of the physician, not just the doing, that counts. Physicians are not merely bearers of knowledge and skills, vitally important as those are, but are themselves the instruments of care" (Cassell, 1997, p. 7).

The College of Family Physicians of Canada (2003) defines the role of the family physician based on the following four principles of family medicine (See Appendix B for full text):

1. The family physician must be a skilled clinician.
2. Family Medicine is a community-based discipline.
3. The family physician in a resource to defined practice population.
4. The doctor/patient relationship is central to the role of the family physician.

Harrison (2001) allows us to understand the fullness of what this means by reviewing the definitions provided by Willis (1995) and Heath (1995). According to Willis, generalists can best be defined in terms of what they do not do; anything that a patient brings to a family physician is of interest. Heath's definition is similar; "All aspects of human existence are legitimate concerns of the general practitioner provided that they are presented by the patient. This means that the general practitioner is obliged to deal with the complexity of each individual patient and should never be content to respond to a patient by saying 'That's not my business or my problem' " (Heath, as cited in Harrison, 2001, p. 67).

Holland (1995) sees family doctoring as fertile ground in which to understand the stress experienced by care-givers because of the exceptional circumstances created by their professional field:

> Frequently understandings develop as a result of studying extreme situations. It is as if the exceptional serves to force the main issues out into the open. Family practice is just such an extreme. A doctor's responsibility is unusual in that it extends across the twenty four hours of each day, as well as covering the physical, social, psychological and clinical areas of caring for adults. Once other professions had continuous responsibilities but now I can only think of one other role in life that is close to this total care, and that is parenting. However, parents care for their own children, and do not have the pressure of clinical responsibility. (p. 6-7)

Given that the ability to build therapeutic relationships is a core aspect of family medicine then McWhinney (1996) suggests that self-knowledge on the part of the healer is essential, even if the path to such knowledge is hard:

> How can we expect our patients to grow in self-knowledge if we lack self-knowledge ourselves? Yet how difficult the pursuit of this knowledge is; how much easier to live a life of comfortable self-deception. To confront with complete honesty our own inner selves is a painful thing. For physicians it is particularly

difficult; it is all too easy for us to see ourselves as members of an elite, successful in a highly competitive field, the objects of awe and admiration ... We cannot begin to know others until we know ourselves. We cannot grow and change as physicians until we have removed our defenses and faced up to our shortcomings. (p. 81)

Other writers (Hilfiker, 1985; Holland, 1995; Maoz et al., 1992; West, 2001) draw attention to the necessity for family doctors to gain self-knowledge in terms of their ability to sustain their own well-being. Family doctors are entwined in the physical, psychological and social lives of their patients. Alongside curing disease or preserving life stands the importance of witnessing and relieving suffering. The majority of elderly patients, those with chronic diseases, and most dying people are cared for by family physicians (Cassell, 1997; Holland, 1995; Latimer, 1995). As Weston (2001) points out, connecting with dying patients in a deeply personal way and providing continuity of care requires courage:

One example, which illustrates the distinctiveness of family medicine, is the care of dying patients. Deliberately involving oneself in the last stages of another person's life, investing time and energy to become attached to someone who will soon die, is a daring and courageous act. Physicians, deprived of their "bag of tricks", have no cure to offer. Their knowledge of drugs and available support services may ease their patients' suffering, but, more than anything else, it is their attentive concern and love that are helpful to the patient. (p. 1)

Having the ability to connect deeply and empathically with clients/patients is paradoxically one of the qualities that can render people in helping professions most vulnerable to experiencing vicarious traumatic stress (Carmel & Glick, 1996). So the very qualities that foster a healing relationship are a risk for those who are not provided with effective means of support. Maoz et al. (1992) capture this dilemma:

Doctors working with the same population over a long period become very involved with their patients, especially when dealing with emotional and social problems. Professional detachment, a dubious asset at the best of times, but an effective defense for doctors, becomes weakened in family medicine. This makes doctors more emotionally vulnerable to patients' problems but allows the opportunity to treat the patients by harnessing the emotional response. (p. 43)

Scope of practice.

As we have seen, painful feelings such as uncertainty, anxiety, helplessness, frustration and isolation are often part and parcel of working in a profession that calls on us to help others to heal their suffering. For family practitioners, the nature of their work can increase the difficulties experienced by other physicians (Hilfiker, 1985; Holland, 1995; West, 2001).

The broad scope of their practice adds significantly to the levels of uncertainty that family doctors can experience. Because family medicine specializes in treating the whole person in their social contexts, the range of issues that people bring to them is immense. Often these are not, strictly speaking, medical problems but the whole gamut of their social, psychological and interpersonal difficulties. Often, for a variety of reasons, family doctors feel obligated to assist with these problems even if they could be better handled elsewhere (Clarke, 1996; Hilfiker, 1985; Holland 1995). The depth of the doctor-patient relationship, the reluctance of patients to speak to strangers, financial constraints, lack of community resources and the doctor's desire, commitment and sense of professional obligation to help all weigh upon the family practitioner. Holland (1995) speaks to how easily family doctors can become overwhelmed by the scope of their practice and the ideals of their profession. He notes that "doctors frequently have a distrust or uncertainty about referral to professionals in other disciplines who are not qualified doctors" (p. 69). Given that a large percentage of a family doctor's patients are presenting with and/or experiencing psychological difficulties, the reluctance of physicians to refer to counselling and psychotherapy services and their confusion about the qualifications and functions of people working in these professions adds to their own levels of responsibility, workload and ultimately stress.

Added to this is the astonishing rate of advances in medical knowledge and technologies that doctors are expected to understand and integrate and which no one person can ever reasonably expect to do. Reiser and Rosen (1984) describe how most doctors handle this:

> What most doctors do to solve the dilemma is to draw a box around an area of relative "expertise" into which they then withdraw. They put a perimeter around the huge and momentous total picture. Where the doctor draws his box depends on many factors. Some draw it around molecules. Others draw it around an organ system. As one very sincere and successful academic physician expressed it, "I'm a liver man." A few brave souls try to draw larger boxes and speak of themselves as generalists or family practitioners. Clearly the fear – an eminently understandable one – is that the larger one draws the box, the greater the risk that one's knowledge base will be vitiated and ultimately prove faulty. (p. 34)

Family physicians draw very large boxes. They are at risk of buying in to idealized conceptions of their role, being all things to all people, being expected and expecting themselves to fix things across the whole spectrum of patient needs. Both self and patient-imposed expectations about availability can lead family doctors to "put patients not only first, but also second, third and fourth until they themselves, as well as their families, are relegated right off the bottom of the priority list" (Holland, 1995, p. 38). When doctors do this and neglect their own self-care and needs for self-preservation, the inevitable result, Holland (1995) suggests, will be exhaustion, a sense of failure and potentially a vicious cycle of increasing dependency on the part

of the doctor's patients. Hilfiker (1985) is eloquent in describing his own experience of struggling with limits in a profession where accessibility is one of its defining tenets:

> It is, of course, foolish to suppose that I could have responded to everyone's
> need. There seemed, however, to be no personally acceptable way of defining
> what the limits of my response should be. . . . The feeling grew and grew that I
> had to protect myself from other people's needs, that they would tear me apart if I
> didn't take care of myself first. While my soul called for a life of service, my
> emotions called out for the life of a hermit. (p. 42)

Working in a scope of practice that seemingly has no clear boundaries, Holland (1995) encourages doctors to reflect on and define reasonable and re-negotiable boundaries for themselves - to consider how being responsible and Holland's term "response-able" need to be combined: "If the patient is to be encouraged to be response-able for himself, then the responsible thing for the response-able doctor to do, is to encourage, enable and challenge the patient to develop the condition of being response-able for themselves" (p. 122).

Drawing boundaries is not a simple issue, particularly for doctors working in smaller communities. The joys and rewards of knowing patients intimately and understanding/living within the social contexts of their lives makes it hard for doctors to draw lines between being personal friends and medical friends (Berger & Mohr, 1967; Holland, 1995). Conversations with family doctors who have worked in small communities have sensitized me to what it is like to hear the sounds of ambulance sirens in a small community, wonder which of the people you know is in trouble, prepare yourself to meet them and their families in the emergency ward and find the fortitude to operate on people with whom you have sustained relationships. Others have spoken of the difficulties of even trying to go shopping at the local supermarket without patients wanting to connect and ask advice about their health concerns. The joys and the stresses of being a family doctor, along with the expectations (both on the part of patients and physicians) are intricately braided and it takes time, reflection, support and courage to unravel and re-weave them in a ways that are personally sustainable and satisfying.

Family doctors usually see diseases early in their evolution and often alone in making critical decisions. Doctors working in larger hospital environments can consult with and share responsibility with consultants and teams. They can admit patients for continuous observation. Family doctors are often much more isolated physically and in sharing professional responsibilities (Hilfiker, 1985; Maoz et al., 1992). They have to decide (sometimes over the telephone when they are on call and dealing not only with their own but also, in shared practices, with colleagues' patients that they do not know) what is the best course to take. In a more litigious culture and in the face of derision from colleagues if they over refer to emergency services, family doctors walk a very fine and lonely line.

Feelings of helplessness and frustration are also exacerbated by their commitment to dealing with patients over continuous periods of time. Family doctors sit in the extended suffering of chronic illness and death. They are obliged to deal with intractable problems and seemingly intractable patients week after week. A number of the physicians I have spoken with introduced me to what they referred to as the 80/20 rule of patient care, the common experience that "a relatively small number of people produce work out of all proportion to their number and medical conditions" (Holland, 1995, p. 50). Several authors point out how easily family doctors can feel trapped in what seem to be ineffectual, stagnant relationships with particular patients. Unused as they are to openly discussing feelings, unsure of how to proceed without seeming to blame the client or themselves and caught by their commitment to providing continuity of care, some doctors can reach the point where they dread or resent the expected next visit from a particular patient, yet do not feel they have the means or the right to discuss this with the patient and, if needed, refer them to another practitioner. Based on my own work with family doctors, I have seen some of them caught between their ideals of service and the reality of working with demeaning, offensive or outright abusive patients. Holland (1995) speaks of the importance of a doctor knowing "he does have the choice and freedom to accept or reject the patient who is now in front of him for care" (p. 53) and that in certain situations, termination of the relationship is sensible, freeing and ultimately interpersonally respectful.

The context and sustainability of family medicine.

Family doctors, like others in health care professions, are currently under pressure to take on ever increasing workloads. The rising costs of running a family practice, increased paperwork, the pressure to see yet more patients in a day and trying to help patients navigate and tolerate the increased complexities of the health care system, all compromise the very thing that is at the heart of family medicine, the doctor-patient relationship (Holland, 1995; West, 2001).

One of the main joys of being a family physician is the opportunity to build rewarding and sustained relationships with clients (Berger & Mohr, 1967; Cassell, 1997; Hilfiker, 1985; Holland, 1995; Maoz et al., 1992; van Zwanenberg, 2001). Media are quick to point out how patients suffer when doctors have to limit the amount of time they give to individual patients but we hear little about how being hurried and overburdened impacts doctors well-being (Sotile & Sotile, 2002). An excerpt from one of the Canadian doctors who responded to the CMA 1998 survey captures their current dilemmas:

> I have practiced in a remote area for 21 years and handle up to 180 births per
> year with no back up ... I see 50 patients or more each day (no choice) and have
> nothing to show for it except total and absolute exhaustion. I'm writing this at
> 2230 hours after [seeing] 48 patients, 3 ER calls, surgery until 2200 hours, and
> now charting until midnight. (Sullivan & Buske, 1998, p. 525)

Some writers draw attention to the fact that family medicine is seen to be less prestigious than other specialties and has struggled to carve out recognition as a separate discipline, either claiming specialist status or defining family medicine as opposite and complementary to specialist areas (Harrison, 2001). Family practice can be more onerous, or at least more unpredictable, in terms of time commitment and potentially both more and less challenging. In the seminal study by Becker et al. (1961), many of the students began to question their goal of becoming a family doctor as they approached graduation. They felt that the breadth of knowledge and skills that were needed to be a good family doctor was overwhelming and that the typically heavy workloads in family practice would prevent them from doing a good enough job for their patients. Many of the soon-to-be graduating students started to see specialization as a way of containing the breadth of knowledge required, enabling them to control workloads more easily and provide a better chance of providing good care.

Advances in medical technology have moved medicine away from its traditional grounding in an ethics of care and compassion towards an ethics of intervention in which "the caring aspects of the healing relationship have come to be neglected, and even denigrated" (Pellegrino, 1985, p. 8). Many patients today gather health information for themselves from sources such as the internet. They are both more aware and more assertive about their rights and more knowledgeable about the increasing array of specialized and alternative health services that are available today (Clarke, 1996; Harrison, 2001). Maoz et al. (1992) remark that some patients view family doctors as gatekeepers to specialist referrals and treat them as if they were traffic policemen. However, if family doctors are seen as having referred unnecessarily or sent too many patients to emergency services "they may face the justifiable derision of colleagues as the patient is sent home with a diagnosis of indigestion and a sarcastic letter. Status in the eyes of colleagues is important" (p. 43). Authors point out that medicine is a hierarchical culture and that although collegiality is vital, it is not generally taught or honoured in either training or practice. The culture is engrained with a basic competitiveness that makes cooperation among doctors difficult and often results in poor communication (Maoz et al., 1992; Greenberg, 1990).

Cassell (1997) sees that as part of cost cutting measures, there is increasing and detrimental pressure placed on family doctors to act as gatekeepers:

At a time when money speaks so loudly, primary care has come to be seen by many as a kind of medicine with financial, social, and organizational advantages, and with little regard to it as a kind of medicine in its own right. ... Some other defining characteristics that have been discussed are that primary care physicians are first-contact doctors, that they may act as gatekeepers – in aiding the more rationale use of resources – and that they are not specialists or are not functioning as specialists. (p. 4)

The whole issue of gatekeeping is a thorny one. Pellegrino and Thomasma (1988) define three ways in which family physicians can act as gatekeepers:

- "Traditional" gatekeeping is in line with the traditional responsibility of practicing rational medicine and what they call beneficence-in-trust. The physician uses only those tests and treatments that are beneficial and effective for the patient – this they say is the proper exercise of gatekeeping – morally imperative and economically sound.

- "Negative" gatekeeping usually occurs in some kind of pre-payment system in which the physician strives to limit the use of health care services. This kind of gatekeeping is morally dubious because the physician can be caught in role conflicts – on the one hand the responsibility to be an advocate for their patient and on the other serving as guardian of societal resources.

- "Positive" gatekeeping occurs when physicians encourage the use of health care facilities for personal or corporate profit – this they denote as morally reprehensible.

As I noted earlier, the current health care climate in Canada is demoralizing for many physicians. The efforts to contain health care costs place bureaucratic restraints on what family doctors are allowed to do for their patients and undermines their professional expertise and ethical commitment to providing the best care they can. Many are being forced into the unenviable position of being reluctant negative gatekeepers with resultant strains on their emotional well-being, their relationships with patients and their energy levels as they try to fight or circumvent situations that they experience as ethically unacceptable. As Donovan (2000) says:

> The guiding principle for the physician is no longer the patient's best interest and values but maximization of therapeutic benefit under budgetary constraints ...
> Attention to patient needs is further diverted by payment systems such as capitation, which – through incentives, withholds and payment limits – forces the physician to act as a double agent for the organization and all its enrollees as well as for his or her patient. (p. 20)

A recent article in the Vancouver Sun (Wednesday, March 5, 2003) drew attention to the significant decline in the number of medical students who are choosing to enter family medicine. In an era of rapid technological expansion and increased specialization we may be confronting both the end of family medicine as we know it, or at the very least, increasing difficulties in finding a family doctor. West (2001) reports similar problems in the UK. In addition to rising rates of stress, clinical depression, alcoholism and suicide among doctors there is "accumulating evidence of declining morale, increased turnover and intense problems of recruitment and retention, especially among GPs in the inner city" (p. 5).

Harrison (2001) summarizes the changes occurring in both patient's expectations and the reality of general practice in today's culture: the reality of today's practice is far from the ideals of the constantly available personal doctor who provides comprehensive care; people are more

interested in speed of access to services than they are in continuity of care or a personal relationship with "their" doctor and will access what they want in a variety of ways; and GP's today demand realistic workloads and the opportunity to have lives outside of medicine, neither of which their traditional job description provides for.

Moving into partnerships has for many doctors been seen as a way to alleviate the stress of being constantly available, be able to find greater balance in work and family life and share financial costs. While this can work well in many instances, doctors may experience partnership situations as less effective and efficient (with regard to sharing patients and having less intimate knowledge of their concerns) and as not truly solving the debilitating effects of being on call. Being on call involves disturbance to sleep patterns and results in tiredness and a reduction of recreational time. The disruption of sleep patterns that is endemic to medical practice does not end with on call duty time and can continue even years after doctors have stopped practicing. While sharing on call duties with partners may reduce the number of evenings or weekends that a doctor is on call, during those times when she or he is covering for the group practice the demands and responsibilities are increased because they are looking after their colleagues' patients as well as their own (Holland, 1995). Even if the on call time is relatively quiet, the emotional readiness and physical preparedness it requires can be draining in ways that are difficult for other people who have not experienced it to understand (Hilfiker, 1985).

Medical partnerships can also be a major source of interpersonal stress (Harrison, 2001; Holland, 1995; West, 2001). As we have seen, the culture of medicine has traditionally engendered competitiveness among doctors and fear that sharing personal feelings of inadequacy or stress would lead to them being a target of shaming or blaming. Conflicts over perceived workload inequities or about shared decision making is difficult in climates where people are unused to talking about their feelings and do not have a strong tradition of inter-collegial trust. Fear that the distress being experienced by one member of the team will become contagious can further prevent doctors from supporting one another adequately (Holland, 1995; West, 2001). What could be a major source of professional support and stress reduction becomes the reverse:

> It is as if the doctor's partners are all striving to prevent the distress of medical
> work from further insinuating itself into their lives ... In an attempt to hold back
> the flood, they react by ignoring it in their colleagues, as if denying it will
> somehow make the other's stress go away. It is a vain attempt to stop work's
> tentacles from spreading from doctor to doctor, or into the doctor's home, but
> unfortunately such behaviour only serves to distance them from the person who
> is stressed, making his situation worse ... Without feelings being considered and
> received by his colleagues, the doctor finds himself shutting off in his turn from
> the feelings of family and patients alike. Often he will then be horrified at himself,

believing – and concerned – that he is losing his humanity. (Holland, 1995, p. 149)

Harrison (2001) finds that the tension of trying to balance general, primary care with the need to maintain currency and expertise leaves family doctors today questioning whether to go for "breadth" (the more traditional view of offering open ended and accessible services) or to opt for "depth" (sub-specialization, limited availability and a more restricted place in a primary practice team). He exposes the disparities between the rhetoric of family practice (comprehensive, all inclusive, unendingly available service) with the realities of family practice in current social, economic and political climates and concludes by wondering what remains at the heart of general practice. Whether, in fact, in this context, the generalist can survive.

Other authors note the growing prominence and need for family medicine in solving current health care issues (Cassel. 1997; McWhinney, 1996; West, 2001)). As a society we are experiencing a growing diversity of social and health care needs (Clarke, 1996), a growing mismatch between high technology medicine and the health care needs of large groups of the population (Cassell, 1997) and increasingly complex ethical decisions about care (Pellegrino, 1985). Family practitioners need to fill the gap left by the impersonality of modern science and some believe that the concept of the physician as healer, as well as scientist, is poised to rise again like the phoenix (West, 2001). The complex structure of contemporary medical care adds to the difficulty of providing sustained ethical care.

> Unfortunately, the "trust relationship" required for so momentous a decision as, let us say, a no-code order is becoming ever more difficult in contemporary medical care. Team care, multiple consultations, rotations of house staff, institutionalization, stress at the moment of decision – all complicate the relationship. In public and teaching hospitals there is often no one with a sustained relationship with the patient who can serve as a personal physician in the delicate process of making moral choices. This is an intolerable impediment to ethical patient care in the complicated nexus of today's clinical decisions and the reconstruction that medical ethics will demand. (Pellegrino, 1985, pp. 26-27)

Without an ability to respond to care in a more holistic manner, both patients and health care providers can become stranded in a wasteland between cure and death (Gadow, 1998; Scudder, 1990). Family doctors are the "lynchpins of the health-care system" (West, 2001, p. 204). As Nuland (1994) says:

> Between the lines of this book lies an unspoken plea for the resurrection of the family doctor. Each one of us needs a guide who knows us as well as he knows the pathways by which we can approach death ...The clinical objectivity that should enter into our decisions must come from a doctor familiar with our values and the lives we have led and not just from the virtual stranger whose

superspecialized biomedical skills we have called upon. At such times, it is not the kindness of strangers we need but the understanding of a long time medical friend. In whatever way our health care system is reorganized, good judgment demands that this simple truth be appreciated. (pp. 266-267)

Strengthening collegiality and self-care.

Despite the needs for interdependency and collegiality medicine remains a hierarchical culture. In reflecting on Robert Frost's poem *The Silken Tent*, Reiser and Rosen (1984) provide both a plea and a warning:

Instead of quarreling with each other from the safety of our theoretical boxes, we must begin to appreciate that medicine as a human experience involves all of us at all levels of the systems hierarchy, embracing "everything on earth the compass round". Each of us, with our own legitimate expertise, must begin to realize that we are all strands linked by a silken tent, a tent woven from the fabric our own shared humanness. This is a very simple notion, yet one that is heeded too rarely. To medical students, we would say: As you dig your way through the mountains of facts, beware of those who burrow their own little holes in those mountains and then growl at approaching strangers. We are all miners. (p. 35)

Reiser and Rosen (1984) close their book with the contention that medicine "is a human experience, propelled forward by science but guided by love" (p. 170) and offer a 'desiderata' (which I will highlight) to young men and women entering medicine:

- Remember that being a doctor is a privilege
- Remember you are free
- Empathize with the plight of your fellow professionals
- Remember why you decided to become a doctor
- Remember medical school does not last forever
- Forgive yourself
- Accept ambiguity and personal limitations
- And, physician, heal thyself.

In 1984 Reiser and Rosen stated that we must "nurture the needs, hopes, and sensitivities of the promising young men and women who have elected to adopt this unique, stressful, beautiful, and perilous career. We must encourage introspection, healthy relationships, play, openness, and joyous, creative expression. We must spawn a generation of doctors who are not afraid to love" (p. 175). It is sobering to be reading almost twenty years later in the literature how much work remains to be done if we are to accomplish this goal.

Many doctors continue to be legitimately fearful about expressing their feelings or telling their stories despite the importance of this for their own well-being and enhancement of the doctor-patient relationship. For family practitioners this is further compounded by their relative

status in the medical hierarchy and the current predominance of the science as opposed to the art, or he/art, of medicine (Cassell, 1997; West, 2001). In looking at the in-depth experience of family doctors who work in inner-city contexts in England, West (2001) confronts the systemic difficulties that family doctors experience in giving voice to their experiences:

> The difficulty is that doctors have been taught to distrust their personal stories in the name of big science. Such science can be a normalizing truth that tends to disqualify, limit, deny or contain other personal stories (White & Epston, 1990). GP's are on the edge of the profession and its hierarchies of power and knowledge. Science has provided the discursive and bureaucratic base through which the medical profession has rationalized its privileged status in society but it has tended to marginalize other ways of knowing. What is suggested here is that doctors must find some means to weave more authentic and experientially inclusive stories, using subjective/autobiographical understandings and psychological insights, alongside the science. (p. 208)

How can we assist family doctors to weave the more experientially inclusive stories that West (2001) and many others see as critical to enhancing the well-being of family physicians? In a recent study group meeting that he facilitates for a number of students like myself who are interested in engaging in research with physicians, Dr. David Kuhl (personal communication, July 15, 2003) challenged me to look again at how we turn the desiderata offered by Reiser and Rosen (1984) into a reality. How do we work toward having a fifth principle added to the characteristics of family practice medicine? Currently, the principles that guide family practice inform doctors that they are responsible for and embedded within the context of treating the whole patient, providing comprehensive care, continuity of treatment and availability. There is, despite everything we know from research and practice, no principle that directs or commends, requires or commands, or simply allows for family doctors to take care of themselves.

For myself, the challenge of adding a principle of self-care to the defining characteristics of family practice seems to be caught in something of a chicken and egg dilemma. Several authors have commented that the importance of self-care for family physicians will never be fully recognized until doctors are willing to lift the shrouds of silence and speak openly among themselves and with others not only about external pressures, but also, the significant personal and emotional stresses they experience in their work. However, to what extent will doctors be able or willing to engage in such conversations and self-disclosure without a guiding principle or cultural endorsement of the validity of self-care, the legitimacy of emotions and the importance of both seeking and receiving support?

Before such necessary conversations can be brought into wider social discourse, it is likely that they will need to become more familiar and common place among family doctors. Numerous times in my readings authors refer to the importance of collegiality and some of them

speak personally to the benefits they have received in joining with peers in conversations and groups to reflect on the challenges of being a doctor. In considering how we may be able to expand on opportunities for mutual support among family physicians, I will briefly review some existing group-based models that are described in the literature.

Balint groups.

Balint groups have been recognized and endorsed for a number of years as one way for family physicians to create a collaborative learning space and gain peer support. However, the focus of such groups remains largely on the doctor-patient relationship. Although Balint groups in mainland Europe have become more open to addressing the interplay of personal and professional issues (West, 2001), the more personal needs and experiences of the doctors remain a somewhat secondary issue – ones to be addressed individually outside of the group – and the main objective continues to be the improvement of doctors' skills in terms of the doctor/patient relationship (Balint, 1957; Maoz et al., 1992; West, 2001).

Traditionally membership in Balint groups has been voluntary. In some countries (for example, the U.S.A. and Israel) Balint group seminars have been introduced as either compulsory or strongly recommended electives in family medicine residency programs. Maoz et al. (1992) note that this change "has sometimes caused much resistance among the residents and made it difficult to discuss cases for which doctors feel personally responsible and about people who would be their patients for a long time" (p. 128).

The designated focus of Balint groups (i.e. the doctor/patient relationship) does not address the legitimate concerns that doctors experience about disclosing feeling of uncertainty, inadequacy or mental distress among colleagues (West, 2001). As West concludes:

> ... even when GPs engage in Balint groups and consider, in depth, the emotional dynamics of the work, issues surrounding the interplay of personal and professional identities tend to be omitted from the conversation, even when crucial to the performance of the role. This is partly for fear of what others might think or say. (West, 2001, p. 144)

The Accelerated Recovery Program for Compassion Fatigue.

In the field of trauma research, treatment models that have been developed to address vicarious traumatic stress (Catherall, 1999; Gentry et al., 2002; Pearlman, 1999) are generally focused on working with those who are already experiencing vicarious traumatic stress reactions and do not combine both prevention and treatment.

For example, Gentry et al. (2002) recently developed the Accelerated Recovery Program for Compassion Fatigue (ARP) "a five (5) session model for the treatment of the deleterious effects of compassion fatigue (CF) in the lives of professionals who encounter trauma secondarily through their work" (p. 128). Originally developed as a standardized individual treatment model the program has been expanded into train-the-trainer and small and large group workshop

formats. The authors recognize the "unique challenges of a professional asking for help" (p. 129) and the importance of connection with others to help compassion fatigued professionals on what they call "the road back home":

> Developing a personal "therapeutic community" is also mandatory in the
> prevention of CF. Breaking isolation and constriction can often provide immediate
> lessening of the problems associated with CF. The professional will be
> challenged to identify and develop underutilized resources for support,
> nurturance, and enrichment. (p. 131)

While the ARP model shows promise (Gentry et al., 2002), it does not address how to draw professionals into a supportive community of colleagues before the onset of vicarious traumatic stress reactions. Nor are the bases for creating a supportive community of colleagues built into the program. As in many individual approaches, participants are encouraged and challenged to build and maintain support outside of the treatment program. Family doctors may experience significant difficulty in finding the time, opportunities and resources to single handedly build a supportive network in the current culture of medical care.

Effective Emotional Management.

After more than 25 years working as counsellors and consultants in the medical field, and researching stress, burnout and resiliency among physicians, Sotile and Sotile (2002) have developed a model for stress-hardiness that they call Effective Emotional Management (EEM). They describe this model as moving beyond traditional approaches by incorporating the two essential and interrelated components of stress management, personality-based coping patterns and relationship dynamics. Sotile and Sotile (2002) contend that if physicians learn EEM skills they can both avoid or eliminate the negative consequences of emotional mismanagement and gain greater collaboration with colleagues, increased cooperation from patients, and affection with loved ones. They also point out that EEM makes good business sense in terms of decreasing negative interpersonal interactions and positively affecting morale, teamwork and productivity in the medical workplace.

The EEM model is presented in detail in their recent book entitled *The Resilient Physician* (2002) in which they draw on a comprehensive review of relevant literature to describe stress and stress resilience among physicians. Throughout the book they include a number of inventories that can be used to assess individual coping styles and interpersonal dynamics and offer a broad range of advice and strategies to address various issues including: balancing work and family life; understanding and managing relationships in the medical workplace; anger management; negotiating conflict; the disruptive physician; listening and communication skills; coping with change; understanding and managing the stress of medical training; and, making your workplace a positive interpersonal culture.

Sotile and Sotile (2002) suggest that their book can either be used by individual physicians to enhance their personal well-being and stress resilience or applied in a group work formats by medical teams. Sotile and Sotile (2002) note that "collegiality and collaboration serve as the cornerstones of a stress-resilient medical organization" (p. 295). They present a developmental schema for considering the challenges that may impede the creation and maintenance of a collaborative work climate; offer strategies for addressing common problems; and outline a day long sample curriculum for staff and physicians who want to work toward building a positive workplace culture.

The EEM model offers a breadth of ideas and strategies that will undoubtedly prove valuable to those who learn and apply them. It appears to have good potential for assisting with team building and conflict resolution among people who are committed to creating positive climates in the shared workplace. However the model is not designed to create a climate of collegial support among physicians, either those who work together or in different locations. Sotile and Sotile (2002) recommend that physicians attempt to build this kind of collegiality outside of workshop or workplace settings:

> We have found it to be of particular value for medical colleagues to periodically interact with each other in settings other than work. Herein lies the team-building value of staging yearly practice retreats, office holiday celebrations, or casual social affairs that bring your families together. Seeing a colleague in new contexts expands your perceptions of that individual; you now see him or her not only as a physician-colleague but as a person – someone who has a spouse, children, interests, and abilities outside of medicine, even a sense of humor. Such experiences serve to build traditions that will deepen your collegial relationships and mature your organization. (p. 315)

In conclusion, while all three of these approaches are valuable in terms of the purposes for which they were designed, none of them intentionally address the need for building climates of support among family physicians or address how in joining together in cohesive groups doctors could provide the necessary therapeutic conditions for being the prime agents of change in terms of their well being and right to self-care.

Summary of the Literature Review

The literature provided evidence of the significant degree of distress that exists among physicians and the risks that doctors can run of experiencing burnout and vicarious traumatic stress if they do not have adequate emotional support. It pointed to features in the medical culture that inhibit doctors from disclosing personal distress or seeking help and to the fact that self-care has never been fully addressed within this professional context. The literature described the exceptional circumstances that family doctors face and indicated how the current complexities, structure and climate of the health care system further compromise professional satisfaction and

sustainability. It confirmed the need to expand resources to promote well-being and sustainability among physicians and revealed that there is currently a lack of group-based initiatives designed to provide family doctors with opportunities for collegial connection and building a climate of mutual support.

Literature pointed to the benefits of biographical learning and the possibility that exists for emancipatory learning when people are provided with opportunities for critical self-reflection and re-storying their experiences in a safe, democratic, and cohesive group environment. Prior research indicated that a group-based life review process has the potential to promote self-awareness, personal and interpersonal learning, and connection among group members. Given evidence in the literature, the significance of this study was to examine whether a group-based life review program could provide a meaningful way for family doctors to share their experiences, create mutual support, and address issues of self-care and sustainability.

CHAPTER 3

Locating the Research Methodology

Introduction

This inquiry is grounded in the working assumptions of constructivism, social constructionism, and narrative epistemologies. I begin this chapter by highlighting aspects of these epistemologies so that readers can more fully understand how I am situating the investigation. I then provide the rationale for adopting a collaborative narrative methodology to explore the research question being asked in this study. I conclude by considering the process of narrative research and draw attention to issues related to articulating narrative understanding and the importance of reflexivity in narrative research.

Epistemological Assumptions of Constructivism and Social Constructionism

What distinguishes constructivism from other epistemological orientations is the emphasis placed on the selective, generative and organizational nature of human perception, memory and understanding. As Spivey (1997) notes: "Constructivists view people as constructive agents and view the phenomenon of interest (meaning or knowledge) as built instead of passively 'received' by people whose ways of knowing, understanding, and valuing influence what is known, seen, understood, and valued" (p. 3). To know is to construct.

Constructivists contend that there is no such thing as a single "truth" or objectifiable "reality". Knowing and understanding are fluid, partial and context dependent – influenced by individual, relational, temporal and sociohistorical factors (Arvay, 2002a, 2003; Burr, 1995; Gergen, 1999). Because "reality" is seen as socially constructed and context dependent, multiple versions of reality exist at any point in time and in principle, the forms of our descriptions and understandings are boundless (Mahoney, 1991; Gergen, 1999).

Knowledge is not viewed as something that we either have (or do not have) or as something waiting to be discovered, but "as something that people *do* together" (Burr, 1995, p. 8). Shotter (1986) describes this as a practical knowing, ". . . a 'knowing from' (a knowing from within a situation that takes into account, and is accountable in, the situation in which it is known). Rather than having to do with finding, with discovering something already existing but hidden from us, it is a form of knowing to do with making, with bringing into existence something that is as yet only intimated or implied in what is currently in existence" (p. 213).). As Gergen (1999) explains "Truth" is replaced by situated, locally negotiated "truths". The adequacy or acceptability of any truth telling is dependent upon the willingness of others to support our view of things within a particular culture.

Social constructionism places a primary emphasis on discourse, the performative aspects of language practices and how such discourses function within social relationships. Language is viewed as creating, rather than mirroring reality (Arvay, 2002a; Burr, 1995; Denzin, 1997; Gergen,

1999). While recognizing the varied viewpoints and dialogues that exist within constructivist and social constructivist epistemologies, Gergen (1999) proposes four working assumptions that I experience as useful foundations for my proposed research:

1. For any situation, there exist a potentially unlimited number of descriptions and interpretations. Language (not only spoken or written words but all varied forms of representation) do not mirror, picture or capture an independent world. In principle therefore (although not in practice) no one description or interpretation can be ruled as superior or more truthful than another.

2. Language and all other forms of representation gain meaning from the ways they are used within relationships or contexts. Meanings are co-constructed in relationship and our quest for a sense of assuredness or grounded reality can only be achieved through relationship. Furthermore, the relationships and discourse practices operating among human beings are contextualized within the surroundings they inhabit, and are culturally, historically and socially relative.

3. As we engage in co-constructing our experience in language practices, we constitute social life and participate in creating our future because language is a critical element of action. The process of maintaining viable connections and traditions, transforming social life and building new futures depends upon our capacity and willingness to generate meaning together to engage in "generative discourses, that is, ways of talking and writing (and otherwise representing) that simultaneously challenge existing traditions of understanding, and offer new possibilities for action" (p. 49).

4. Reflection on our forms of understanding is vital to our future well-being. Because the generation of what we consider to be reasonable or valuable is always from within a certain tradition, we are typically blind to alternatives that lie outside of our adopted framework. The ability to engage in generative discourses requires reflexivity – an ability to place our own viewpoints into question, listen to alternative viewpoints and grapple with the complexities of multiple perspectives and framings of reality.

From a social constructionist view, then, there is no one "self" but a plurality of selves that we construct and negotiate with others given the discourses that are currently available to us. Our constructions and representations of ourselves are influenced (circumscribed to lesser and greater extents) by language systems, cultural and social arrangements and patterns. However, we are open to change as active agents engaged in what Shotter (1999) refers to as "joint action": a dynamic, reciprocal process of co-constructing ourselves and others.

Narrative Epistemology

Narratives are both a product and a process (Polkinghorne, 1988). They fill our personal, social and cultural environments in a multiplicity of forms and a central premise of narrative epistemology is the universality of narrative (Arvay, 2002b). Roland Barthes (as cited in

Polkinghorne, 1988) claims "the narrative is present at all times, in all places, in all societies; the history of narrative begins with the history of mankind; there does not exist, and never has existed, a people without narratives" (p. 14). A narrative epistemology assumes that we make ourselves, and others, known through the stories that we construct (Bruner, 1986; Cochran, 1985; Cochran & Laub, 1994; Denzin, 1997; Kenyon & Randall, 1997; Mishler, 1999; Polkinghorne, 1988; Sarbin, 1986). Narrative is the primary way in which people structure and make meaning of their experiences. As Arvay (2002b) states:

> How and what we tell in our stories becomes a means by which we make meaning. In our storytelling, we not only create a narrative, we are constructing ourselves or, as Theodore Sarbin (1986) claims, we are always involved in the activity of self-narration: the "I" construes the story in which the "me" will be shown as one of the main characters, or actors. (p. 208)

Through its narratives, a culture provides models of identity and agency to its members and it is through our own narratives that we construct a version, or rather versions, of ourselves in the world (Bruner, 1996). We do not simply absorb or follow various cultural plots in storying our lives. Depending upon the contexts in which we find ourselves, we actively construct and re-construct ourselves as we select, adapt, adopt or resist the discourses that are available to us at any particular time. Mishler (1999) notes that, "We express, display, make claims for who we are – and who we would like to be – in the stories we tell and how we tell them. In sum, we perform our identities" (p. 19). Such performances, however, are not simply private matters – our stories are subject to negotiation, social sanctioning and/or perceived cultural legitimacy (Bruner, 1991; Burr, 1995). However, story telling and story construction provide endless opportunities for re-authoring our lives and revising and reinterpreting the life accounts we have previously constructed (Bruner & Weisser, 1991; Richardson, 1997).

Narrative provides a way of interconnecting and signifying seemingly disconnected events or activities. It is a means for linking past to present and to potential futures. At the level of individual lives, narrative provides a lens through which we can negotiate the evolving meaning of our life and achieve a sense of wholeness (Polkinghorne, 1988; Richardson, 1990). Narratives allow for an illumination and reconciliation between the expected and exceptional and provide information about the subjective experience of the storyteller and the intentions, feelings, beliefs, and values that inform the action or events they are describing (Arvay, 2002b; Bruner, 1991; Clandinin & Connelly, 2000; Polkinghorne, 1988; Riessman, 1993; Sarbin, 1986). As Randall (1995) succinctly notes, "the way we story our lives directly affects the way we understand ourselves; the way we understand ourselves directly affects the way we act; and the way we act directly affects the way the world is" (p. 9).

Bruner (2001) suggests that autobiography (in Western culture) serves two main functions: On the one hand, telling our stories serves as an act of entrenchment in which we

present ourselves to others (and to ourselves) in a way that is culturally comprehensible. On the other hand, we don't just tell any old story. We tend to tell those that we consider worthy of telling, ones that are interesting and that in some sense mark the individuality and exceptionality of our lives. To meet the criterion of tellability, stories must violate canonical expectancy but do so in a way that is culturally comprehensible. This complex then "involves not only the construction of self, but also a construction of one's culture" (Ibid p. 35).

Arvay (2002b) provides a succinct description of the nexus between constructivism, social constructionism and narrative:

> All claim that the self has agency, lives within multiple "realities", is relational and contextually bound, is a process or a life unfolding, operates within self systems or cultural systems, and makes meaning by contrasting differences both dialogically and through human activity, often at a tacit level of awareness. The most important feature that all three share is the understanding that humans construct the meaning of their lives through language practices (p. 209).

Rationale for Using Narrative Inquiry

Narrative inquiry does not provide a detailed road map to a precise or pre-conceived destination or solution to a problem. Rather it opens doorways to multiple meanings, suggests ways to create and dwell in spaces of collaborative meaning making and encourages us to develop an expanded orientation toward our questions and "create new understandings and the possibilities for new realities" (Hoskins, 2002, p. 242).

In this study I was seeking to enter into a space of dialogically structured meaning making with the participants so that we could strive to create a rich understanding of their experiences in the life review program. Polkinghorne (1988) suggests that researchers are generally faced with four problems when they attempt to study meaning:

- Meaning making is not a static activity and it is therefore hard to grasp.
- Each of us has direct access to only one realm of meaning – our own. Studying meaning requires the use of linguistic data which is always contextually situated and linguistic statements lose much information when treated in isolation.
- Analyzing linguistic data relies on using hermeneutic reasoning which does not lend itself to the production of certain and necessary conclusions.
- The complex recursive and relational patterns among various levels of abstraction, awareness and control make meaning a difficult area to investigate.

Research into meaning making is not well suited to methods that use quantified data or have as a goal predicting or controlling behavior, "instead, it provides a kind of knowledge that individuals and groups can use to increase the power and control they have over their own actions" (Polkinghorne, 1988, p. 10). Shotter (1999) describes explaining and explanation as belonging to the realm of physical sciences where the goal is traditionally to get things right.

Human action that is mediated by meaning is generally regarded as the realm of interpretation rather than causal explanation. As Bruner (1996) states, "Explanation does not exhaust interpretation, nor does interpretation exhaust explanation ... But the two are fundamentally different, and play different roles in the search for knowledge" (p. 112). He goes on to stress that being interpretive does not imply being anti-empirical, anti-experimental or anti-quantitative. It simply means that we have to take into account the triad of perspective, discourse and context and try to make sense of what people tell us in the light of this triad before we begin explaining things.

Research methods must always be selected to best fit the research question. Lieblich, Tuval-Mashiach, and Zilber (1998) suggest that when researchers are addressing real-life problems "it may be advisable to approach people whose lives are relevant to the issue in an open manner, exploring their subjective, inner experience on the matter at hand" (p. 5). These authors point out that along with the interest that psychology has in being able to predict and control the behavior of humans and animals, the mission of psychology is to explore and understand the inner world of individuals. One of the most direct ways to learn about this inner world is through the personal narratives that people construct and tell about their lives and experienced reality.

A number of authors have pointed out that the majority of studies on the experience of being a doctor are external accounts (Holland, 1995; Kleinman, 1998; Montgomery Hunter, 1991). In this exploratory study, it was crucial to create an understanding from the doctors' own perspectives and use a methodology that would allow myself and other readers to learn from the voices of the six doctors in the life review program.

The purpose of group-based life review is not to explain ourselves (either ourselves or others) as some kind of finished product, but rather to provide an opportunity to create new ways of understanding what we know and choose to k/now about ourselves. It is a process that inherently recognizes that our life stories can be seen as open and unending. "They are, as Bakhtin (1981) put it, 'unfinalizable', for life always opens up more options ('real' and 'fictional' ones), includes more meanings, more identities, evokes more interpretations than even the number of all possible life stories could express" (Brockmeir & Carbaugh, 2001, p. 8).

A collaborative narrative methodology provided the most appropriate means for reflecting the dynamic, fluid and dialogical nature of constructing and re-constructing understanding that is inherent in the life review process itself, and in the process of re-searching, co-constructing and interpreting the meanings of the participant's experiences.

Narratives reflect not only our individual experiences in the world but also the social and cultural discourses within which we are embedded (Bruner, 1991, 1996; Burr, 1995; Mishler, 1999). The process of studying and interpreting personal narratives can illuminate the personal, interpersonal and socio-cultural conditions that delimit how individuals dialogically re-construct

and re-present the meanings of their experiences. In this way, stories created through a collaborative narrative research process can provide useful information about the ways in which current medical discourses may constrain or expand certain kinds of professional development opportunities and initiatives for family physicians.

It is through narratives that cultures provide models of identity and agency to their members. Potentially, if the research narratives are experienced as resonant, they may speak to other family doctors who read them and open spaces for self-reflection and giving voice to their own experiences. Narratives can serve as teaching tales with the power to transform practice (Arvay 1998, 2002b; Bruner, 1996; Hoskins, 2002). As Hoskins (2002) says: "Understanding how people construct their lives and are also constrained by certain discourses allows for a deepened understanding of the complexities of negotiating identities in a postmodern context" (p. 237).

Narrative as a Research Process

Based on their own research experiences, Lieblich et al. (1998) suggest that conflicts and contradictions are part and parcel of doing narrative research because life stories and their readings are as complex and multi-layered as human identity. However, the open-ended, unpredictable and emergent nature of narrative research does not imply an "anything goes" approach. These authors contend that interpretive decisions should not be "wild" - they require justification. Researchers "are responsible for providing a systematic and coherent rationale for their choice of methods as well as a clear exposition of the selected processes that have produced their results" (p. 2).

Denzin (1997) distinguishes between the analysis of narrative and narrative analysis as two approaches to narrative research. The analysis of narrative moves from stories to common elements. Stories are collected and subsequently analyzed through concepts from existing theories or inductively through the materials themselves. Narrative analysis moves from elements to stories. Events and experiences are collected and synthesized into a story or stories by means of a plot line. In the present study, I initially engaged in narrative analysis, co-constructing the participants' experiences in the life review program and re-presenting these in a story form. Following this I then moved into a process, a narrative analysis, exploring where there were common themes among the stories and also noting where there were distinct or singular elements.

In the face of a complex variety of approaches to narrative research Mishler (1995) says that researchers must make decisions about the main purpose of the study and the primary focus of the analysis. Is the researcher more interested in the facts of the story and the succession of happenings or in how the story is constructed and represented? In reflecting on these questions I found the typology described by Lieblich et al. (1998) to be particularly helpful. These authors propose four different perspectives or interpretive lenses through which to look at stories: From the "holistic-content" perspective, focus is placed on the entire story and its content taking

account of both explicit and implicit meaning; the "holistic-form" quadrant focuses on the formal aspects of the entire story (rather than the content) and considers aspects such as plot structure over time and the metaphors used; a "categorical-content" perspective focuses on analyzing the content of specific parts of the story irrespective of the content of the whole story – word or other story segments are counted and placed in categories that the researcher defines as relevant to the research question; the "categorical-form" quadrant focuses on the morphological and discourse levels of sections of the story by counting and categorizing characteristics of the language and style used. The authors clarify that the quadrants are not exclusive and that synthesis between form and content analysis can prove very fruitful. Of these four perspectives, I decided that taking a holistic view of both the content and form of the stories would serve as a useful and layered interpretive framework for understanding the research narratives and illuminating the process of meaning construction.

Recognizing the situational limitations and dialogically co-constructed nature of knowing, implies that there cannot be a separation of the investigator from the investigated (Arvay, 1998; 2002b; Greene, 1994; Schwandt, 1999; Smith, 1989). When researchers are following an experimental positivist research paradigm, they position themselves as neutral observers and generally write themselves out of the research text. In seeking to verify pre-established hypotheses, the legitimacy of the research is judged according to traditional criteria such as rigor, validity and reliability. As Lincoln and Guba (2000) explain, the researcher in this model retains control of the research process and is presumed to be an objective, "distant scientist". However, when we enter into constructivist narrative research, control of knowledge generation is shared between the participants and the inquirer. From this perspective, the researcher assumes the position of a "passionate participant" whose purpose is to facilitate the generation of multivoice reconstructions. Establishing the authenticity and trustworthiness of narrative research relies in part on "individual reconstructions coalescing around consensus" (Lincoln & Guba, 2000, p. 170).

In this study, I positioned myself as a participant-inquirer for the purpose of inviting and co-constructing stories about the doctors' varied experiences in the life review program. The narratives that are presented in this text are collaborative documents that were mutually constructed in research conversations. There are no set standardized rules or criteria for evaluating the worth of narrative research findings (Riessman (1993). Authors suggest a variety of alternative criteria to evaluate legitimacy (Clandinin & Connelly, 2000; Lincoln & Guba, 2000; Lieblich et al., 1998). Given this complexity it is my responsibility as the researcher to provide readers with a sufficiently detailed and transparent understanding of the methodology that I followed in this inquiry and select criteria that allows others to assess the quality of the study. In this inquiry, I chose four criteria to evaluate the worth of the study: resonance, consensual validity, persuasiveness, and pragmatic use. These will be described and discussed in Chapter 4.

In the remainder of this Chapter, I will now turn to discussing two key issues that I needed to address as I engaged in narrative inquiry.

Articulating Narrative Understanding

From a constructivist narrative perspective, understanding is a practical and unavoidable experience of being in and of the world (Schwandt, 1999, 2000; Shotter 2002). Understanding is both lived and living. It emerges dialogically "in the space between the living, bodily expressions of one individual and the spontaneous bodily responses to them by another" (Shotter, 2002, p. 296) in what Shotter refers to as a complexly intertwined "third space". Shotter (2002) contends that understanding the nature of such spaces can only be studied from within the practices in which they are created:

> Thus to investigate their nature, their structure, the calls they can exert on us,
> what is possible for us within them and what is not, we need some utterly new
> methods of investigation, quite different from the "onlooker" methods inherited
> from the natural sciences. Instead of dealing with regularities and repetitions, as
> in modernist inquiries, we must deal with quite specific "once-occurent events of
> Being" (Bakhtin, 1993, p. 2), occurring in the quite distinct and specific realities of
> understanding emerging between us in the many different relationships in which
> we become involved. (p. 299)

In this study, entering into Shotter's "third space" invited both myself (as a participant inquirer) and the participants to be open to space-moments of learning and re-cognize that meaning-making is emergent, dynamic, relational and context sensitive.

In rejecting the traditional mind/body split, postmodern narrative epistemology challenges the view that thought and language can be understood as independent and disconnected from bodily experience or that the history of selfhood begins only with the acquisition of language (Arvay, 2002b; Eakin, 1999; Mahoney, 1991; Polkinghorne, 1988; Shotter, 2002). We are invited to re-embody experience and meaning and to recognize that long before anything emerges in our conscious mental experiences "we can find in the very structure of our responsive bodily activities the precursors or prototypes for what we shall later talk of in mental or cognitive terms" (Shotter, 2002). As Mahoney (1991) puts it, "Feeling literally illuminates and energizes activity" (p. 176).

In exploring the contributions made by Merleau-Ponty to understanding language, Abram (1996) notes that "Communicative meaning is always, in its depths, affective; it remains rooted in the sensual dimension of experience, born of the body's native capacity to resonate with other bodies and with the landscape as a whole" (pp. 74-75). We learn the sounds and gestures of our native languages bodily. In dialogue we respond not only, or even primarily, to the spoken words of another, but to the multi-layered and embodied experience of the encounter: gestures, movement, rhythm and tone of the sounds of speech, felt sense of the shifting emotional climate

and responsiveness between us, and our experiences of the environment in which we are encountering another. Shotter (2002) provides a quotation from Merleau-Ponty to express this: "... in my experience of others ... I inevitably grasp my body as a *spontaneity which teaches me what I could not know in any other way except through it*" (p. 289).

In my training and work as a professional counsellor I have learned the importance of paying attention to not only the words that are expressed in trying to reach mutual understandings, but the importance of taking into account all the varied ways in which we are interpersonally experiencing and expressing an embodied encounter. Paying attention to the multiple ways in which meaning is interpersonally communicated allows for both an expanded ability to explore and interpret implied knowledge and also enhances a more authentic and collaborative way to dialogue about the relationship that we are interpersonally experiencing and negotiating. Neumann (1998) reminds narrative researchers in their encounter with those they are researching, "empathic knowing, whatever its limits, is as much about the present moment (of the telling) as it is of the past experience (of that which is told), however enwrapped in the past the present moment may be." (p. 437). Both during my participation in the life review program and subsequent research conversations, I sought to remain both experientially and reflexively attuned to my own embodied experiences, my interpretations of what was expressed bodily by others (in gestures, voice tone, silences and emotional expressiveness), and my sense of the situated and evolving emotional climate.

A narrative approach to inquiry advocates pluralism, subjectivity and relativism. There is no single true perspective on a topic, no correct interpretation or right way to read a text. Meaning is fluid, partial and situated and as Riessman (1993) says, "we are interpreting and creating texts at every juncture ... our narratives about others' narratives are our worldly creations. There is no 'view from no where' (Nagel, 1986), and what might have seemed nowhere in the past is likely to be somewhere in the present or future ... All we have is talk and texts that represent reality partially, selectively, and imperfectly" (p. 15).

From a narrative perspective, understanding is interpretation because we are continually taking something as something and "to understand is always to understand differently" (Schwandt, 2000, p. 195). Citing Gadamer, Schwandt (2000) describes understanding as a risk and an adventure which can be dangerous but "is also capable of contributing in a special way to the broadening of our human experiences, our self-knowledge, and our horizon, for everything understanding mediates is mediated along with ourselves" (p. 196). From this perspective, researchers are required to question who they should be toward and with the participants in a study. It necessitates engaging reflexively with one's own biases and "acknowledging the ongoing liminal experience of living between familiarity and strangeness" (Schwandt, 2000, p. 207). To seek understanding requires a willingness to risk confusion about ourselves and the other person

we are seeking to understand. It demands that we engage in genuine conversations that challenge our own self-understanding and stance in the world.

Clearly, any research grounded in these assumptions has to acknowledge that there can be no one, or final, interpretation of experiences. Any interpretation is a re-interpretation. Any text that is produced is entangled in other texts. It is a construction from certain perspectives and situates both authors and readers within particular discourses or ideologies (Denzin, 1997). The core of postmodernism is doubt (Richardson, 2000). It suspects all claims to truth or authoritative knowledge as serving particular interests. Taken to its extreme, radical relativism implies that "even the doubt must be doubted. There is no center that can hold" (Gergen, 1999, p. 30). And yet, as Richardson (2000) says, "a postmodern position does allow us to know 'something' without claiming to know everything. Having a partial, local, historical knowledge is still knowing. In some ways, 'knowing' is easier, however, because postmodernism recognizes the situational limitations of the knower" (p. 928). The goal then of constructivist and narrative research is not to uncover the truth of a phenomenon but rather to articulate an understanding, a reading of events and experiences that may be useful.

The understandings that were collaboratively created during this study and that I, as the researcher, have translated into this current document are inevitably like snapshots in an album of photographs. They provide images of an experience taken from a particular angle and revealing a certain expression and play of light and shadow. However, by their very nature of being still photographs, they can only illusively encapsulate what was, and is, the fluidity and evolving process of living. Bal (1997) provides a useful description of the tension that exists in constructing narrative texts: " ... a text is a finite, structured whole composed of language signs. The finite ensemble of signs does not mean that the text itself is finite, for its meanings, effects, functions, and background are not. It only means that there is a first and a last word to be identified; a first and a last image of a film; a frame of a painting, even if these boundaries, as we will see, are not watertight" (p. 5).

Reflexivity in Narrative Research

Research conversations are complex, dynamic, contextual interactions. Arvay (2003) emphasizes that narrative researchers face multiple questions about interpretation, re-presentation and voice in constructing a research text and notes that these concerns "are fundamentally about reflexivity. Reflexivity from a narrative perspective problematizes the researcher's process and examines how power relations are attended to both within the research relationship and in the construction of the research narratives" (p. 257).

Reflexivity can be understood as a turning back of one's experience upon oneself while recognizing that "the self to which this bending back refers, and the experience upon which the process is predicated, must also be understood as socially constructed" (Steier, 1991, p. 3). He goes on to explain that if we allow for multiple perspectives and acknowledge that the self to

which we are referring may be different as a result of it's own self-pointing, then the reflexive looping back may unfold as a spiral.

Steier (1991) offers the suggestion of seeing research as translation. This forces a de-privileging of the researcher's viewpoint and requires that we recognize that conversations are historical, interactive and contextually situated with no one voice representing the way it really was:

> Paradoxically, seeing research as **translation** allows that, as we reflexively understand our research to be about ourselves, we open up greater (rather than fewer), degrees of freedom for the voices of the others. It allows us to begin to question where our own categories do not fit, and where we have created 'false notes' out of good music" (p. 177).

Clandinin and Connelly (2000) propose that if researchers are to truly inquire and interpret narratively they cannot pre-determine the course of the analysis because narrative analysis is relational and the boundaries are interactively permeable. As these authors point out:

> Narrative inquiry always has a purpose, though the purpose may shift, and always has focus, though focus may blur and move. Narrative inquiry boundaries expand and contract, and wherever they are at any point in time, they are permeable, not osmotically permeable with things tending to move only in one way but interactively permeable. Researchers' personal, private, and professional lives flow across the boundaries into the research site; likewise, though often not with the same intensity, participants' lives flow the other way. (Ibid. p. 115)

Clandinin and Connelly (2000) contend that the researcher's experience is always a dual one – being part of the experience itself yet also remaining the inquirer experiencing the experience. Tensions around relational intimacy and reflective distance are always alive in narrative research from the initial creation of field texts through to the construction of research texts. The authors suggest that researchers situate themselves within a three-dimensional research inquiry space that includes temporal continuity (past, present, future), personal and social interaction, and situated context. Within this space the inquiry and the inquirer can move in any of four directions: inward, toward internal conditions such as feelings, hopes, values; outward, to existential conditions in the environment; backward, to past experiences; and forward to present and future conditions. They see research into human experience as experiencing it simultaneously in these four ways and to ask questions pointing in the four directions.

Working within the three-dimensional space, we work not only with our participants but also with ourselves as researchers. Both Behar (1996) and Clandinin and Connelly (2000) challenge researchers to recognize that they are vulnerable, embodied, complicit observers who cannot hide behind the presentation of an idealized, inquiring self. Narrative researchers need to

be willing to enter the anxiety, ambiguity and ambivalence of the research process without a pre-determined map so that mutual, relational, respectful learning can evolve and hopefully lead toward the creation of texts "that, when well done, offer readers a place to imagine their own uses and applications (Clandinin & Connelly, 2000, p. 42).

From the inception of this inquiry and throughout the process, I kept a research journal in which I recorded extensive field notes and personal reflections. I found this invaluable in helping me to work within the three-dimensional space that Clandinin and Connelly (2000) recommend. It encouraged me to stay reflexively aware of how my own experiences and ways of making meaning were shaping my perceptions. It also allowed me to explore how interpersonal issues of intimacy, distance, authority and authorization were entwined and negotiated as we participated in the life review program and collaboratively constructed the meanings of their experiences in the research narratives.

As I struggled with how I could authentically address these issues, I decided to adopt Arvay's reflexive collaborative narrative method as the foundation for my approach to this exploratory inquiry. Arvay (1998, 2002b, 2003) developed the method as a way to put the heart back into constructivist research and move more consciously toward interactional and dialogical forms of research practice and representation. In the following chapter, I outline the epistemological foundations of the method and describe in detail the procedures that were followed in this study.

CHAPTER 4

A Reflexive Collaborative Narrative Method

This research study was designed to explore the meanings that family doctors construct about their participation in a group-based life review program and to co-create an understanding and re-presentation of their experiences through individual and shared reflections, research conversations, and collaborative interpretations.

In this study, adopting a collaborative narrative method provided a way to both inter-stand the meanings that participants constructed about their experiences in the life review program and to critically explore how cultural discourses were at play in the stories and in how we interpersonally negotiated the construction, interpretation and representation of the research narratives.

According to Arvay's (2003) method, research conversations are designed to invite stories. The complexity of inviting stories requires entering into the third space (Shotter, 2002), trusting that meaning-making activities will emerge dialogically, and envisioning the co-investigators not as respondents or informants but as co-actors in the research performance. I am in agreement with the epistemological basis and assumptions of the method (Arvay 1998, 2002b):

- Knowledge is local, partial and socially co-constructed through dialogue.

- Meaning is constituted through language and human beings create their identities through the stories that they tell (to themselves and others) about their experiences. Stories provide both coherence and continuity to our lives and reveal our intentions and purposes.

- Human beings are meaning makers. We impose meaning on our own constructions and those of others. Understanding an other is inevitably an act of interpretation.

- Cultural stories within which we are embedded influence what we tell to whom, and under what circumstances.

- Research texts are human constructions written by people who have a situated and vested interest in the research. Therefore narrative researchers should include themselves in the text in ways that allow readers to gain a better understanding of how interpretations were constructed.

- Reading research texts is an interpretive process. There is no single or universal way to respond to a textual account.

- Researchers should strive to create non-hierarchical, collaborative research relationships with participants and be conscious of power differentials that exist within research relationships.

Arvay (2003) outlines seven stages in the research process: (1) setting the stage: a reflexive preliminary interview, (2) the performance: a collaborative research conversation designed to invite stories, (3) the transcription process, (4) four collaborative interpretive readings of the transcript, (5) the collaborative, interpretive interview, (6) writing stories, (7) sharing the stories.

Inviting participants to engage in collaboratively interpreting and discussing the interview transcripts makes heavy demands on the time and involvement of co-investigators. The current research study was designed to understand the experiences of participants in a group-based intervention. Prior to the two research conversations that we held, the participants in this inquiry had dedicated significant amounts of time to attending the life review group meetings and reflecting and writing prior to each meeting. It was not feasible to ask them to put in additional hours to collaboratively interpret the research transcripts according to Arvay's (1998) original research design. Arvay (2002b) suggests that when time is an issue, researchers can accomplish narrative analysis through the four interpretive readings without the participation of the co-investigators. In doing so, they need to remain reflexively cautious that the stories do not become their sole interpretation of participants' lived experiences. The method has been successfully adapted in this way by Black (2003) and Smitton (2003).

The research procedures that were followed in this inquiry will now be addressed in detail.

The Research Journal

The first step in conducting research of this nature was to begin by keeping a self-reflexive research journal. The journal provided a means for recording descriptive field notes and things that struck me as interesting or puzzling. It allowed me to express the emotional responses that were evoked in hearing others' life stories and reflecting on, and sharing, parts of my own. During the sometimes unsettling, sometimes exhilarating journey of being a researcher, it was the place where I could keep track of my shifting perceptions, develop self-awareness, reflect on methodological conundrums, pose myself new questions and see where I needed to seek both further clarification and support to push through blocks.

When it came to writing the interpretative narratives my research journal was a resource for re-membering the context of our interactions during the life review group and research conversations and a record of the thoughts, feelings and intuitions I had at various times. It was a road map of how the research process had unfolded. Most importantly, it allowed me to juxtapose ways that I had interpreted experiences in my journal during the life review process with the meanings that participants shared with me during our research conversations. In varied ways, reflexive journaling helped me to remain open and curious about our multiple perspectives and strive as Fine, Weis, Weseen and Wong (2000) recommend, "to come clean 'at the hyphen'

meaning that we interrogate in our writings who we are as we co-produce the narratives we presume to 'collect' " (p. 123).

Selection of Participants

The participants were a self-selected group who voluntarily chose to join the inquiry. The selection of participants for this case study followed a purposeful, and more specifically, a critical case sampling approach (Creswell, 1998; Merriam, 1998). I was seeking participants who had the knowledge and experiences required to adequately respond to the research question and the time and willingness to participate in the inquiry (Morse, 1994).

Selection of participants was based on three primary considerations. First, participants had to be family practice physicians, doctors who were qualified to work in Canada as general practitioners. Second, the participants had to have practiced in Canada as family doctors for a minimum of six years so that they had sufficient experience to address the research question. Third, the participants needed to be available to attend the group-based life review program and research interviews and be able to commit the time required outside of these meetings to participate fully in the study.

The group size was limited to six participants to ensure that there was adequate time in the group meetings for participants to share their stories. It was hoped that there would be diversity among the participants in terms of age, gender, and type of family practice. However, because participation was voluntary and self-selecting, no criteria were put in place to limit participation on the basis of gender, age, or location and type of family practice.

As the group meetings and research interviews were held in Vancouver, British Columbia (BC), it was assumed that most of the participants would currently reside and work in the Greater Vancouver area or in parts of B.C. that are within easy travel distances from the city. It was also assumed that language barriers would not preclude the participation of family doctors for whom English is not a first language. Being licensed to practice family medicine in British Columbia, Canada requires fluency in the English language above the levels needed to participate meaningfully in a life review program and research interviews that would be conducted in English.

Inviting Participation

Participants were initially invited to join the study through word of mouth. A letter of invitation was prepared (Appendix C) that was distributed by the facilitator of the group-based life review program using his professional networks. The life review facilitator is himself a family physician and also has an interdisciplinary doctoral degree with a focus in counselling psychology. Daniel (a pseudonym that will be used for the purposes of this study) seeks to combine his knowledge and skills in medicine and counselling psychology in his work as a researcher, service provider and educator. He has established expertise in leading in-service and professional development initiatives for physicians and other health care providers, and a broad network of professional contacts within health care.

In addition, Daniel and I delivered an oral presentation during Family Practice Rounds at a major hospital in Greater Vancouver. We spoke briefly to the project, invited participation, and distributed the letter of invitation to doctors who expressed interest in learning more about the study. During the oral presentation, Daniel recommended that where doctors were in shared practices, it would be preferable to have only one doctor from each group practice volunteer for the study. This was done in an effort to expand diversity and also to take into account interpersonal sensitivities that might heighten the anxiety of engaging in a process of self-disclosure with one's immediate work colleagues.

Family doctors who indicated a desire to learn more about the study were telephoned so that we could discuss the research process in more detail, review the criteria for participation, and consider whether they wanted and were able to join the research project. Of the eleven doctors who expressed an initial interest in joining the study, three realized that prior personal and professional commitments would conflict with the time frame of the study; one did not meet the criteria for selection, having only been in practice for two years; one doctor knew that her office partner planned to join the group and based on our recommendation in the oral presentation, felt that her colleague should have the first opportunity to join.

Following our telephone conversations, six family physicians (four women and two men) indicated a strong interest in joining the project and introductory conversations were scheduled with five people. For one volunteer, one of the pre-scheduled meeting dates created a conflict with on-going commitments. After some juggling and co-ordination among schedules I was able to find another date that would work for everyone and scheduled an introductory meeting with the sixth volunteer.

Subsequently, another physician who had heard about the study from a friend contacted Daniel to express interest in volunteering for the study. However, by that time we had reached the maximum number of participants for the life review group.

Setting the Stage: Preliminary Conversations

Kvale (1996) provides two contrasting metaphors to illustrate different theoretical approaches to research interviewing. In more traditional interview approaches, the interviewer is like a miner attempting to "dig nuggets of data or meanings out of a subject's pure experiences, unpolluted by leading questions" (p. 3). Conversely, the interviewer as a traveler wanders through the landscape with local inhabitants, enters into conversation with them and asks questions that invite subjects to tell their own stories about the world they live in. Meaning is not something that exists in a static or finished form waiting to be discovered. Meaning making is a fluid, dynamic, emergent, relational and context sensitive process. In any situation there will always exist a multiplicity of meanings that we create and dialogically negotiate as we language and embody our experiences within relationships. The traveler metaphor is clearly more compatible with my own theoretical orientation and intention in this collaborative inquiry to invite stories through

conversation (Arvay, 1998, 2002b, 2003). I have therefore chosen to follow Arvay's (1998) lead and prefer to speak of research conversations rather than interviews in recognition of my assumptions about the relationship between discourse and meaning (Mishler, 1986).

Preliminary conversations lasting approximately one hour were held with each of the six potential participants in the study. The participants decided the locations where these conversations were held and the times that would fit best with their schedules. Four of the conversations took place in the doctors' offices, one was held in my home, and the sixth at a coffee shop that we both frequented and enjoyed. One of the conversations had to be rescheduled at the last minute. As I was arriving for our meeting at the end of evening office hours, the physician received an urgent call to attend a delivery. By this point in the research, I was already conscious of these busy doctor's lives, the unpredictability with which they had to contend when they were on call, and the need for us to take into account that responding to patients' needs took priority over scheduled meetings.

The purpose of the interview was to begin developing rapport; share the reasons why I was interested in the research topic; facilitate dialogue about the research process, time commitment involved, and the roles and responsibilities that both I, and the participant, would have in this inquiry. My intention was to be transparent about my values regarding life review, my personal experiences with the model, my views about collaborative research relationships, and the philosophical values in which the research design is grounded.

The preliminary conversations provided an opportunity for the participants to raise questions or concerns and talk about their initial reasons for joining the study and what they hoped to gain from participating in a life review group with colleagues. It was also the time when we began to get to know each other outside of the "researcher" and "participant" roles. As each conversation progressed, it flowed beyond the boundaries of focusing on the study into a reciprocal sharing of parts of our professional and personal lives that connected us as people and laid the foundations for our research relationship.

Towards the end of each conversation we took time to review the consent form (Appendix D) together and dialogued about ethical issues such as confidentiality, the potential risks and benefits of being part of the study, and the right to withdraw from the study at any point. I suggested leaving the consent form with each participant for a week so that they could reflect on their decision about joining. In every case, the participants choose to sign the consent form at the end of the meeting stating that they felt certain about their desire to join the study and that their questions and concerns had been addressed in our conversation.

The six doctors who participated in the study were all practicing family physicians in the Greater Vancouver area. Their ages ranged from 39 to 59. Two of the six had been in practice for approximately 15 years and four had practiced for 25 years or more. While all were currently practicing as family doctors in an urban setting, between them the participants brought a wealth

of diverse experiences as doctors: teaching and mentoring residents; experience in rural practice; working overseas in a developing country; involvement in medical research; and experience in specialty clinics focused on working with specific illnesses or client populations.

The Life Review Program for Family Physicians

There were a total of eight participants in the life review group; the six family doctors, Daniel as the group facilitator, and myself. Thanks to a major hospital, we were able to hold our meetings in a spacious and private conference room in an office building. During the life review meetings I positioned myself as a participant-inquirer, witnessing the life review process and responding to the stories that were shared.

Being present as a participant-inquirer during the group meetings and reflexively journaling my experiences provided both a foundation for establishing collaborative peer relationships with the participants, and greatly enhanced my capacity to understand and construct with them the narratives of their experiences. Participating in the group allowed me hear and experience the emotional impact of the stories that were shared, and in responding to them share parts of my own life experiences. It allowed me to be part of the spontaneous conversations that emerged during our break times and as we gathered together each evening. Being present at both an experiential and reflexive level was important in both helping to illuminate how the lenses I was wearing were colouring my perceptions and in challenging me to extend my choice of lenses (Arvay, 2002b; Steier, 1991; Peshkin, 2001).

Daniel and I had considerable experience working together as co-leaders of groups prior to this inquiry. As the researcher in this study, ethical guidelines precluded me from assuming the role of co-leader. However, I was actively engaged in assisting Daniel with the logistics of the group process, in preparing for each meeting, and in dialoguing about how the process had unfolded after each session. Our collaborative planning and debriefing conversations allowed us to explore the intersections between the research component of the study and the group process, including the shift in our relationship from working as co-leaders to being leader and researcher. Dialogues with Daniel and my research committee helped me to struggle reflexively with what sometimes felt like the uncharted waters of participant inquiry and explore the tensions of living among the multiple "I" positions that are an inevitable part of collaborative inquiry (Clandinin & Connelly, 2000; Reinharz, 1997).

Before the start of the research inquiry, I designed the life review program for family physicians in collaboration with Daniel and my research supervisor. The structure of the program followed the original life review design (Birren & Deutchman, 1991). As Birren and Cochran (2001) suggest I adapted the number and focus of the original themes and created themes and sensitizing questions that would be responsive to this particular group context.

In addition to writing on the various themes, I invited the participants to keep a personal journal of anecdotes or notes to themselves about their experiences during the process. This is

not part of the original life review model. I included it as a way of possibly enhancing the group members' reflections and learning during the life review process and expanding the re-collections of the experience that we would share in the research conversations.

The original design of the group-based life review program called for six sessions of approximately 3½ hours duration. These sessions were scheduled in the evening at more or less regular intervals over a period of seven weeks. By the time we had reached the third group meeting, it became clear to Daniel and myself that six sessions would not be enough to provide adequate time for both the rich sharing that was occurring on the various themes and appropriate time for group closure. When this issue was brought to the group, the decision was made to add a seventh meeting that would that would allow for closure, and (at the participants' request) an opportunity to provide feedback about the structure and process of the group and thoughts about future directions.

In some life review groups, participants value the opportunity to have a follow-up meeting several weeks after the process has ended. When the participants in the group knew that this was a possibility, they were unanimous in their desire to schedule a follow up meeting and this was held eleven weeks after the final session.

The first meeting was dedicated to building an initial sense of inclusion and personal control among the group members following the model developed by Borgen et al. (1989). We reviewed the structure and purpose of life review and the guidelines that I had prepared about group process, writing on the themes and journaling their life review experiences (Appendix E). As a group we collaboratively established group agreements to promote confidentiality, respectful communication and a non-judgmental group climate. The draft group agreement (Appendix E 4) was expanded upon to establish how we could most effectively address the issue that a number of the doctors would be on call during the sessions.

The participants were reminded that in keeping with the principle of confidentially inherent in life review, no audio or videotaping would occur during the meetings and that they were not required to show me what they wrote on the various themes or in their journals as part of the research process. I believed it was important to respect the confidentiality of the stories they chose share in the group and their personal writing, and only include in the research narratives what they chose to share with me in the collaborative research interviews following the program.

The first meeting was also a time to engage in several introductory activities that allowed the participants to get to know each other and become oriented to the process by sharing a branching point in their lives related to becoming a family physician with one other group member (Appendix E 5). The meeting closed with reviewing the theme that participants would prepare for the second session.

The following five sessions followed a similar format, with the exception of the second session which began by inviting participants to speak to their learning goals and what they hoped

to personally gain from participating in the program. After a short introductory activity to allow members to reconnect with the group and speak to any issues that they needed to bring forward or put to one side so that they could be fully present, the group members shared and responded to the stories that they had individually prepared. The sessions ended with reviewing the theme for the following week and a brief closing activity. Each meeting focused on a different theme (Appendix F), in the following order:

- The major branching points in your life.
- Your family.
- Your career as a family physician.
- Your experiences with stress, distress and bearing witness to the suffering of others.
- The meaning of your life, and your aspirations and life goals.

The final (seventh) session provided the opportunity for the participants to speak to what they had either personally or professionally gained from their participation, provide Daniel and myself with feedback about the program, and share ideas that they felt could make the program more effective and responsive to the needs of family doctors. A closing activity ensured that all of us had time to acknowledge the work we had done together and express our feelings about the group coming to an end.

A follow up meeting was held almost three months after the final session. It was an opportunity to reconnect, reflect on our work together, and explore what the participants were carrying forward from their learning and experiences in the program.

First Research Conversations

Individual research conversations lasting from 1½ to 2 hours were scheduled with each participant in the three weeks following the final group session. With the participants' permission, our conversation was audio taped for subsequent transcription. Three of the conversations took place at participants' homes at their request and three in a small office adjacent to the conference room where the group had been held.

Initially, when I spoke to the group about my desire to create an understanding of the co-researcher's experiences through a collaborative conversational interaction, I realized that some of the participants were a little confused. They expressed being more used to traditional structured interviews in which they would be expected to respond to a series of pre-established or guiding questions. I consulted with Daniel and my committee members about my dilemma of not wanting to direct or de-limit the interviews and yet sensing that some participants were concerned about trying to second-guess what would be expected of them. To alleviate potential anxiety, I decided to prepare a short handout (Appendix G) in which I suggested we could start our conversations with taking a chronological view on how their experiences had unfolded over time in the group. As physicians are very used to taking patient's life histories, Daniel thought this may provide a familiar and comfortable way of framing the research conversations.

As Arvay (2002b) points out, inviting stories is a complex act and requires more than interviewing skills: "It is about entering the 'third space' by being present to it and trusting that the process will unfold – a leap of faith that meaning making activity will unfold dialogically" (p. 213).

When I thought about wanting to co-create and maintain collaborative research relationships, I was conscious that trying to hold a stance of reciprocity within the framework of "doing research" is a complex issue. As researchers we need to question ourselves about who we are speaking for, and to, and for what purpose and be willing to ask ourselves who is claiming that the research relationship is collaborative and to what ends (Arvay, 2003; Haraway 1991; Fein et al. 2000; Harrison, MacGibbon & Morton 2001; Richardson, 1990).

I began each conversation with a "starter statement" as a way of both inviting stories and encouraging choice about how participants wanted to begin:

> As I said in the short handout, I'm hoping that today we can have a conversation about your experiences in the group. I don't have a set series of questions and there isn't any right or wrong way of doing this together. One way I'd suggested in the handout is to start by tracking back to the beginning, to your initial decision to join the group if that makes sense for you. Or you may prefer to begin by speaking more globally about your experiences. It's whatever feels right, or fits for you.

In several instances, as we began to talk, I was very conscious of the inescapable power differentials that appear to be inherent in any research interview situation, no matter how collaborative one's wants to be. Following my starter statement, one participant said, "Why don't you choose how to start." Another commented, "I thought I'd like to start by going back to the beginning, if that's OK with you?" Initially, there were comments such as, "I don't know if this is interesting?" or "I don't know if this is the kind of thing you're expecting?" Quite quickly however, these kinds of statements receded as we flowed into a more natural, conversational dialogue. Five of the six participants brought their personal journals with them to the interviews. To varying degrees, they would pause to leaf back through them, reflect on what they had written, and sometimes either summarize their writings or directly quote from their journal. At the start of one conversation, a participant asked what we would do about the tape recorder when she wanted to pause and take time to reflexively review her journal writings. Would we turn it off, so that there wasn't a long silence? I responded that we would just leave it running; take the quiet time needed for her to read her journal as we would if we were talking without recording our conversation, and reassured her that I had extra tapes with me so we could take all the time we needed.

Kvale (1996) reminds us that the original Latin meaning of conversation is "a wandering together with" and that interviews are literally inter-views. Voice is not something that we discover but something that we create together. In constructing the other, we are likewise reconstructed (Lincoln, 1997). During each research conversation I was actively engaged in an emerging,

interactive dialogue. I consciously used the skills of active listening, empathic reflection, paraphrasing and clarifying to reach a mutual understanding of what the participants were telling me and to express an openness and desire to hear whatever they chose to share. Although the focus of each conversation was on the participant's experiences in life review, we wandered into other avenues as we wove together an understanding and interactively explored the meanings of being in this program. I responded authentically to questions the participants asked me about my own recollections or feelings and, occasionally, I offered an anecdote from my own life that resonated with experiences they were describing.

The conversations were evocative and at times emotional. We shared laughter, surprise, frustration, joy and some tears. When painful emotions emerged during the conversations, I responded empathically and tried to create a welcoming and safe space to honour the expression of feelings. I deliberately withheld from probing or using counselling skills such as advanced empathy to engage in exploring the issues more deeply. Kvale (1996) points out that research interviews are distinct from therapeutic conversations that people have requested, and "it may be unethical to attempt to instigate new self-interpretations or emotional changes" (p. 156). I was however conscious, as I had been during the group sessions, of the multiple positions I was balancing and the tension I sometimes experienced between my counsellor/group facilitator 'selves' and the less known positioning as a participant-inquirer.

I was interested in understanding how my presence in the group as a researcher and non-doctor may have impacted the life review process and also the significance of the group facilitator being himself a family doctor. In the first interview, the participant spoke spontaneously about these issues. I decided, following this conversation, that I would explore this gap in my understanding with the other five participants and raise these questions myself if they did not emerge naturally as we talked.

Following each research conversation, I reflected on the interview and recorded my recollections and feelings in my journal. I made notes about both the context and content of the conversation. I recorded my perceptions of the feeling tone between us, and expressions of emotion. I recalled what was said in body language or, in several cases, brief enactments to illustrate part of a story. I wrote about what had struck me as significant, the emotional impact of listening to what was shared, and comments and questions to myself about my sense of my own performance. I then reflexively listened twice to the audiotape of the conversation and wrote further notes, insights, and questions, in my journal.

The Transcription Process

Transcription is always incomplete, partial and selective and can never hope to reproduce the living research conversations (Mishler, 1986). As we move from a multi-dimensional, contextualized, embodied conversation to an attempt to re-construct that through

transcription, the best that we can hope to achieve is a degree of verisimilitude (Denzin, 1995; Reissman, 1993). Moreover, as many authors point out, the process of transcribing is inherently interpretive and theory laden (Arvay, 2002b; Clandinin & Connelly, 2000; Kvale, 1996; Lapadat & Lindsay, 1999; Mishler, 1986; Riessman, 1993).

I fully transcribed the first research conversation myself so that I could both immerse myself in the process and develop a schema (Appendix H) for recording features such as the length of pauses, interruptions and where there was overlapping speech (Arvay, 1998, 2002b; Black, 2003). Initially, I transcribed the audiotape of our conversation as a rough draft, recording all aspects of the speech produced including pauses, silences, repetitions, incomplete words, over-talk, and affective expressions (such as laughs, tears, shouts). I noted any parts of the speech that were inaudible or difficult to hear clearly and environmental sounds (e.g. pages of a journal being flipped through, a telephone ringing). I was pleased that I had followed Dr. Arvay's advice to take two tape recorders to each interview as certain passages that were muddy on one recording were sometimes more clearly audible on the second tape. I subsequently chose to have draft transcriptions of the remaining conversations completed by a person who is skilled and experienced in doing this kind of work. We discussed the intent of verbatim transcription and I familiarized her with the schema I had developed.

Once each rough draft was prepared, I went through the transcription process a second time. This allowed me to check for accuracy; interpolate the notes I had made in my journal about things such as body language, movement, and contextual features; and attempt to reflect on paper my interpretations of voice tone and emotional expressions.

Naturally, the audiotapes of our research conversations in this study were only a partial representation of what happened in the interviews. In carefully constructing the transcripts my goal was not to imagine or pretend that it was possible to recreate in textual form the experience that unfolded between myself and each participant during our conversations. Because transcription is inherently interpretive, what the process provided was a way to be reflective about the numerous decisions I was making and consider how my assumptions and rhetorical purposes were shaping the construction (Lapadat & Lindsay, 1999). As I went through the drafts that the transcriber had prepared, it was fascinating to see how interpretive processes were at play (especially when words were spoken softly) and the degree to which transcripts become decontextualied representations (Kvale, 1996). For example, on one first draft the transcriber heard, "There's not a lot of illness in my practice." After re-listening carefully to the audiotape and re-situating these words within the context of our conversation and what this person had described during the life review sessions, the sentence was re-transcribed as, "There's a lot of mental illness in my practice." In a similar situation, what was initially recorded as, "Many losses of patience," became "Many losses of patients" when interpreted within the context of the participant's story.

Reflexive Listening and Interpretive Readings

In keeping with the holistic form and content approaches described by Riessman (1993), I decided to work with the whole text as a way of understanding the interplay between the parts and the whole. As I reflected on the transcripts, I returned frequently to listening to the audiotapes. While I had used devices such as a bold font to indicate emphasis and noted affective expressions in the transcripts, the words on the page remained flat. Listening repeatedly to the audiotapes was, for myself, an essential way of re-embodying our conversation, enlivening the text, and exploring the meaning of voice tone, inflection, silences, and significantly repeated words or metaphors. It helped me to identify narrative episodes that I would then mark in the text, be attuned to how stories and themes circled within others, and notice how our voices converged, diverged and sometimes merged as the dialogue unfolded.

I used the four interpretive readings described by Arvay (1998, 2002b, 2003) as a way to enter more deeply into exploring each text from different interpretive perspectives. The first reading was for content, accuracy and a sense of the storyline. The second reading was to locate the participant in the story, to engage in an empathic interpretation of how the participants were presenting and positioning themselves in the interactive dialogue and choice of stories that they shared. The third reading was for the research question, to explore the meanings that were expressed or implied about their participation in the life review program and the constructive feedback they provided about the group process and facilitation. The final reading was a critical reading to interpret the influence of culture and social context in the stories that were shared. In this reading I was seeking to understand how issues related to socialization processes and the context of medical culture how medical discourses were woven into their stories.

I used four different coloured markers to highlight in the margin parts of the text that spoke to these different readings: green for the self of the narrator; yellow for the research question; pink for feedback and future recommendations; blue for the cultural context. Having completed the four interpretations, it was interesting to see that while a few parts of each text were marked by a single colour, in most instances what emerged in the margins of the text was a braid of three or four colours as the interpretive threads co-mingled and intertwined throughout the dialogue.

As I listened to the audiotapes and reflected on the transcripts from these different interpretive angles, I frequently returned to re-reading my personal research journal. Juxtaposing my recollections with the transcribed conversations allowed me to dwell more deeply within the experiences they were describing; it illuminated where my earlier perceptions about various events were expanded or shifted as a result of our research conversations; and it helped me to stay in touch with how my own experiences and ways of understanding were shaping the process of interpreting the texts.

Writing the Initial Narratives

Authors point out that narrative researchers are confronted with moral and ethical questions as they think about how they will represent their research participants and consider who is protected, and who is not, in the narratives they present to readers (Arvay, 1998; Denzin, 1997; Fine et al., 2000; Richardson, 1990; Steier, 1991). In moving from transcription to representation, I became very aware of some of the dilemmas I was personally facing as a participant inquirer. Confidentiality is an important part of my professional code of ethics and practice as a counsellor and the stories that were shared in the group program were held in confidence among us. For several weeks I felt very conflicted about what to include and exclude in the initial narratives. I struggled with feeling very protective about the personal stories that were shared in our research conversations and wanting, at some level, to treat these with the same degree of confidentiality as those that had been shared in the group. At the same time I was committed to representing the understandings we had constructed during our dialogues with as much narrative truth as possible. Struggling with this issue brought more clearly into focus the need to respect what the participants had chosen to share with me and avoid limiting the richness of their stories by being overly cautious. We had agreed that pseudonyms would be used in the narratives and changes made to any specific names of places or people to ensure anonymity for the participants and others. Five of the six participants chose their own pseudonym and the sixth person invited me to choose one for her. The participants also knew that once I had written an initial narrative it would be sent to them for editorial review and that we would meet to discuss any deletions, additions or changes that they felt were necessary.

In constructing the narratives I wanted to create texts that could invite readers to engage with the participants stories. After debating how I could privilege the voices of the participants in an authentic and respectful way, I chose to write the narratives as first person accounts and use this literary device to retain the vitality of their experiences (Arvay, 1998, 2002b, 2003). I framed each narrative as a conversational recounting of the participant's experiences in the group-based program. I decided that this approach allowed me to more accurately reflect their individual styles of re-storying their experiences and, although my voice is not represented in the text, I want the reader to understand that the narratives were a collaborative process of constructing meaning. The narratives presented in this text are evolving stories filled with complexity and future possibilities (Mishler, 1999).

Second Research Conversations: Revisiting the Stories

Once the initial narratives were written and reviewed by my doctoral advisor, I contacted each of the participants to set a time when we could meet to discuss their individual narrative. I reminded them that the purpose of this second conversation was to explore their impressions of reading the story, the degree to which they felt it resonated with their experiences, and changes that they felt were needed to add to the clarity and accuracy of my interpretation. I arranged to

deliver a copy of the narrative to them ahead of the meeting so that they could have adequate time to digest and reflect on the narrative before we talked about it. I included a brief cover letter asking them to read the narrative for accuracy and note any places in the text where they felt the story needed to be expanded or changed in some way. I also invited them to make a note of any new or different insights that may have come to mind since our research conversation that they would like to be incorporated into a revised narrative. The meetings were scheduled for times and locations that best suited each participant: two conversations took place in the participant's homes; two in the doctor's offices; one at the location where we had held our group meetings; and one at my home. Three of the conversations were relatively brief, ranging from 25 to 35 minutes, and three were longer, lasting between 1 to 1½ hours.

The participants' responses to the narratives were very positive. All of them commented that they resonated with their narratives. Some expressed surprise at seeing how much they had said and commented that it was affirming to read the story. The six participants responded with some of the following statements: "There isn't anything I want to add or change in the story. It reflects my experiences very fully." "My initial reaction was, 'Did I say all this?' I liked what I said. This story captures my experience, feelings and beliefs in a comprehensive and integrated way. I really resonate with this story." "The story captures the essence of my experience. I certainly see myself in the story. I believe in the things I'm saying here." "For me the story is resonant with how I described my experiences in our conversation. I definitely see myself and hear myself in this story." "It's very good. It has really captured the crux of my story. I remember saying all these things and how I felt when I said them." "I resonate with this story and I can really see myself in it. It captures my experience in an accurate and comprehensive way."

The participants requested very few changes or additions to the narratives. While none of the changes they suggested transformed the interpretation of the stories in a substantive way, all of them were incorporated into a revised text. One narrative was not changed at all. In another narrative the only change that the participant requested was that I accurately report the genders of his children (which I had disguised to promote anonymity) as he felt this added to the richness and meaning of his story. In two narratives a sentence was changed to more accurately express what they meant at that point in the story. One participant commented that there were two sentences in her story that didn't feel quite right. They represented what she had said in our conversation but she felt, upon reflection, that her words did not really capture her felt sense of the experience and needed further clarification. We spent some time exploring the meaning she wanted to express and re-wrote the sentences in a way that was more resonant for her. In the sixth narrative the participant felt that it was important to add some sentences that would expand and clarify the meaning of what she was saying for people who read her story. During our conversation she wrote these additions to the story and we discussed how best to incorporate them. Together we also re-phrased some sentences in a way that she felt more accurately

reflected her experiences. For example, in a couple of places I had used a third person voice as she had done in our conversation when describing certain feelings. In reflecting on the narrative she chose to personalize these to strengthen her ownership of the experience.

All the participants commented that it was personally interesting and valuable to have their experiences laid out in a comprehensive and integrated way. Four of them expressed that the research interviews and subsequently reading their stories provided them with additional layers of insight into their experiences. For example one of them commented:

> The research interview was like a review of my life review. Your questions helped me to crystallize the experience and allowed me to remember things I might not have recalled or brought into focus otherwise. Now having this story brings it all together in an integrated way that is really useful to me. I plan to keep it in my journal so that I can go back and re-read it from time to time as I think about my life.

Another participant spoke of the importance of the whole research process as allowing for a depth and breadth of self-awareness that would be impossible to gain on one's own. He commented that his own narrative was personally very useful in providing him with an integrated picture of his feelings and beliefs and hoped that others would get to read all the narratives:

> These stories are really important. They are primary data. These are the voices of doctors speaking about their experiences directly. And they are not simply emotional accounts but represent a cognitive integration of their experiences, thoughts and feelings.

Criteria for Legitimacy: Evaluating the Worth of the Study

> The processes of analysis, evaluation, and interpretation are neither terminal nor mechanical. They are always emergent, unpredictable, and unfinished (Denzin & Lincoln, 1994, p. 479)

Questions of validity and legitimacy have become thorny and much debated issues in a postmodern context. Bochner (2000) contends that the subtext of any claims that researchers make about validity are rooted in a positivistic heritage and an attempt to establish Truth or rationality rather than truths and subjectivity. Bochner believes that this makes criteria limiting, thwarting and destructive to the heart of work that deals with phenomena that are intrinsically messy, complicated and uncertain. Others have suggested the need for new criteria such as rhizomatic, crystalline, or voluptuous validity (Lather, 1991). Some authors view criteria such as educative authenticity or catalytic authenticity as approaches to legitimacy that are more responsive to postmodern perspectives (Lincoln & Guba, 2000). For the purpose of evaluating the worth of this inquiry, I chose the following four criteria as being consistent with constructivist and narrative epistemologies.

Resonance.

This criterion addresses the perceived congruence of the representation between the researcher and co-researcher (Arvay, 1998; Riessman, 1993). As narrative researchers we can only understand people's experience through interpretation and there can never be an exact correspondence between the actual experience and the story that is constructed about the experience. People's stories are not static. They evolve and shift over time as new insights or different perspectives come to mind. However, the criterion of resonance allows participants to establish whether the constructed research narratives are an adequately faithful representation of the experiences they shared with me.

Each participant in this study re-viewed and co-edited the initial narratives of their experience in life review. Without exception, all six participants validated that the re-constructed narratives were resonant with their experiences. In addition, the peer reviewers also commented that the narratives resonated with their experiences in medicine. (Their comments are highlighted in the next section: Independent Peer Review.).

Consensual validity.

As described by Lieblich et al. (1998) this refers to "sharing one's views and conclusions and making sense in the eyes of a community of researchers and interested, informed individuals" (p. 173). I chose this criterion because it reflects Denzin's (1997) concept of verisimilitude: Does the text feel truthful to the reader? Does it make sense to other researchers in the field of inquiry? Does it provide readers with an opportunity to resonate with the experiences of the person in the text? Three steps were taken to establish a criterion of consensual validity in this research project. First, the co-researchers were collaboratively involved in reviewing and editing the narratives. Second, the constructed narratives were submitted to both internal and external peer review. Third, I sought feedback on the research texts from my supervisory committee who have combined expertise in the areas of life review and family practice medicine. The oral reports I received and written comments from the two peer reviewers support the criterion of consensual validity.

Persuasiveness.

Persuasiveness asks if the interpretation is reasonable and convincing. As Riessman (1993) notes, the criterion of persuasiveness "is greatest when theoretical claims are supported with evidence from informant's accounts and when alternative interpretations of the data are considered" (Riessman, 1993, p. 65). Ultimately, persuasiveness depends on the response of readers to the text. If a reader experiences a sense of emotional intimacy with the experience being portrayed in the narrative, or can imagine at some level what it would be like to personally experience what they are reading about, the text has verisimilitude (Denzin, 1997; Polkinghorne, 1988). In this study attempts to establish persuasiveness were accomplished by involving the

constructed narratives were also judged by peer review. Oral and written reports indicate that the research texts are persuasive.

Pragmatic use.

Pragmatic validity refers to the potential usefulness of the research findings at both an individual and societal level. The criterion of pragmatic usefulness was established through the participants' own comments about their experience of being engaged in this research study. The participants spoke of a range of benefits that they individually gained from being in the life review program and commented that the group process they had engaged in was beneficial in terms of enhancing connection, resilience and sustainability among family doctors. All of the participants believed that many other doctors would benefit from a similar experience and hoped that the research project would result in the development of more programs of this kind. At the follow up meeting, all the participants expressed the desire to continue working together as a group and set another meeting to explore this possibility. They also wanted to proactively pursue ways to ensure that other doctors had opportunities to be involved in programs like this. Following the meeting, a small working group was formed to look into this issue. The criterion of pragmatic usefulness was also investigated by asking the peer reviewers if they thought it would be useful for other people to hear the stories. Both reviewers commented that other people could certainly benefit from reading the stories, especially other professionals.

Independent Peer Review

The purpose of this step in the research process was to have the narratives critiqued by both internal and external peer review in terms of the four criteria that were chosen to evaluate the worth of this study, namely: resonance, consensual validity, persuasiveness and pragmatic usefulness. With the consent of the participants, the narratives were reviewed by Daniel (the group facilitator) to gain the perspective of someone who had been present throughout the life review program. They were also reviewed by a family physician who had previous experience with group-based life review. These two reviewers were given copies of the six narratives along with the following instructions:

> Please read the stories twice. The first time is to familiarize your self with the six stories and get a general sense of what each person is saying. The second reading is to allow you to consider the following questions:

1. *Do the stories seem credible? Do they ring true for you? Are they believable?* (This question addresses the criterion of consensual validity)

2. *Are the stories emotionally engaging? Can you at imagine at some level what it would be like to experience what you are reading about in the stories?* (This question addresses the criteria of resonance and persuasiveness)

3. *Do the stories have some pragmatic value? Would it be useful for others to hear these stories? Could people learn something from these stories?* (This question addresses the criterion of pragmatic use)

Their written comments on the narratives follow:

Internal peer review.

The work of family physicians is to listen to the stories of their patients at 15 minute intervals. Over the years they often know their patients in a way that few other people know them. It is often in listening to the stories that healing takes place. In those instances listening is the medicine. Doctors are no exception. They too have stories and can experience healing as others listen to their stories. It is that feature which is captured in the stories created in this research project. As the facilitator of the life review process I heard all the stories told by the six participants. The tone, the mood, the content, and the meaning that was present through the life review process are present as I read the stories. Their authenticity is such that I re-experience the life review process—I hear their voices, see their expressions and feel the emotions that were present through the seven sessions.

Other people could certainly benefit from reading the stories—the sense of community, the purpose of self-reflection, the practice of keeping a journal, the need to speak one's truth to others who will receive it with gratitude and respect, the awareness of isolation as a physician— as the features are somewhat universal. The stories might be particularly beneficial and pertinent to other professionals. One of the interesting features of the stories is that the participants found value in different themes—branching points, family of origin, stress in the work place. Generally, looking back can contribute to providing direction for the future. That too was the experience of the participants. They seemed to have a deeper understanding of what they would next want to do professionally and personally. They were guided by their own stories—stories that strengthen the individual as well as the community.

External peer review.

"Do the stories seem credible?" Absolutely...they ring true and are very believable. Having been a family physician (FP) in clinical practice for over 15 years, I can say that the incidents that they describe and the constraints they are increasingly facing as healthcare evolves ring very true. The fears and anxieties they describe (and seemingly take on as natural part of the profession) are stories I often hear. The struggles to balance their professional and personal lives ring true. So too do the joys of the profession and their devotion to the patients and the practice of healthcare.

"Are the stories emotionally engaging? Can you imagine at some level what it would be like to experience what you are reading about in the stories?" Yes, I can imagine experiencing what has been described. In fact, I have experienced more than just some of what was described. (Throughout the time that I read and re-read the stories, I stopped a number of times to ask if I was projecting my own experiences onto their stories rather than hearing their voices telling their stories. I do think I was able to hear their voices and stories).

I found some stories more engaging than others. Some I found more "intellectual" than others. I wasn't sure if this reflected an attempt to be analytical during this interview or a more global detachment. Interestingly, I found one participant's description of her detachment very engaging. It was the contrast to her earlier stated involvement that made me very curious.

"Do the stories have some pragmatic value?" The greatest challenge is that they are seen for what they are rather than as the "gripe sessions" one participant mentioned. From the stories it is very clear that the process was of assistance to each of them. As a number related: it is very unusual to have so many physicians attend all sessions at the end of very busy workdays.

'Could people learn something from these stories?" So many others can learn from their stories:

- Other colleagues; the normalizing value of the stories is immense. I would hope that it would inspire other physicians to consider a similar process (to assist not only themselves, but therefore also their families, co-workers and patients). The value of the sessions themselves in reducing professional isolation was also a very clear theme. I also strongly agree with the comment that this work should be considered a normal and essential part of professional development of the individual and essential for the sustainability of the profession.

- Families, coworkers, physicians from other disciplines would hopefully have a better understanding of the profession and FP's.

- Policy makers and leaders: I think very few understand the issues that family physicians face. I see well-meaning people simply having no idea of the reality of the day-to-day lives of FP's. Whether they don't wish to hear, or cannot hear is unclear.

Thematic Analysis

A further step in exploring the meanings that the participants made of their experiences in the group based life review program involved thematic analysis. I wanted to examine more closely where there were common threads among the experiences of the six doctors and where there were differences or singular voices.

I began this process by following Arvay's (1998) approach and systematically analyzed each narrative using the question that van Manen (1990) recommends for selective thematic reading: "What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?" (p. 93) I read each narrative twice and highlighted key words and phrases. I then drew out the themes that emerged from each narrative, listed them, and began to look for common patterns across the six texts. There were multiple sources of data in this research study. I therefore triangulated the themes that had emerged from the co-constructed narratives with my observations and experiences in the program and additional reflections that the participants had shared during the second research conversations and follow

up meeting. This allowed me to see where there was added evidence of the themes I had identified and be open to disconfirming or expanding them.

In constructing a thematic analysis I re-connected to how strongly the narratives spoke to both the doctor's experience in the program and the broader cultural stories in which their experiences were embedded. In my initial analysis I tracked some of these themes separately and then realized they were inextricably interwoven as part of the group experience. Similarly I became aware that certain themes (such as gaining new self-awareness or affirming aspects of the self) grouped more succinctly into a theme of enhanced self-understanding.

The thematic analysis led to 15 separate themes that upon further reflection were collapsed into 10 conceptual groupings (Table 1). While each of the 10 themes have distinctive qualities, there is also a natural overlap and interplay among them. To enhance the trustworthiness of my conceptualization, the thematic analysis was reviewed and critiqued by my committee members who were familiar with the research narratives and my experiences as a participant/inquirer during this research study. The themes are described in Chapter 5 following the individual narratives of the participant's experiences in the program.

Table 1

Conceptual Grouping of Themes

Struggling with constraints to self-care and professional support	• Lack of time for self-reflection and connection • The need to create non-stigmatizing collegial support groups
Experimenting safely with self-disclosure among colleagues	• Concerns about professional norms • Personal control about the degree of self-disclosure • Witnessing others risk self-disclosure
Expert group facilitation	
Isolation, relationship, and collegial support	
Normalizing concerns and frustrations	
Affirming vocational commitment and esteem	
Sharing the burden of painful events and witnessing trauma	
Sharing the distress of potential or perceived mistakes	
Personal and interpersonal learning	• Integrating life experiences and expanding self-understanding Learning from other's experiences and life stories • Keeping a journal amplified personal learning
Promoting professional sustainability and self-care	

CHAPTER 5

Findings

The purpose of this chapter is to present the narrative accounts of the six doctors who participated in this inquiry followed by a description of the common patterns that emerged through thematic analysis of the research findings.

The narrative accounts were jointly constructed through participant inquiry and a reflexive, collaborative research methodology. Each participant's experiences are told from a first-person perspective to privilege the voices of the doctors and allow readers to engage more fully with the stories. Further, I chose to retain the conversational quality of re-storying that occurred in our dialogues as a way to situate readers more authentically in the research context. As readers you are invited to imagine that you are listening in on a re-presentation of our research conversation. Each narrative is structured to reflect the varied ways in which participant's chose to recall and recount their experiences. For example, Vanessa chose to follow a fairly tight chronology as she initially traced the meaning of her experiences through the group process. Chantal, on the other hand, reflected back more globally on what life review meant to her at this time in her life. To enhance readability, each narrative closes with the participant's feedback about the group structure and facilitation, and thoughts about future directions. All but one of the participants brought their personal journals to the research interview. Some of them chose to quote directly from their journals to enhance my understanding of their experiences during the program. In the narratives, these quotes are presented in an italicized font.

Here are the doctors' stories.

Doctor's Stories

Eric's Story

Quite a few months ago Daniel had mentioned that there might be a Life Review group for family doctors happening in the fall and wondered if I'd be interested. And I said I'd be very interested. I'd heard of some other workshops you and Daniel had done and you'd both been part of the training group we did a couple of years ago about working with people who've experienced trauma. And I found that to be just a very good thing. So I was quite looking forward to the Life Review group happening. I was kind of disappointed when I didn't hear anything more about it by the fall. I just thought well, everyone is so busy, something must have come up or maybe they found someone else.

The real thing is that by my age you become aware of the amount of pain you absorb as a physician over the years and how much that affects all of us – however much we would rather not think it does. You can talk over certain things with your spouse and family and friends, but there's other things you can't really share with them. So the idea of getting together with other family doctors, it both concerned me a little bit and also at some level I was craving that – an opportunity to be among colleagues and talk about the doctor part – the experience of being a doctor.

The concern for me, in thinking about joining the group, was that from medical school on I've never felt that I could honestly disclose any of the bad feelings, the soul feelings that come up – the insecurity or worries. I'm a pretty conservative, traditional kind of guy. I grew up in the Prairies and was married by the time I was in medical school. I had some classmates that I really looked up to a lot, and that was good. But there was also a certain kind of society, certain ways you were expected to behave if you wanted to fit in and survive in that medical school culture, some of which felt really foreign to me. It felt like some kind of rooster walk - every one expected to be self-promoting, strut their stuff, and look the part both socially and academically. Of course I adapted, as you do in your twenties, and learned all the necessary behaviours to perform in that climate. So on the surface, I appeared very perky, but deep down, I really didn't know how to deal with it.

It certainly wasn't a climate in which you would ever describe your professional vulnerabilities. You just very quickly learned to defend against that by learning what you had to learn, and taking on the behaviours that you needed to survive. I guess it was necessary to do that, but I've never felt at home with it, never been in a safe place where I could talk about my vulnerabilities as a doctor. Since then, I've always been a little distrustful of disclosing any kind of professional vulnerability in the medical community and occasionally when I've tried to do that, sometimes it's backfired. So I've learned to play my cards close to my chest.

Some people may wonder well, why not just go and do psychotherapy if you want to talk about concerns or worries? But I knew there was another part of the piece for me. Individual

psychotherapy wouldn't allow for a shared experience that might say, wait a minute - maybe this medical culture is not pernicious. Maybe there is something there that can be very healthy and wholesome. I found that a very attractive idea.

Of course, we have a Physician's Support Program and a Physician's Health Program but they are things that people go to, I think, in more extreme situations, or only under duress. They aren't places where functional, but sometimes distressed, reasonably normal people can sit down together and talk, in an existential sense, about having a bit more ease with their lives as doctors. So that was a really important part of the piece for me when I said 'yes' to joining this group. Thinking that if there was some way we could come together and honestly talk about the experience of being doctors, it was worth a try.

I was worried prior to the group starting and on the first evening. I didn't know where we were going to need to go. How far we were going to need to disclose. What kind of personal work we might be doing in a group context – so it was a little frightening. But when we started in the first session right into some kind of story telling, albeit on a pretty superficial topic, I think we saw that there wasn't going to be an unspoken set of rules. The ethos said that when we listen to each other, we're not going to offer advice; we're not going to try and fix things; we're only going to talk about how we feel about what they've said. We were going to speak from the heart. The other ingredient that I think was critical in the group was that after you'd shared your story, you very quickly heard the others' stories. So you didn't feel personally exposed - you weren't the only one sharing something.

I don't think the healing part of this process is anything new. It's as old as the human race - it's storytelling. But this was different. Because if you think about any other scenario in a culture, going way back, where you would tell your story, it wouldn't be as unencumbered a milieu as this one. If you're sitting with your family, you will filter your story to click with the family rules and secrets. If you were telling it around a village well, you'd filter your story to fit with the rules around that. There's always a set of rules – unspoken, and very controlling. What happened here, was that the structure said this is the way it's going to be; this is the way we are going to do it. And that structure, I think, liberated us from all those other unspoken things that get in the way of telling our human story in other cultural contexts.

The other thing about the process that I felt was good was that there was a certain moderating influence of the group. As we went along, people were allowed to find their own comfort level with how much they wanted share. I learned the most about that from Robin. In Branching Points, she talked about being worried that her stories might seem uninteresting or superficial because her life had been so relatively care free, compared to other people. Then later on, in the session that I had to miss, she obviously told a very powerful story that I could see had a profound effect on the group.

I was quite struck by the degree of disclosure in our group, but there was a real safety to it, it was never out of control. It was clear that we could disclose, and that we would not have to disclose too much. You can go to a certain level, you're still keeping some things inside you and that's OK – that doesn't disqualify you from the process. It's not like a T group where you sit up all night and wear yourself down to the point where you are thrashed and maybe over-disclose, do things that are inappropriate for you because somehow you think if you're not really baring your soul then you are disqualified from the process. I've seen how destructive that kind of process can be in working with a number of my patients over the years. This was different. It was like a purgatory of psychotherapy – neither heaven nor hell! We knew in advance what was going to be discussed. We could go as far as we wanted, but we wouldn't be pushed to go any further than that. So for me, it never felt that things were spinning out of control. I never had the sense of thinking, "Oh boy, someone's going to have to talk to that person."

So was it the facilitation, the structure, the nature of the people who were in the group that made this work? Probably all of them combined. What was very significant for me was what happened in the first session when we were paired up to talk about why we chose to go into medicine. I told this great story that's true but it's a very easy, neutral story for me to tell. My partner told this very frank, honest story about how she got into the business. And that was very precious to me. She was so disarmingly frank and I had never seen that before among doctors. I left that session feeling that I really wanted to be worthy of her honesty. That was the only thing I wrote about in my journal after that session. Wondering whether she might feel she shouldn't have told me such a lot, particularly when I came out with this pretty superficial story. Wondering how we were going to feel the next time we met and hoping there was nothing about the way I reacted to her story that made her feel bad. For me, her honesty was very profound. She seemed to feel, "Look, we've got to get right at it here"! And thanks to her, I understood that more powerfully, and much more quickly, than normally I would have done.

So in the intervening week, before our next session, I was reflecting on how I was going to deal with this. I really wanted to let her know that I wanted to be worthy of her honesty and find a way to encourage her, and myself along with her, to be as frank as she had been in that first encounter. There was an odd feeling about it. Because of what she offered me in that first session, I remember hoping that she would be the person I would connect with the best in the group, and also a feeling of really wanting her to like me. That is a thing with me - wanting people to like me, and not often sure that I'm confident that they do. Maybe it goes all the way back to medical school – not being sure in that environment that I was accepted or liked for who I really am. Sometimes wondering how I might have been different if I'd felt that way. I don't know, perhaps it's a theme that goes more back to my roots.

So that was how I went to the second meeting. And what I learned was that there is enough structure in the process helping us all along that I didn't have to take on the agenda

myself of worrying about, or somehow fixing, my relationship with Vanessa. I think she would have understood how much I wanted to be worthy of her confidence, not because of an interpersonal thing that happened between us, but because we were in a group process that took us through that. It was really interesting for me to experience that.

This was the session when we discussed Branching Points. I've reflected on that quite a lot in my life up until now, so in that sense it wasn't new stuff and didn't hit me as a powerful theme. What was new for me, as I shared my reflections on the theme, was the realization about just how early in my life I got onto that road of achievement - the achievement/reward road. Achievement/reward is a very dominant theme in a doctor's life. If you want to be a doctor, you've got to figure it out in high school and after that it's all achievement and reward, there's no other thing. For me to realize that I had got on that road much earlier, that it has affected me since I was eight years old, was significant. It's a very stifling way to live your life – you lose yourself.

That insight tied in with the other metaphor that came up for me as I reflected on the theme. The image of a tree with two trunks. The career trunk that is very thick and full of branches and another more slender trunk that represents all the other important things and interests in my life. Medicine is very compelling, very absorbing, and certainly as a younger man I never stopped to question the long hours, being on call, being up at nights. That's just what you did as a doctor and it's pretty hard to compete with medicine for interest. For me, I have never, ever been bored as a doctor. I've never, not wanted to go to work. I've always relished the privilege of relationships with patients and the constant learning. And when you're doing clinical medicine and a patient is in a critical condition, there is that sense of commitment - knowing that you and the rest of the team will roll up your sleeves and be there, no matter how long it takes. It is a very rewarding experience to feel that you are an important part of a healing process.

So if, all of a sudden, your tree starts to get unbalanced, there are lots of reinforcements to that imbalance. But by the time you're in your fifties, and you're beginning to sense the stress in your relationships, and the gaps in your life, that's when you begin to say, "What happened? What about me?" And that's when you want the control to be inside yourself and not out there. I don't think doctors know how to do that very well. I think we are very slow at coming to that as doctors. Perhaps it's true of everyone as they get older, but I certainly heard this theme in our group and resonated with it.

I thought about it recently when I heard a story about a Zen master who was going to pour a cup of tea for one of his supplicants. He started to pour the tea, and just kept on pouring it into the cup until it ran all over the table. The supplicant asked, "What are you doing?" And the master replied, "I'm trying to teach you something. Your cup is so full I can't get anything into it. You've got to learn how to empty yourself." Doctors are just so full of agendas, and requirements, and expectations, and so on, that I think it is very hard to empty yourself. I found that to be a very

strong theme in our group: that whole question of how do you make the space, how do you make the time for yourself.

That's what was so incredible about this process. I was the only person who missed a session and that's because I had to have surgery. Just think of that! I can't imagine a doctors' group being that faithful to a process. It was so oxymoronic I remember at the beginning. We were all bitching about time and all the logistics around time. And yet the proof was in the pudding, we all showed up after a full day's work for what were some brutally long nights. That was the measure of the value of it as far as I'm concerned. And in the end, what we were really saying was this should go on, wishing it could go on always – knowing that it couldn't.

For myself, the Family of Origin theme was the least important. It was clear that some group members covered some significant ground in that session, so they may have something different to say. But for me, at my stage of life, there was a sense that my family of adulthood has become more important than my family of origin. I had the sense as I reflected on that theme that it was time to move on and not spend time dwelling on the past. A feeling of, "You're sixty years old, for God's sake. Get on with it!" So for me it was more important to think about the centrality of my wife in my life and the joy that our children have brought, and continue to bring, to our lives. To think about how, and who, I want to be in these relationships, in my family in the future. So as a theme, I think it's important to include it, but maybe it could be framed more generally - along the lines of what does family mean to you?

When we reflected on the career topic it was very helpful for me to be able to talk about my feelings of uncertainty and self-doubt. I sensed that a lot of us would want to work more on that - down to real individual issues and experiences of uncertainty. Perhaps in future groups it would be valuable to have a whole session focused on that. Uncertainty was a very definite theme in the group. It came up over and over again.

I always knew that I wanted to be a family physician. I was always drawn more to the art rather than the science of medicine. It's interesting that while both my son and my daughter have chosen medicine as a career, neither of them wants to be a GP. I think part of it is that they know what that has meant to me financially – not a very smart choice from a financial point of view! But the other part of the piece they recognize is the incredible difficulty and uncertainty. The talk among their colleagues is, "I don't want to do family practice. It's too hard! How can you ever know enough?" They find it very intimidating.

Of course, when you're a medical student, you don't yet have the understanding that you don't need to know all of it and you're not encouraged to talk about the uncertainty you may be feeling. So you spend the initial years just building up tremendous competence, in the hopes it will take away the anxiety in your soul. But by the time you're about forty, you can't keep running away from it. You know that in the end there's going to be something every day that will make your tummy twist a little. That's very hard to deal with.

It's not that uncertainty is just a medical thing. It's part of the human condition. Some of the recent theological writers I've been reading talk about the same stress of handling uncertainty in religions. When you can't handle uncertainty, you become fundamentalist. So, I find myself wondering if what happened in our group could happen within medicine at large? Could it happen in a broader spectrum? I think it's desperately important that it does. But did the fact that we could talk about this in our group have something to do with our relative age and experience? We weren't at the same stage that residents are at – we'd all had enough experience to know that there isn't a fundamental truth that we could appeal to.

One thing this session really helped me with was the odd feelings I was having about my changing role in the hospital. I used to be very involved in the hospital environment doing clinical work, teaching, mentoring residents, administration. When I started practice there were no emergency room doctors, so, as a family doctor, if your patient went to the emergency room they called you. So the hospital was a sort of natural venue for connecting with other family doctors and building strong, mutually respectful relationships among GPs and specialists that were very beneficial to patients. There were still walls there among us, but boy, they weren't nearly as high as they are now. Now, as a family physician you are quite frequently left out of the loop. I experience a significant loss of natural opportunities to connect with other family doctors and the sense of being, known, respected and included as a colleague by specialists has really diminished. Also, with the restrictions that are going on in health care nowadays, it's a lot more difficult to maneuver the system on behalf of your patients. Hospital work now, can be a sinkhole of energy, time and effort that leads to almost no satisfaction and not a great deal of benefit for your patient. For example, a few weeks ago I had an elderly patient who was in urinary retention and I was afraid he might have a spinal cord tumor. So I phoned the Emergency Room and sent all his documentation through on the computer. I hadn't heard anything by the next day, so I phoned, but didn't get a call back. I was down at the hospital that evening so thought I would go and visit him and see how he was doing. He wasn't there - he'd been sent home! Nobody had thought to call me, as his family doctor, to say, "This is what we've done and we've discharged him." It's really frustrating when that happens. As a GP you are holding the responsibility for supporting and monitoring your patients and trying to help them with the complexities of their life worlds, and then you get left out of the loop.

In terms of trying to set some manageable boundaries for myself, I'd pretty much decided that I needed to confine hospital work to offering support and a caring relationship to my patients. But I was feeling uncertain about this decision and questioning whether I should somehow be pushing myself, trying to find ways to be more involved, even though it felt impossible. It was important to me to be able to talk about my unease and very, very helpful to get feedback from others in the group and to hear about their experiences. Basically what they said was, "Times have changed; get over it; you've just got to realize it's different now; feel OK about it."

I'm aware that there wasn't a lot of critical feedback in our group and perhaps that would be a further stage of the process if we stayed working together for a longer time period. If people had said, "Eric, we don't agree with your decision. You really should try to find more time to be involved in the hospital." I would have taken that seriously. But as it was, even people like Ray and Kate and Chantal, who are highly involved in the hospital world and the academic world, were saying that apart from the sense of teamwork that exists in the case room if you are involved in obstetrics, it's logistically impossible for GPs who aren't hospitalists to be involved in the same way we used to be. That was an important reality check for me.

I don't know that we resolved a lot. But simply being able to talk about feelings of uncertainty in the group was very important because those thoughts and feelings are almost never shared among colleagues. For me, just understanding that these people for whom I had a great deal of respect, these five highly effective doctors, were experiencing the same feelings I was having left me with a sense of reassurance. A sense that I can go back out there and work away and know that I'm not losing it. The feelings I have are normal - they go with the territory.

As our group process grew along, I began to realize that doctors are really quite wonderful. That's what I was seeing - that behind these medical, collegial walls are amazing, effective, committed, caring people. And the tragedy is that somehow, someone doesn't open up those walls like we were able to do in the group -- it should be generalizable.

I think the most important theme was the one I missed, the session on stress, distress and bearing witness to other people's suffering in our work. I couldn't be there because I was in surgery that day following the accident I'd had. But I heard enough about the session to understand how strongly the sharing on that theme had affected the group. I could see the profound effect of being able to talk about distressful events and the impact we experience as doctors when things go wrong. By the end of the group, that's the theme that seemed to stand out as particularly significant and that a number of us were suggesting warranted more time -- maybe having at least a couple of sessions to talk about it.

It got me thinking about the possibility of having critical incident rounds in the future if people had enough of the kind of experience that we had. Right now, if a critical incident happens, there really isn't a safe place or a process in place to deal with it, to debrief it. Sure, we had morbidity and mortality rounds at the hospital to discuss what went wrong in a particular situation, but the trouble with those is they were just factual. When you saw the errors and omissions that had been made, you were supposed to able to dispassionately react to those facts and take away what you needed to take away. But the missing piece was, "How does everybody feel about this?" So the main result of those rounds was that everybody just went away internalizing the angst and distress and thinking, "Oh shit, I hope that doesn't happen to me. I'd better not do that!"

I was imagining the possibility of being able to bring people together and say, "Lets talk about this critical event. This is where you can talk about how you feel when things go south." For it to work well, I think it would have to come from an experience like we've had: An experience that would allow people to realize that you can trust, that it won't all blow up in your faces. It would be valuable if those kinds of meetings had an interdisciplinary flavour, too – not just medical rounds, but bigger groups that involved nursing as well. That should be able to happen if things became more sophisticated and more open to sharing at a deeper level.

Palliative care has shown some important leadership in honouring patients that have died and the relationships you had with them as caregivers. Academic medicine, on the other hand, takes people's names away under the rubrics of confidentiality and anonymity. As far as I'm concerned, if you take someone's name away, you take them away! It would be like saying, "John Smith had this, and this went wrong. How could we have done better by John? How do we feel about what happened to John?" That's very different than saying, "What went wrong? Who screwed up? What fact was missing?" It is such an unfortunate delusion to say that if you name the patient and talk about your feelings, you identify with the loss too much and can't keep it arm's length. Are you kidding! You can't keep it at arm's length anyway! I think a better way would be to describe the relationship without having to deny it, and to understand the relationship enough that it has some professional balance. That, I believe, engages a better professional behaviour.

It was ironic that just before the session when we were going to talk about critical incidents I had an accident and had to go to Emergency. Then I ended up having a six-hour surgery the next day and couldn't be at the group meeting. The whole experience of going through the surgery and the after-care has led to some interesting reflections and insights.

Recently, I've been reading a book that talks about experiencing faith not just as a mental activity such as 'belief', but in a more holistic, embodied, experiential way. That is what I felt through the care I received in Emergency and in being prepared for surgery. An embodied experience of faith in the people who were there and the system that is in place when there is a critical need for care. At a point when I was feeling vulnerable, I witnessed this team of professionals offering their best to help me - each one of them bringing their special and unique gifts together to bear on the problem. It wasn't because I was a doctor that I was being treated in some kind of special way, but rather a sense that anyone in need would have received the same level of exceptional care. So, for me, there was a deeply felt sense of faith in the human goodness and dedication of these professionals and a feeling of deep gratitude for the health care system we have in this country. We can all see and talk about difficulties in the system, but it is such a privilege to have it there when we really need it.

The career theme also led me to reflecting a lot on the challenge of being a GP. The point is that if you're a relationship person, if the things that really intrigue you are relationship

issues rather than factual issues, you're apt to be drawn to family practice. But it can be a double-edged sword: You get yourself into a specialty that is high on relationships but you're always worried about your lack of factual knowledge because your scope of practice is so broad. And if what drives you to some extent is a need to be liked, to have patients like what you do for them, then it can take a lot more energy out of you. I know that needing to be liked is a theme in my own life, but I also think it's probably something that drives a lot of family physicians. It is part of the nature of general practice to put more energy into fostering a relationship with our patients. I've really become aware of this for myself in the last weeks when I've been seeing a number of specialists to follow up on my surgery. It's almost like there is no relationship there at all – and I'm a colleague of theirs! I probably get to spend two or three minutes with them.

The first time I followed up after the surgery, I wanted to discuss the issue of how soon I could go back to work. The specialist wanted me to take two months off. I was feeling bad because I work one day a week at a clinic where there is really no one who can replace me, so I wanted to see if there was some way of negotiating the time frame, because he hadn't really explained why he wanted me to be off work for so long. Basically, all he said to me when I raised the topic was, "Well, I guess you'll have to decide what's good for you. Why don't you go and talk to your GP about it." Talk about a cop out. As soon as I put a human issue in front of him, he just backed away and said go talk to your GP!

My sense is that many specialists don't let themselves even get close to the feelings and tensions that GPs experience around relationships with patients. They go into scenarios based on the strength of their factual knowledge and what they can do. The whole issue of whether people like you or not, or feel they have a relationship with you, isn't part of the equation for them.

We talked a lot in the group about the importance of relationships with patients and all the complexities that go along with that. Just as this group process really brought home to me the concept and importance of having 'doctor-friends', it has led me to explore and understand more the concept of a 'patient-friend'. It's never good to look after your friends as patients - those boundaries are fairly clear. But maybe what we are seeking to understand is what does a 'patient-friend' mean: A relationship that is defined and circumscribed and has certain professional boundaries; yet at the same time acknowledges that there is a depth, an authenticity, to the relationship. So that when you feel really terrible about one of your patients getting a very serious diagnosis, you know that the distress you are feeling is OK. It's a fact! It's a reality! You're not losing your perspective as a physician – it's simply the truth of a doctor responding to a patient-friend.

Just the other week, I got some results back on a patient that really rocked me. He's an older man who has a number of health problems and he was really looking forward to getting surgery to have a colostomy reversed. Some of his test results were a little out of line, so I persuaded him that he had to see a specialist and get more tests done before the surgery. He

was pretty annoyed with me for delaying the operation, but we have a good enough relationship between us that he agreed to alter his plans for the medical betterment. Now these investigations have come up with a diagnosis that just totally blows the lid off of everything. It's a damned good thing he didn't go ahead and have major surgery, but my first reaction was just, "Oh no, shit. That's all he needs!" I've had other patients who have died from a similar diagnosis - it's no fun. And so now the real question is, how can I be the patient-friend? How can I help him through this and be of service to him? What's the prognosis? What's my first statement to him going to be? There's no way that I can be dispassionate about issues like that. And the appointment that I'll have with Jack to begin talking over all these things, will be just one of many on that day. The next person might be someone who is pissed off, because now I'm running late and all they want is acne cream.

I think that is sometimes why we can get a little worn down as family doctors. Each one of those appointments in a day is an encounter with a patient, and we can talk about the problems associated with the length of visits, but from my experience an encounter with a patient won't end until they've experienced what I call a relational event. They won't be ready to get up and leave until I figure out what they are looking for and fill that relational need. When you've been working with a patient for a while you have an intuition about what they want, or need, so it isn't as hard to do. And by their very presence, some really experienced GPs bring a relationship into the room. But when you are first starting out in practice, or when you are working with a new patient, it is fascinating to see how you can cast your fishing line to discover that relational need.

One thing I think I know about myself is that if I couldn't have those patient-friend relationships, then I wouldn't do medicine. That is one of the main reasons that I returned to family practice after a five-year break working in a specialty clinic where I could only see people for a prescribed number of weeks. What was really interesting, when I went back to family practice, was to reconnect with some of my former patients. It wasn't the patients who were more dependent on me who came back, because they needed quite quickly to find someone else to rely on. It was the people for whom I had been really effective. It was a great pleasure to realize that whatever it was that I did, or was doing, for some people was really right. Sometimes, as a doctor, you've got no way of knowing that. That is part of why this group was valuable. Somehow, as doctors, we need to be able to tap into that – the feeling that what you are offering is valuable and valued.

I was surprised that the shortest session was the time when we looked at the theme about meaning in life. It wasn't because we weren't creative people, I had quite the opposite opinion, but it was as if all of a sudden we didn't know what we were going to say about that theme. I think if you'd met with any of us at age twenty, we'd have had a lot more to say about the meaning of life - maybe we've put that on hold. I'm not sure why it was such a hard theme. I have reflected on things like that a fair amount and it wasn't that you had to come up with the right

answer to the meaning of life. Maybe it is hard to talk about because it's a question that has a dark side as well as a bright side, and to really understand it and explore it, you'd have to have longer than a week and you'd have to address the dark side.

What was so significant for me as a result of this group process was the awareness of the importance of having what I conceptualized as 'doctor-friends'. Not simply colleagues - but doctor-friends. People who understand your world and your work and who are supportive -- who you can risk being real with. I would say without doubt that this group has been the best thing that I've been involved with on a personal-professional level. In seven weeks we built a community of doctor-friends in a way that was safe, and worked, and had some parameters around it -- and there was a reality there. It was possible again for me to be a colleague in a way that allowed me some vulnerability and safety. That's a big accomplishment.

It's nice to tell your stories and to reflect on your life, and all of that is there in the process. But the most important thing, the most profound thing for me, is finding some doctor-friends again and being able to connect with them on a real level. To think that there are five other doctors in this town that I can now connect with in a real way. I didn't know them before the group, I don't know them as friends, and we don't socialize together. But I now know them as doctor-friends. It's not that I wouldn't love for these people to be my friends, to be able to move from our experience in the group to friendship, but I know things don't generally work like that.

If the word got out in the medical community that you can go to these groups, and it feels really good to be there, and all of a sudden there's more people you know and can connect with in a real way - if that word got around, it would be very transformative. It would be a wonderful outcome of this process -- very healing to a professional.

A key thing for me in this process was the intense respect that I was able to feel for the other physicians in the group. Feeling that respect, and then coming to the understanding that mutual respect recursively requires self-respect. What came out of it for me was a whole new sense of my worth as a physician. And that, almost immediately, had a material effect in my professional life. The affirmation I experienced wasn't just a group of nice friends saying, "Oh, you're great." People can do that, but they don't really know. Here, in this group, I was immersed in a seriously, reality-based, mutual learning process that caused me to see what I respected in others, and then to recognize that in myself. So instead of being so desperate to please patients, I was able to say, you know, I'm pretty good at what I do, so let's start with that. Let's start with, "This who I am and I'm willing to give you what I've got. And it's pretty valuable. So if you had to wait ten minutes for it, I guess that's the way the world is for you today." That has been very important for me. If I had to say one main thing that I'm taking forward from this group it would be that -- this new feeling of self-respect and self-worth as a physician.

Feedback on structure, facilitation, and future directions

I believe that people took the risk to be real because of the process. The facilitation was incredibly important. Also having the ground rules, the structure, and the understanding that they were in place, made it work. The length of time was important and so was the size of the group: Having six people allowed for a rich diversity of experiences and perspectives, but if there had been more, it would've been hard to have enough time to hear the stories or to pay enough attention to the uniqueness of each story. As I said earlier, the theme that was the least important for me personally was family of origin. But I think they were all important, so can't imagine what could be left out.

It was good that there were two of you leading the group. Logistically that might not always be able to happen in the future, but I think having two leaders gave a sense that there was more control of the situation. The group is far less apt to hijack two leaders, than one leader. Having leaders who obviously had professional training in facilitating groups was, I think, essential to the safety of the group. Daniel's combined medical background and counselling background gave him a profound kind of qualification. But I don't think it was Daniel as a doctor that made it possible for him to do what he did in the group. It was his counselling training and group facilitation skills rather than his identification with us that was the most valuable. One of the big mistakes that is often made in medicine is that doctors think they can do everything. So I would worry about a situation where this whole program would begin to be done by well-meaning doctors who weren't necessarily trained in counselling and facilitation. That would be a concern for me because I could see this derailing because there wouldn't be appropriate attention to the process and to maintaining safety in the group. Doctors who wanted to lead groups like this would need to have an additional qualification, like Daniel has.

I don't think it made any difference that you were in the group as a participating researcher and a non-doctor. If anything, there was actually a positive impact to having a non-doctor person in the leadership because I think you were able to not identify with some of the things that got our guts going. I don't think someone could just come out of a PhD Counselling Psychology program and facilitate a group like this. I could see you facilitating a group like this very effectively because you have enough of a sense of our culture to function within it without having to ask for a lot of clarification. That credibility and understanding of our circumstances as medical professionals is very important. I think if a leader had to ask for a lot of clarification, there would be a question of credibility. The other thing I think might happen, if people didn't have enough understanding of the culture, is that they could really overestimate some of the stresses of the profession - things that doctors don't necessarily experience as stressful.

I guess partly why I think the process has enormous potential is because it allowed us to do directly what we've only been able to do secondarily until now. I've belonged to a Practice-Based Learning (PBL) group for a good number of years. As part of the continuing medical

education system, the Mc Master group sends out some very authoritative curriculum materials and you get together once a month as a group of doctors to discuss them. It's a very valuable way of enhancing your knowledge base and connecting with other doctors. What most of us in PBL groups experience is that when we get to together there's a real yearning to talk about our experiences as doctors – what is going on for us in practice. So in the first few sessions, we tend to push the syllabus to one side. The problem is though, that this sharing is not named as a legitimate part of the agenda. So while the chance to connect on a more personal level is valuable, there's both a sense of guilt about taking time away from the syllabus, and the sharing is sort of ad hoc. It lacks direction and there isn't a facilitator guiding it, so after a while it sort of wears out and you tend to focus more on curriculum.

This process was different because of the structure, the confidentiality, and the facilitation. It allowed us to create safe, protected space and time for sharing at a deeper level. You didn't have to suspend sharing with colleagues like you have to in a dinner party, or a game of golf, or even in a PBL group – you could just get right at it, and that was powerful. Obviously the people in this group were dead keen to be involved, which is why they volunteered. That probably wouldn't be the majority of people who could benefit greatly by this kind of process. I think you could float the idea of this kind of group in family practice and get another six people in a snap. But I think it would be valuable to generalize it further, to see how it could happen in medicine at large, which may be more difficult. It would be important to think about how the group is offered. That's where I think it would be helpful to have testimonials from physicians like ourselves, because I think that if any one of us had known what the outcome might be, we would have been even more enthusiastic about participation.

It would be really important to make clear to other groups what the experience of preceding groups has been. To have physicians who would reassure people that it is safe, describe the process and be able to say, "This is not some kind of T group. This is a professional development program that has been extremely valuable. But it is on a personal level. It isn't about learning how to do some particular medical procedure better. This is about your own personal and professional development."

I think there is an incredible place for a whole range of groups like this to meet various needs. One thing that I think would be a valuable permutation would be to have a group like this for late career physicians – physicians sixty to sixty-five and beyond. To be able to look at what do doctors approaching retirement do. How do you find the meaning, the safety, the credibility, and the spirit to live through the pre-retirement years of practice? In Britain, they are bringing older doctors out of retirement and offering them refresher courses so that they can fill the shortage of doctors in that country. I don't know that we will be in that situation in Canada. But for the next ten years at least, there certainly isn't going to be any incentive to have doctors retire early because we're short of doctors. So at that later stage in our careers, when research shows

that our experiential knowledge is very strong but our factual knowledge is not as good as younger doctors, how do we reassure ourselves that we are still OK? There is no mechanism for that. The College of Physicians will probably make us write a test. I suppose it's is one way of reassuring themselves that we're all right, but it's kind of a useless exercise. I think it could be really interesting to have a group where as older doctors you could exchange ideas and compare notes and be able to experience that feeling of mutual respect and look at how we honour our experience and take confidence from that.

I realize this group was part of a research project but I hope there is an implementation plan - a plan to offer other groups like this. I would hate to think that this research gets kind of lost out there in the ether. I don't know what the plans are, but I hope this kind of process grows like Topsy.

Robin's Story

I'm not really sure why I decided to ask for a position in the group. My interest was sparked by the presentation at Family Practice rounds. Quite apart from any personal reasons, I've always enjoyed hearing Daniel talk. I thought that if he felt that this would be useful professionally, that indeed he probably was very right and I'd like to learn more about it. I also thought that it would be interesting for me to take some time for personal reflection because the combination of family life and family practice work is so busy that there hasn't been much space for that in my life. Things come up in the moment but you tend to put them aside because you need to push on with all the things you have to do. I had a sense of somehow living vicariously through the experiences and feelings of my patients and children, and not really pausing or having the time to reflect on my own feelings. So although I didn't know a lot about what the process would be like, and was initially concerned about whether I could do justice to the time commitment involved, I felt that at this point in my life it would be very interesting to take some time for reflection.

I really resonated with what one of the other group members talked about. He pointed out that when issues come up - in terms of personal issues or feelings that you have in interacting with your patients - you are always conscious that there are other people out in the waiting room. So you have to tie up as best you can what is happening between the two of you, or how you are responding to what they are telling you, and frame it as, "This is what we are going to do. This is what the plan is. This is when I will see you next." Then, when that patient leaves you have to sort of say, "Okay that's done with, put it on the back burner," so that you can get on to being attentive to the next person's problems. So you never actually have the time to really reflect on, or deal with, your own feelings - you just put them to one side and carry on. I think we get very good at doing that as family doctors and we probably do that a lot in terms of our personal life as well. And eventually that is not very healthy.

I think that having the time to reflect and talk about things is something that is very necessary for professional as well as personal health. Since the group I've been thinking about how one could incorporate the kind of experience we've had into training. To use it as a way to teach physicians how to wrestle with some of the difficult issues that come up - to give them the time and space to wrestle with those things. At what stage in one's career does one start insisting on this? Should it be inserted at medical school level, or in residency training? Or do you need to have a little more experience in terms of dealing with patients before you see the value of this kind of process and are therefore able to use the time most efficiently? I'm not sure what the answers are to those questions but for myself, I know that all of the things I was looking for have been positively reinforced by the group experience. I can't think of any negative things that I experienced by virtue of going through this process. I think my only thought is, this is wonderful and it should be made readily available for all of us in whatever stage of our career we are in.

The great thing that seems to be the most limiting is just time and I think that is the limiting thing for just about everything in our lives. Most people who go into medicine have, like me, been able to enjoy very full professional lives and to not feel that you're missing out on the other things that you do besides medicine, or that life is passing you by, it simply means that you just continue to be fairly busy, all the time. In this life review process, having a specific time where it was your job to sit down and reflect was invaluable. To have a time where you knew that you were going to sit down and just think about what you were doing and incorporate that into your daily life, or certainly into your weekly life, was so valuable when most of the time you are running really hard just to do what you are doing.

In thinking about my experience in the group, it helped me to go through the journal I'd kept. To look at it chronologically in terms of how each theme was addressed, what I had heard from other people, and then recall how that information, or the feelings that were brought up for me, were dealt with in my everyday life. We'd planned a family vacation at Spring Break, so I took my journal with me on holiday and spent some time reading through it on the beach!

I was so impressed when Vanessa brought one of her old journals into one of our sessions. I recognized the hard cover book that she had written it in. It was the kind we used at University to do our chemistry and physics labs. - I knew where that book came from! When she opened it up and began to read from it, here was Vanessa in her late teens or early twenties. What an amazing treasure to have – to look back on yourself that far to university days, and in some ways regain or recall your old self. Even now, when I go back to reading what I was writing in early January, it's sort of a different me than is here today.

I was surprised when we had the first session because there were people in the group who I have known for a long time - not really well, or socially, but people that I know on a professional basis and have a great deal of respect for. Three of us are in the same call group, so most of our conversations would revolve around exchanging information about patients that we would be covering for, or patients whom we had covered for. I'd also met two of the other participants when they were residents and was very impressed with how I saw them functioning at that time. So although I didn't really know them, I assumed that they would have vibrant, really interesting practices. In that situation, I thought this will be interesting. I didn't know whether the fact that we already had professional relationships outside of the group was going to keep us more circumspect in terms of the kind of personal information that we felt free to discuss, or whether it was going to be something that we could, in fact, build on.

My experience was that being in the group together definitely expanded the relationships in a very positive fashion and I am so glad to know those people on a more personal level. Beyond that introductory session, coming to the subsequent meetings was something I really looked forward to.

One of the things that struck me in the very first session was when we paired off and were listening to each other tell a story – just being asked to use our listening skills and not having to record the stories. The listening skills that I use professionally involve having to remember the salient details and write those down. Legally, I need to have a written record. Not necessarily of what was said, but the information that I gained from the patient and what I chose to do about it. I always have to be writing things down. The sheer luxury of being able just to listen to someone for the sake of listening to the stories was wonderful. Knowing I wasn't going to be quizzed on it, or have to have it in writing. That if, five years from now, some court asks me about what was said, I don't have to have it written down for posterity's sake.

The chance to tell a story, and not be interrupted, was a pleasure for me. My family claims that I talk too much and have a very circuitous way of getting to the point. So sometimes, when we are in a group that includes people other than the family, they will send me surreptitious hand signals to tell me to wind up or get to the point faster! Also, my work involves listening to other people for most of the day, so I am sure I took full advantage of the opportunity just to let my thoughts flow. At the same time, it was reassuring to know that there was someone keeping track of equal time for everybody. Knowing that someone else would look after that for me was quite a treat. I didn't have to take responsibility for watching the time or worry about, "'Oh, is this too much? Am I coming to the end? Should I wind up now?" I could just keep talking and know that Daniel would tell me when it was close to the time to stop. That system worked really well for me.

The Life Line exercise was quite a surprise for me in terms of the initial anxiety I felt when we were asked to move the X that marked our lives closer to death. I hadn't ever thought about my own life ending in the same way before, and it was a bit overwhelming initially. It brought home things that I should be doing. I became aware of the fact that I don't have any sort of real memory of ever having made a life plan. Things came easily for me and one thing just flowed to another - you go to High School and then, of course, you go onto University like your parents did - so there was never any big decision making that I ever had to do when I was younger. Then I started to realize that maybe not making a plan is a way of ensuring that you won't ever be disappointed that you didn't complete the plan! And that might be sort of a way out of not using your gifts as well as you should.

I began to reflect that maybe a time has come in my life where I would feel more drawn to making a plan. A realization that life is short, my life is more than half over. There are things that are undone and that I want to do – things that I could maybe do better with a plan in mind. I have time, and I have health, and I have support, and all of those things, and I should have a plan so all of that can be utilized efficiently.

When it came to describing the major branching points in our lives and then, even more so, when it came to describing our family, I wasn't quite sure how open to be about that. There

were a lot of issues that I knew I hadn't dealt with. I didn't know if I wanted to lay this bare to the group when I didn't have a plan to offer that would sort of say, "Don't worry about me. I am OK dealing with this. I will get on with it later." I didn't want to burden the individuals in the group with my family issues. I think initially I also had some fear of being misunderstood. I was worried that people might think that things were worse than they were, that I was more distressed than I really was.

I wasn't ever the first speaker in those initial sessions and hearing how open everybody else was made it a lot easier to say, "This is where my family is. These are where my branching points were. These are the things that were stressful for me." Because every other person in the group was very open about the things they discussed, it made me feel much more comfortable discussing those things too.

Quite apart from any sharing in the group, I found the exercise of reflecting on the family theme quite helpful. Just sort of saying, "OK. This is the family I come from," and using the thoughtful questions in the handout to help frame what I was looking at. Things such as: Where did you or how did you learn to express joy or spontaneity? Where did that come from in your family of origin and where does it come from now? I came to recognize how I still very much respond as the child in my family of origin and how my parenting has reflected a lot of what had come before. Actually that surprised me. To actually sit down and think about it, and to recognize, as the days go by, how the relationships I experienced in my family of origin are mirrored in my interactions with my daughter, or in the interactions with my son, or in the interactions with my husband.

I started to be aware that I may not have as much control over how I am, in those interactions, as I would have assumed. And if I don't have total control over it, then maybe I don't need to feel as guilty as I do if I've exploded at the wrong time, or if I haven't sort of stepped up to the mark and been very, very supportive when somebody else is feeling unwell. Realizing that in my family of origin, I may not have experienced being supported in that way and that, at times, I may not have had the energy to be able to be incredibly supportive - and maybe that's all right. So I feel a little more forgiving of myself, and it's also allowed me to be a little more forgiving of my parents, in terms of some of the things I would have wished they had done differently. When Kate was describing her family situation, I was particularly struck by the forgiveness that she had already granted everybody. I was thinking, this is so honourable, and to be able to do that, if I could do that, it would soften things compared to the way I have dealt with my family, with ongoing family situations in my family of origin, up until now.

I found the sequence of the themes and the way that they built on each other was just right. With branching points, we could sort of test the waters, decide how comfortable we felt and how much we wanted to share. Then as the comfort level grew, we could approach topics that were more intense. So that by the time we came to the session of talking about stress and

distress, it was so much easier for me to talk about the things that really were difficult for me. It was a time where all of us were feeling so well supported that we could bring up those very difficult issues and try to describe them as best we could, when we probably hadn't really ever done that before. Certainly I hadn't really looked at them carefully. They were such very sore issues that they had to be put on the back burner in order to get on with life and what I had to do day by day. I felt sorry that Eric couldn't be at that session and didn't have the chance to do that too and have the rest of us there to support him. It was valuable to be able to connect with him at the end of the next session and spend some time together talking about stress and distress and my experience in speaking to that theme.

Up until that point in the group, I had been chatting to my husband about the various things I was thinking about as they came up. Not about everything of course, or who was in the group or anything that had been said. But he would always ask how it went when I came home. I'd tell him that useful things had happened; that I didn't want to discuss any of the details because a lot of what went on was confidential; that he wouldn't really understand what happened unless he heard the stories and I couldn't share those with him. But I'd tell him it was very moving, and I feel tired by this, or I feel exhilarated by what I heard. He was really good about just letting it rest at that and not probing in any way. My husband also works in health care and I think he would really benefit from being in a group situation like ours. So I'd said to him, "If an opportunity comes up later on, I really strongly encourage you to do this."

At the time when I was preparing what I was going to discuss about stresses and distresses he wasn't physically absent but he was incredibly busy at work. He was leaving early in the morning, I was leaving early in the morning, he was coming home at 2 and 3 AM and I was sound asleep. So that there was just no time for anything other than brief instructional conversations - "Have you eaten today? Where will you be tomorrow? Do you know this is happening on the weekend?" So I didn't have a chance to say that I was planning to talk about this particular issue. He'd really been the only person I could talk to while the court case was going on and I was in frequent meetings with the lawyers and the Association. It would have been nice to be able to talk to him about it and let him know that I was going to talk about how I felt about these events in the group. Another situation that I'd planned to talk about during that session, which we just didn't have time for, was the death of a baby to a strep infection. It was also sort of my alternate. Something I would share if, in fact, I didn't decide to talk about the court case.

When I was speaking about the situation in the group it quite took me by surprise that I was as tearful as I was about the interaction with the patient and the court case. While it was happening, I only remember trying to think what could I possibly do to avoid this ever happening again. I was so horrified that my patient was dying and that some years before I had missed giving her the results of a screening test for several months because they were misfiled. When

she was in palliative care, I wanted to visit her and be able talk to her and say goodbye – she had been a patient of mine for many, many years. But even though the trial was over and I'd been completely exonerated by the court, the lawyers advised that I must not try to contact her or visit her. So when all that came up, it just completely took me by surprise – to realize the depth of my emotions and just how much grief and sorrow was still there. And I hadn't recognized until then that there was also an element of anger. A sense of thinking, "How could you misplace the fact that I did not want this to happen? That I feel very apologetic. That I feel it was my error that this has happened to you, and you don't seem to be hearing my apologies."

I'm aware that I sometimes have a sense of tension and discomfort in my throat. I've always assumed it was a lymph node swelling and that I have a tendency to that. I used to associate it with going through a rough time, being tired, not sleeping well, probably fighting a virus. Now I know that it happens when I'm trying to suppress crying. After the session, I started thinking, now this is a really familiar sensation, this sense of tenderness in my neck. I realized there's no other cause for this discomfort. It has to do with tightening these muscles in my neck, which I do as a way of choking back my tears. And I probably do it often, more often than I know. That was quite an interesting revelation.

One of the things that occurred specifically after talking about the distress of the relationship with my patient was Daniel giving me the suggestion of writing something to her. He said that it was my right to be able to address her and say what I needed and wanted to say to her before she died – to be allowed to express the loss and grief that I still felt about this situation. Writing a letter was a technique that I wouldn't have guessed at and it was really very useful. I actually sat down the next evening and I wrote the letter and then I revised it sometime on the weekend before our next session. It was a cathartic experience, a feeling of release. Writing the letter to her brought me a sense of closure – it was such a gift.

In the next few days at the office I realized just how useful it had been to go back to that issue and talk about it in terms of teasing out how it has impacted my life. I hadn't realized the extent to which it continues to be a daily issue for me every time I look at test results. I had left the session feeling very supported, very thankful of being able to talk about the issue, and somehow feeling lighter for doing that. The responses from each of the people in the group were only supportive. What I came to in the following days was the feeling that I was allowed to be human. I had made an error and finally I had a sense of reprieve - a sense that I could begin to forgive myself for being human. So it was very cathartic week for me.

On the Monday following that session Daniel phoned me to see how I was doing. It was a rushed day and I had just been grocery shopping or something like that when I grabbed the phone. After our conversation I just felt so looked after. It was just an amazing feeling and I can't ever remember having that happen before. Daniel wanted to check in with me because he was worried that the issue about time constraints had come up at the end of the session. He wanted

to be sure that I hadn't in any way left the meeting questioning whether I should have taken the time needed to talk about such an emotionally significant issue in the group. And indeed, I hadn't even thought about that. I was so absorbed in my own reflections and response to speaking about it that I hadn't even thought about keeping to a 15 minute time limit for speaking and that kind of thing. Daniel's call was a total surprise. If he hadn't called, I wouldn't have felt uncomfortable about going back to the group and discussing the issue again, because I had felt so supported by everyone. His telephone call was just icing on the cake in terms of that sense of support and a chance for me to tell him that it had been such a useful session for me.

When we had our last session it was an interesting time for me. The weekend before that session we had taken our family pet of 11 years for his annual haircut. He hated being groomed so we would let his hair grow really long over the winter and in the springtime take him to be clipped. When they clipped off the hair he was absolutely emaciated - skin and bones. It became obvious that his gradual slowing down was not because of age but because he had a cancer. We took him to the vet on the Monday and the vet told us he had a testicular cancer and we could give him more comfortable months to years of life if we simply had it removed, because these kind of cancers are only locally invasive and once you remove them you don't have cancer anymore, and everything is fine. So we left him at the vet and they were going to do all of the preparatory things like chest x-ray and the blood work – the same things they do for people - and plan a time for the surgery. On doing the chest x-ray they found that he had metastasized all the way through his chest, that this wasn't a typical kind of cancer, that indeed there was nothing to do other than giving him pain relievers. They didn't think he would even survive surgery. So of course, the family was completely floored by this.

We decided to do what the vet suggested - put him on some medications to keep him comfortable and have some time to make the kind of decision that it was obvious we would have to make eventually, the decision that he would have to be euthanized. We brought him home, thinking that he had been up and going for short jogs with my husband three days before this, and that if we could control his pain, that he could still have a fairly comfortable life, and we could sort of get used to this idea. On the pain medications he was stoned, and wobbly, and absolutely miserable, and once the pain medications wore off he was obviously in pain. We kept him home for two days and then made the decision that we were keeping him in this condition for us, not for him.

On the Wednesday when we had our last session, we had made the decision as a family that the next day we would go and take him to the vet and put him down. It was interesting being at that session because I was actually far more comfortable going to the group than going straight home and having to shelter all my family's feelings about what was going to have to be done. I felt a sense of strength in being with the group. I felt that I could come home after that and deal with this sad situation, because I knew that there was that support there. It was an interesting

thing to think that out of six sessions that we'd had up to then, I already had a real sense of strength from being with this group.

So indeed, the next day, our pet was put down. It was the right decision and everybody in the family was sort of able to work through the sadness. That was the day that I stopped writing in the journal. Up to that point in time I'd found that keeping a personal journal was a very useful skill. It allowed me to be able to sort of frame things and put them in boxes. Then I could either elaborate on the box at another time, or leave it in the box and say, "Well I don't quite have the energies to deal with this just now, but it will be here. It's in writing. I can bring it out. And when I do have the strength, I'll deal with that again." The journaling is a skill that I've come to use just since joining the group, it's not something I did before. I've found it very helpful as a way to acknowledge and express my feelings and somehow, in doing that, in taking the time to reflect on what is going on for me, feel a sense of resolution. But since the day we lost our dog, I haven't been able to write anything down and I am not really sure why.

At this very same time, another patient was dying at the age of 92. She had been a patient of mine for 18 years and I had a great deal of admiration and affection for her. She was a retired physician from Eastern Europe who had lived through some amazingly difficult life experiences. She certainly taught me an awful lot more than the physician skills that I offered her, and in some ways, I saw her as a kind of role model. She was hospitalized on the day we were meeting to talk about the meaning in life theme and she elected to have all therapy withheld. She felt that she had led a full life and was ready to let go given the various health problems that she had, and knowing what was involved. So at the same time as I was trying to make decisions as to when we would euthanize our dog, she was making these decisions that she was not going to have her life prolonged. She was just going to let Mother Nature do what Mother Nature was intended to do, and she had led a good life. It was an interesting contrast to experience.

Seeing her go through this, and talking to her about it, and trying to act as her advocate to the cardiologist who admitted her, and trying to acknowledge her wishes, was a struggle. I wanted to recognize her desire to die peacefully and naturally even though I, and other people around her, didn't want to lose her from our lives. Only in the last two days would she accept seeing the palliative care physicians and accept any pain medications because she didn't want to be foggy. All I could offer was care and support and try to talk her into things to make her more comfortable. Reassure her that the pain medication was not active treatment. That it would help keep her comfortable and it wouldn't have her feeling zoned out.

It was a coincidence that this was happening just as we had been addressing the meaning in life theme. In the two weeks before our final session, while I was caring for her, I reflected a lot on this patient's sense that she had led a rich and full life and had no regrets about preparing to die. Being with her as she was dying, and thinking about meaning in my own life,

made me very aware that this is what I would want for myself when it comes to the end of my life – a sense of not having regrets about things left undone.

I think dealing with those two situations of a patient I loved dying, and losing a dog I loved, was a lot to happen at that point in time. There have been frequent tears in the last weeks, and I think I'm becoming more comfortable with that now. So I am looking forward to getting back on track with the journaling and being able to put this in writing, because I think it is going to help me be able to deal with all of this in a really positive way. I am going to get back to where I start to write something every night before I go to sleep.

Taking the time to reflect and work through the various themes helped to focus my thoughts about feeling that I may have invested too much time in terms of living vicariously. To realize that being very involved in what my kids were doing in school and in their extracurricular activities, was probably as much for myself as it was for them. Now that they no longer need my involvement to the same degree, I have to be more honest with myself as to why I did the things I did when they were little and living at home. Now I'm going to have the luxury of more time when I don't have to be somewhere, and I need to be thoughtful in terms of what am I going to do with that. I'm a bit fearful of having my time gobbled up by the parts of work that I don't like, the paperwork and all that kind of thing. The paperwork can absorb a lot of time. I want something more substantial than being so busy that a sense of accomplishment, or feeling that I did manage to get something done, comes down to going into my office the next day and seeing that there isn't three feet of charts stacked on my desk - there's only one! I need to have a project, or something that I'm doing, that will fill the time positively. The group experience has given me the space to think about that, and given me a few more skills in terms of how to address it. To figure out what I'm going to do to gel an approach that will make me feel like I'm accomplishing something.

A very precious gift that I received from this group was feeling truly heard and understood. I was very impressed with how well-spoken people in the group were. I envy that. I would like to have the skills of being able to describe things as vividly as some of the others did. I realize that I have difficulty expressing myself orally, but when I spoke in the group, the way people reflected things back to me and the comments they made afterwards let me know that they really heard what I meant, even though I didn't say it well. I'm not sure whether that's because I was with other family physicians who are very good at reading between the lines, or whether it was because these are individuals who have lived through some very taxing experiences and therefore, were empathetic as well as sympathetic.

To speak to good listeners was a treat because in personal and social relationships I often feel that I'm talking without being really heard or understood. When I thought about that difference, I realized that maybe not feeling heard also has something to do with control – my own sense of needing to be, or feeling responsible for seeming to be, in control. In the group I felt

safe and was able to let go of that. I feel now that I can transfer this learning into my personal life, and that it will allow me to create other supportive relationships, closer relationships, in my life.

For me it's been a wonderful experience. It really has been fabulous and I hope that other people found that it was as beneficial as I did. I hope that I wasn't the only person in the group that found it was such a useful expenditure of time. It is so rare to have the opportunity to connect with other doctors in this way. Ray and Kate talked about the Practice-Based Learning group that they have belonged to over a good number of years, and it would be interesting to know how many sort of mutual support systems, in various less formal ways, have had to develop. I think it probably happens more frequently among younger physicians than it does in my generation of doctors. I personally belong to a group that has been meeting for ten years now. There are twelve of us, and we get together once a month with a topic in mind, and generally an expert is asked to come so that we can fire questions at the expert. Some sorts of other issues do, in fact, get discussed, but it is certainly nothing like the life review group. After ten years, I don't know any of these people personally, and I think that would be useful.

I suspect that most physicians are probably like the ones in my group. We lead very fiercely private, and pretty lonely, professional lives. The medical system has become so frantically busy that I can't remember the last time I ate in the hospital. I don't go to the cafeteria, ever. We don't have the doctor's coffee lounges any more. There used to be a time when you would be able to get together at early morning rounds and sit and have coffee before the guest speakers talked, or you would be taking a break at lunch and you'd meet up in the hospital. That just doesn't happen now with family physicians. You're physically not even close to each other. Generally our paths are leave home, go to the office, go to the hospital, come home. But in this instance the speed and the busyness of our jobs didn't interfere with us being in the group. We all wanted, and made, that time to connect with each other.

I have a sense that the deeper, more personal relationships that I built with Chantal and Vanessa in the group will probably be an ongoing source of support.
We are the senior members in our call group and it was Vanessa and Chantal's idea to coalesce this group so that younger women, who are just coming into general practice with an interest in obstetrics, would continue to do obstetrics if we could cushion them somewhat from the onerous call schedule. When we were having our kids we did all of our own calls - which meant that you were on call all the time. So Vanessa and Chantal felt that it was important to have a system in which you could have some weekends when you were absolutely off duty, and then every sixth weekend, you would be looking after everybody else's patients.

When you first start into practice, you feel obliged to be always available for deliveries because of the way the government pays us. You only get paid for looking after a woman through the nine months of her pregnancy when you deliver her baby. So potentially, you could be seeing somebody once a month up until their delivery, and if you weren't there to do the delivery of the

baby, you wouldn't be paid anything for all those visits. So the question of whether you will be available on the weekend, or not, comes down to the fact that you need to pay the rent on your office! And if your kids are doing something, or they are in a concert or something like that, well you just have to miss it. The system that Vanessa and Chantal worked out was that we would all agree that we would not do deliveries unless it was our weekend on call. That way, you would be paid for delivering somebody else's patient, knowing that the weekend when you are off and doing whatever with your family, someone else would be paid for delivering your patient. We did, in fact, keep fairly close accounts over the first two years because all of us were really edgy about whether there would be some financial equitability. And indeed, there was. Over a period of twelve months it does even out, and the number of deliveries that you miss, pretty much equals the number that you end up delivering. Now, at least, there is some break from being tied to a pager and the chance to have a personal life at the weekends and not have it interrupted. The other three women in our group are younger and they have found this system makes it a lot easier for them, in terms of handling their personal lives.

So before the group meetings, that level of professional support existed among Chantal and Vanessa and I. But indeed, I think that each of us probably feel far more comfortable talking about other things now, or about making time to see each other.

Feedback on structure, facilitation, and future directions.

In terms of feedback and trying to make suggestions for what I would want to change or what I would have wanted to avoid, I'm really hard pressed to say anything. The only thing I came up with is, that should you be canvassing for another group, that it might be useful to have some personal testimonials from us. Just saying how this process was valuable to us, and to be able to reassure others that your confidentialities are not only respected, but also protected. To be able to tell other doctors that reflecting back on what is happening to you personally, is a great asset to have professionally. That this process isn't just to keep you going in times when family practice is getting increasingly rougher, that this is something to your advantage personally. I think it would be very useful for other doctors to hear about our experiences in this group.

I think the size of the group was excellent. It worked well. Having six people gave us enough time to speak. If the group were bigger, it would be hard to try to tell all the stories in a shorter period of time. I also think it might have been overpowering to hear all the stories if there were more of them. You might not have had the same chance to savour the intricacies in everybody's individual stories. If the group were smaller, I think you may have felt more self-conscious about imposing on the group. As it was, there were enough people to sort of shoulder the emotion of the sessions.

Initially I really wanted to be writing down things that people said. They phrased things so beautifully and I didn't want to lose it. I knew if I went home and tried to write it down, I wouldn't remember exactly the phrases that they'd used, that worked so well. But I think it was more

important that I not take any notes. It would have detracted from my listening, from how I was listening to the stories. I would be listening a lot differently if I was jotting things down, rather than simply sitting, and listening, and concentrating on what was happening in the moment. Because you realize you are not just listening to the words, you are listening to what's in between the words. So even though I wanted to write things down when we first started, I think it was really important that we had the agreement that we wouldn't take notes. I think that would be an important part of the process for future groups as well, to not have people take notes.

I understood too, what Daniel was saying about people maybe feeling less likely to want to speak if they think they are being recorded. I don't know that I would personally have had any reservations about that. I may well have the first night, and maybe even in the second session. But once I knew how the group responded, and felt really comfortable with that, I don't think I would have had any objections to anybody in our group writing things down while I was talking.

With regard to the journaling, I don't really think it made a difference for me that it was private. Even though you'd said you wouldn't be asking to see our journals, I think for about the first two weeks into January, I was writing almost as if I expected you to see it, to call in the journals as part of the analysis. I don't think I withheld putting things in because I thought that you might be seeing it, and I don't think my writing changed once I realized that, indeed, you probably wouldn't be seeing it. Knowing that the journaling was private might make a difference for some people, but it didn't for me. Although, when I wrote about the themes I did it separately and typed it. When I did my journaling, I did it in handwriting in the note book you gave us. So maybe I'm not being honest with myself. Maybe I did assume that they were two very separate things. It's an interesting question to reflect on, and I would be curious to know how other people responded to that.

When we first got together as a group, I thought it would be more a case of each of the six of us offering supportive suggestions if problems came up. I hadn't expected Daniel's role to be one of offering feedback. I thought he was going to be more of a facilitator and a moderator, but that he really wouldn't be offering any counselling per se. But indeed, as each session came along, he was able to point out a lot of the strengths that each one of us had. If this is something that is going to be offered again for other physicians, I think the hard thing would be to find enough Daniels to be able to do that for the number of us that actually require it. I don't know that many family practitioners have that kind of a skill. I don't actually think that being a physician, or specifically a family physician, is necessarily that important in leading this kind of group. What is important is the kind of counselling skills that Daniel obviously has. Never having been to counselling myself, I don't know whether other skilled counsellors would have been able to do the same thing.

In the second or third session, I think Chantal was reflecting back to you what the lingo meant, or what the situation meant to a physician if a certain thing was happening. At that point,

the realization came to me that it's good that there is someone here in the group who is not doing the day-to-day in and out with patients like we are, because it forces us to define what our interactions are in the office. To remember that being a family physician is really a very interesting job, and we wouldn't all be doing it for as long as we have been, if we didn't get a lot of positive strokes from it. Having someone in the group who is not a family physician keeps that element alive, that indeed, for the most part, what is happening is good. There are very stressful parts to the work but the good parts far out-weigh the stressful parts of it. So I think it was quite useful to have a non-family physician in the sessions because it limits a sense of feeling sorry for our selves as a group. Without that, you can tend to start to have it be a gripe-fest.

I suppose there could be a potential that people would limit what they said if there was someone in the group who wasn't a family physician and who was perceived to not be positive about the job family physicians do. If that person was at all critical of what happens in a family physician's office, or considered that family physicians were deficient in some way, then that certainly might be an inhibiting feature in terms of what people would be willing to share. I can't imagine that happening with you personally - I can't see someone being interested in doing life review with physicians if they had that sort of negative view about physicians. So I think the benefits of having a non-MD as part of the group far out-weigh any possible deficits.

Kate's Story

I first heard something about this research project a long time ago. Last summer I had applied for and received some research funding. I wanted to do some qualitative work so I asked Daniel if he would act as a mentor for me. He agreed and asked if I might be interested in participating in some research that he was going to be involved in later on. So at the very beginning, I said I'd be interested because Daniel asked me - there was an element of wanting to help him with his research because he was going to help me with mine. I don't think I understood what the project was about at the time, only that it was related to his interests in working with physicians. I think his work is great and I thought that if he were involved, it would probably be a good project. I didn't hear anything about it for a long time after that, and then last fall, he contacted me to check if I was still interested, gave me a bit more information and put me in touch with you.

I have a lot of friends who've talked very positively about their experiences in professional development groups and group therapy workshops. As I learned more about the project it sounded worthwhile and I thought it would definitely be an interesting thing to do. Given the meetings and the preparation and writing time involved, I initially had to figure out if I could do it. It was a very big time commitment. I wanted to be sure that I wouldn't miss any of the sessions, but I had to balance how it would fit in with other group meetings I go to once a month and with child care. My husband, John, and I have three young children and have chosen to share looking after the children ourselves, so we have to negotiate how things will fit together. In a few years time, when the children are a bit older, it won't matter so much to John what I'm doing, but it does right now. Any time I take on a project, it has a major impact on him in terms of child care - and vice versa.

He thought it was only fair that I have the chance to join this group because a couple of years previously we'd done the reverse when he was in a professional development program. He was very supportive about being the one who was left on duty to sort out homework and put everyone to bed while I was at the sessions. So once the meeting schedule worked and we had the dates set, I decided it would be OK to do this, and things fell into place. Probably another small factor that motivated me to join the group was that I knew Ray was going to be part of it. We've been friends since being in residency and when I was making the choice about whether I could, or couldn't do it, I thought we would have fun, doing this together.

The first session was a positive experience for me. After we'd finished, some of the other sessions became more important and I could agree with people who were saying that maybe we could have shortened that introductory session so we could have had more time for sharing on the topics. But that was only in hindsight. Some of the explanation of the process that first evening had already been covered in the individual interviews you had with each of us. So in that way it was repetitive, but at the time I didn't feel bored. The whole session was enjoyable and I

felt more comfortable being in the group by the end of it. I felt that there were a lot of safety measures in place, and although I was a bit anxious about what may be coming later, it felt like a good group of people. When we paired off to share a branching point that was significant in choosing to become a family doctor, I was with Ray. It was fun because I heard some parts of his story that I hadn't heard before. The material that we shared was recaptured in Branching Points, so in that sense it was maybe repetitive, but we really enjoyed our discussions and the time we spent together that first evening.

I was late arriving at the meeting and was completely oblivious about that until I got home that night and listened to a voice mail that Daniel had left earlier wondering if I was having difficulties finding the location, or couldn't make it. I had it in my head that we were meeting at 7.30 PM, so when I heard the voice-mail, I thought, "Oh no, I could have easily been there by 7.00 PM." When I arrived, I was just marveling at the idea that Ray had got somewhere before me - we have a standing joke between us about him always being late! I just sauntered in and didn't say a word to anyone because I had no idea I was late, and although Chantal arrived after me, she was apologetic because she'd written down the wrong address. Normally if I'm late I would be quite apologetic and I felt a bit bad about that afterwards. That wasn't a great way to meet a group – holding everybody up. If I'd realized it at the time, I'd have been mortified, but because I didn't know, I was pleasantly oblivious throughout the whole evening.

I think Branching Points was a good theme to start with. People approached it in different ways – some of them just touched on the tiny details all through their lives and others focused on one or two key points. At first, I wasn't sure how to approach it and more branching points kept coming up as I was working on the drawing I decided to use as a way of looking at the topic. I found it really useful and reflective to go back and look at what the actual branching points might be, the ones that weren't necessarily obvious, and see where the shifts might have actually happened. I enjoyed preparing for the session once I got into it and talked a lot to John about it. Many of the branching points happened early in our relationship, so he was around for a lot of them. It was interesting to do that review and it made me gain some insights that I hadn't had the time to think through, or form, before. Although it's things I've thought about, putting it together in this context was useful for me. I found that topic valuable, and I enjoyed the session and hearing about other people's branching points.

Initially, for the first week or two, I had difficulty trying to decide what to write on the themes. I was trying to find the balance between telling a completely boring story or disclosing things that I didn't want to disclose. Anything interesting felt too private, they were things I didn't really want to share. Anything not private felt boring, and I couldn't imagine people wanting to hear that stuff. So I was trying to take the temperature of the group without knowing what people were going to talk about. Knowing very well that everyone has a story, but knowing that people may or may not decide to share it with the group, and deciding that I would only share my more

private stories if other people did. I was uncertain about how much depth to go into and trying to get a feel for the group. If the group is going to come in and do a very superficial overview, you don't want to be the one who comes in and does the opposite – or vice versa. If every one else was going to come in with a heart felt story, I didn't want to come in and skim along the surface. Wanting to be sure that I wasn't way out of keeping with the temperature of the group was somewhat anxiety provoking for me at first.

This was also the period when I was having the hardest time with the journal. Trying to decide what to write, and even just making the time to write, was a bit of a struggle. You had said to write the journal for ourselves. If we wanted to share something from it in the group we could, but we didn't have to, it was private. Initially, when I was writing in the journal, it didn't feel like the way I would write for myself. The sense of the group was always there, even though it wasn't supposed to be. I found it really hard to remove that sense of an audience. As I was writing, I was thinking about what I was going to say on the topic - worrying about how it sounded, how it made me look, if it was a reasonable thing to share. For the first couple of weeks I was a lot more critical of what I was writing than I would normally be if I were writing just for myself. So in the beginning I spent a lot of time talking ideas through with John, because that was easier than journaling. Then I would try to form an idea of what I was trying to get at and write it down. After the first couple of themes I didn't need to do that any longer because, by then, it was pretty clear how the group would function. By the time we got to the Career theme, deciding what to write or share wasn't a big issue. By that time, I had a clearer sense of people in the group, the flavour of the group, the unspoken expectations of how it would go, and the level of sharing that people would be comfortable with.

If people hadn't disclosed anything, it would have been entirely boring. I was glad that it wasn't superficial and that people took risks to share their personal stories and what was important to them – without that, it wouldn't have felt as useful. I'm also sure there were things that people didn't share and I think that is reasonable. It wasn't as if everything was told in the group, but enough was shared among us that you got to know what people were about - maybe some a little more than others, but overall the level of sharing was pretty consistent. I think you could go on sharing stories for years, there are always other stories that could be shared, but for me there wasn't a sense that I missed anything I wanted to explore in this process. We all talked at the end about the sense of time pressure. Not so much perhaps around wanting to share our own stories but wanting to hear other people's stories, and at times being conscious that someone's time was running out. Some of the stories were very moving. You could tell some of those stories for hours. On the whole, though, I think we coped pretty well with that and were able to get to the core of what people were trying to say.

I like journaling and used to do that a lot in my life up to my mid-twenties. I haven't done it recently and I found the journaling very helpful. In some ways, for me, the process of writing and

thinking things through was maybe even more useful than telling my story in the group. It's hard though to weigh the value of those things because hearing other people's stories in the sessions was so valuable. I think it would be hard to speak in the group if you hadn't done the reflection. What you said would be far more unfocused as you jumped from one idea to another. The writing allows you to formulate your thoughts and then read it over and think about it – go back and forth between reflecting and writing. It allows you to develop and clarify your ideas and then, when you see it all laid out before you, you can decide what you want to share with the group.

I think the journaling and writing is an important part of the whole process and definitely useful for me, but it was time consuming. Generally I would spend a few hours writing on each theme and then, of course, the reflecting brings up things that are normally more on the back burner. Especially in the first few sessions, I'd be processing thoughts about the topic for the whole week and sometimes that would get in the way of other things. I'd be doing something I had to do, but find my thoughts wandering to things that had come up for me while I was reflecting and writing - so I was very busy with this process for the month of January!

After the Family session, I got out my old diaries and spent hours reading them. The only time I could do that was after midnight because usually in the day it's a complete circus in the house with three young children. I'd be reading them until 3 or 4 AM and then I'd still have to get up early the next day. I did that for several nights in a row and then I was saying to myself, "This isn't good - I'm going to be exhausted!" Eventually, I made myself pack them away again. It was interesting for me to go back and read my old journals. For whatever reason I hadn't felt compelled to do that before, although they've been very accessible for many years. I'm not sure why I was drawn to re-read them. I guess it was just revisiting those times and ideas in the reflecting and writing I'd done around that theme. Maybe wanting to validate whether what I was thinking now, had any bearing on how I would have described it then. I found a lot of stuff that I had completely forgotten about and there were some sections where I remembered things totally differently. It was really good to go back and recapture some of the pieces and very interesting to see the how the writing I'd done back then fit with what I was thinking about in the here and now. It sort of completed the process for me and it was useful – a useful way to spend the time. So I have no regrets about doing that. I started thinking about keeping a journal again and I may still do that. I really liked having that record of events in my diaries, especially about these major pieces of my life that I've pretty much shelved or forgotten about. For me, these are great stories. Not that anyone else would care about them, but for me it's really nice to go back and recapture that time.

The Family theme was the most important one for me and it was the theme that I would have been most interested in spending more time on. I think I was a little out of synch with everyone else on this, a bit different than the rest of the group. When we were giving feedback in the final session, the tone I picked up was that people had been building up to talking about work

issues and vicarious traumatic stress. They wanted more time on those themes and seemed to feel that branching points and family of origin were just sort of background issues until we got into the real stuff around career. My experience was entirely different. For me personally, the work-related themes were an anticlimax. It's not that they weren't useful and valuable, but they were less significant for me. They were interesting and important topics, but they didn't touch me as deeply. Perhaps that's because I don't find my work that stressful.

Family was the hardest theme for me, the one that was the most personally intense. I was feeling very apprehensive before that session. I had a lot of anxiety building for several days beforehand and was experiencing a lot of ambivalence about the whole process. It was difficult to get down to doing the homework because I was questioning, "Do I need this? Do I have the time? Do I want to write this? Do I want to share this?" I had no idea what I was going to say until I actually said it in the group. At the break time, I was pacing around the hallway thinking to myself, am I going to talk about this, or am I not going to? Is it appropriate to share this, or not? I talked to Daniel very briefly during the break, just to get his sense of things. When it actually came to telling my story in the group, I shared about half of what I had written, and that felt about right for me. I shared what I wanted to share and I'm glad I didn't share more than that. So it was OK, it felt right. There was a sense of relief after doing the presentation and I was glad to hear the other people's stories. Daniel called me a few days later just to check how I was feeling, which was a nice thing for him to do.

I had mixed feelings about people's feedback. I wrote about that issue in a lot more depth towards the end of the group, but it came up for me in this session. On the one hand it would be really hard to tell a personal story to a stranger and be left wondering how it had affected them and what they thought about it. On the other hand, some of the feedback I received was so effusive and positive that it made me feel a little bit uncomfortable. It was essential for me to hear from people after I'd shared my difficult story – if only to know that they didn't think I was some kind of wacko! But a lot of the feedback felt like a personal assessment - along the lines of, "You are so courageous." For me, that wasn't as helpful as someone telling me what they felt when they heard my story. I think it is harder for doctors to get to that and talk about what they feel. Maybe other people wouldn't feel the same way as I do, but I found that while some of the feedback was helpful, some of it wasn't.

I don't think I had too many new insights around the Career theme. I didn't feel very good after that session when we talked about our careers as family doctors. I was worrying quite a bit that I may have come across as discounting what other people were saying. I was thinking particularly of Vanessa talking about her frustrations with family practice these days. I share her opinion on all those issues, but then, just after she's spoken, I come out and say that I feel really privileged to have this job. I was concerned that might not have been entirely sensitive on my part. When people were talking about the frustrations of full-service practice, I really get where

they are coming from and share many of those frustrations, but that hadn't been my focus when I was reflecting and writing about the theme. For several days after the meeting, I worried that by taking such a different stance in my story, I may have seemed insensitive or as if I was discounting other people's points of view.

I think somewhere in the sharing I mentioned that John and I received an inheritance that allowed us to buy a house. I felt embarrassed about having said that afterwards, it felt like a minor over-disclosure, even though I'm sure nobody else even noticed it. It was really funny to reflect on why that felt private. How come I felt awkward disclosing that, when I hadn't felt at all uncomfortable after sharing things about my family?

I was also worried that when I was listing my different jobs in that session, it may have come across as boasting - although I had certainly not intended it that way. I was embarrassed after the feedback and felt that I was misinterpreted because I thought I'd come across as saying, "Look at all the stuff I'm doing" - and I wasn't doing that. I was sitting in a room with all these doctors who do things that I could never do, and I'm getting feedback telling me how marvelous it is that I juggle all these different jobs. I was thinking, "That's not my point! You guys do more than I do! I'm not saying this is really great. This is my way, but it's not better than yours, and I'm not saying it is. I'm just trying to share something about what I do." I actually left that session feeling much worse than after the Family night when I had talked about the very hard personal issues. It was weird because career issues are not sensitive ones for me. I'd expected that talking about my job would be relatively simple and easy. I guess the night I'd talked about family felt fine because I'd intended to say what I said, and felt comfortable about that. This night, my feelings were more to do with group interactions and not wanting to have a negative impact on other people.

I think the feedback was really uncomfortable for me because it was so very positive. People telling me I was marvelous to do all these things, when I feel that the other people have done an incredible amount of things, and some of them actually do quite a lot more than I've ever done. Most of them started practice at least 10 years earlier than I did. They did all their own call work and took on all the stress of that, whereas Ray and I were among the first group of doctors, 10 years later, who started signing out to house-call services, not necessarily doing deliveries, and taking a different path in family practice. I work hard and I do a lot of work, but it's not harder than any of the others do. It's just a different balance, almost an easier balance, which has allowed me to stay home and look after my kids. I just couldn't sit with that feedback. I think I felt guilty receiving that feedback. So I don't know. It may only have been my interpretation. Maybe no one else had those negative feelings about getting such positive feedback.

My life is very busy but it sort of works – it's a funny little backwards life in a way. We haven't had to have a nanny and we've been able to do our own child care, and I feel good about that. I don't know that that would have worked 10 years earlier in medicine. There seem to be

these subtle shifts that happen in the profession every 10 to 15 years. The group that was practicing through the 80's were in the hospitals all the time and did their own call. Then there was a shift around the late 80's. I don't know what drove the shift, but the walk-in clinics came in, family doctors were going to hospitals less often, fewer family doctors were doing obstetrics, and less of them were doing all their own call. In the 80's women doctors used to take really short maternity leaves – six weeks and they would be back at work. Then the longer maternity leaves started to happen in the early 90's, and there were different expectations of what a good doctor would do. I think it has probably been a little easier on my generation of doctors. Doing obstetrics is really hard – always being on call and realizing that at any moment you could get pulled out to go in and do something potentially stressful. Deliveries are a wonderful part of the career, but it's a lot of work and I have a lot of respect for people who do that. I had initially thought of specializing in obstetrics. I really like the medicine involved, but not the lifestyle.

There is a lot of mental illness in my practice. I see a lot of people who need a lot of time and who take a lot of emotional energy on my part. But much of the time, the issues I'm dealing with are not medically scary. I'm not having people experiencing major medical crises or having heart attacks every day in my office. I have 90% women in my practice, which I think happens to a lot of female doctors, and I do a lot of obstetric care, but my partners in the office do the deliveries. I think everyone's practice is a little different and you tailor it to suit your needs. Mine's a 'talky' practice – a lot of talking and time but not too many drugs or major medical crises. So while there are still lots of problems and the work can be stressful, I don't think that I have it so bad. I recognize that we have stresses that many other people don't experience in terms of being responsible for people's health and sometimes their lives, and dealing with the expectation that mistakes don't happen, and are not acceptable, and aren't talked about – which I hate. But I also recognize that lots of jobs are stressful. The lawyers in my practice do not have the option of working part time - it's 60 hours a week or nothing. So the Mom's who are lawyers are really stressed because it's all or none for them. Being under-employed or working in a menial job can be very stressful too, in a different way, because you have no control. So compared to some people, I think my job is easier.

As a doctor you get accorded a certain level of respect, or privilege, that other people don't necessarily get – it is just sort of assumed that you are not stupid! While I don't want to discount the group's feelings about the stress of being a doctor, I don't think we are the only ones who are stressed. Because we are self-employed we do have the ability to choose how, or how much, we want to work. It's not necessarily easy to put that in place, but we do actually have that ability. I don't personally find career issues too much of a burden. The research I'm doing and the stories that patients come in with are really fascinating. It is so interesting to try to figure out some weird symptom that someone is experiencing. I like the work I do because it's just so intellectually stimulating and you get to meet really neat people.

I remember when we got the theme on stress and distress I was disappointed at first. When you had originally spoken about the themes, I'd sort of laid out what the things were that I wanted to cover and how they would fit under the various topics. When you'd mentioned that there would be a theme about loss and stressful events, I hadn't associated it with career. In my head, I'd written an entirely different story that had nothing to do with work. Then when we got the handout on the theme, it was focused on our experiences as doctors. My initial reaction was, "Oh no, not another session on work," because I had something entirely different in mind for that theme. If it had been framed more generally, I would have preferred to explore issues related to more personal losses, but you don't want to be way off in left field and talking about something that is entirely different from the rest of the group. It would have been really weird to come in with story about personal loss when everyone else was talking about the experience of being a doctor and vicarious traumatic stress that night.

Knowing the people in the group, I'm sure they've had huge personal losses too, in fact I know some of them have, but it still seemed that for most of them the work-related themes were more important. In the final session when people were suggesting having more time on those and shorter sessions on the more personal themes, I was feeling that maybe I was the only person who didn't see it that way. I didn't say anything about my feelings during the feedback, because there was some group momentum about which were the most important topics, and I didn't want to take away from that.

Afterwards, I found myself worrying about the fact that everyone else seemed to find the Stress and Distress session the hardest and most significant. I don't think I'm carrying huge suffering from my patients. If something really bad happens to one of my patients, I think about that and carry it around for a week or two, but then it goes away. It's not the same as if something bad happens to a friend and it is there forever. Relationships with friends are different than relationships with patients. With friends it's a two-way connection, whereas with patients it is more one-way – they don't know you personally and you are working for them, being of service to them. I care about my patients, but their suffering is not my biggest burden. I realized that it was clearly a huge burden for other people in the group and after the session, I remember feeling that maybe it's a problem that I'm not experiencing the same depth of distress – maybe I should be. What kind of person, or doctor, does it make me if I'm not burdened by my patients' suffering? Am I not as distressed by my work because I'm not feeling other people's grief deeply? Is it because I haven't practiced for as long as some of the others, or because I see less patients than they do? I haven't had a child die in my practice, which I know would be a very hard thing to experience. Hearing people talk about the many losses of children they had witnessed were some of the worst stories in the group.

Some of the stresses that I carry around work are more personal. They are not about witnessing grief, but about the kind of expectations that we live under as doctors. The whole issue

of not being allowed to make mistakes and worrying about lawsuits is extremely stressful. I think everybody carries that worry and stress right on their shoulder all the time. A mistake can happen to anyone at any time. It doesn't mean that you are careless, it is just one of those bad luck things that can happen. And when a doctor does make a mistake and is sued, it is a very public and humiliating process. Your name is published in the bulletin we receive from our College, if it is a BC lawsuit, or in the information we get from the national insurance agency, and they report what you've done and what you did wrong. I haven't had that experience, but my understanding is that there is very little support for people going through it. It must be a terrible experience. I think most doctors are very private about it and find it really hard to talk to anyone about what is happening.

What happened to Robin could have happened to anyone one of us in the room. As she was sharing her story, there was a really clear understanding in the room that she was carrying the burden for all of us this time. She was the unlucky one, but it could have been any of us. There was a lot of feeling in the room for what she was carrying and incredible support for what she had experienced during the lawsuit and the pain of losing her patient. I learned a lot from Robin's story. If, and when, I get sued, Robin's story is going to be very important to me.

Another part of work that I find stressful is just the hassle of running a full-service practice in recent years. Over the last ten years, our incomes have declined quite significantly whereas the expenses of running a practice have gone the other way. The walk-in clinics have changed the kind of patients we see. We used to get more of a mix of various health issues, but now we just get the tough or chronic problems to deal with, so it's not as much fun. It's the frustration about how the current structure has impacted our work that I find more stressful than dealing with patient suffering. So I wouldn't say that I don't experience work stress, but it's not overwhelming. I like my job. It is hard sometimes, but everybody's work is, and sometimes I feel very lucky to have this job. I could do a lot worse.

Perhaps I experience less distress around patient care because I only see patients two days a week which is much less than other people in the group. Also some of them have been practicing for 10 or 15 years longer than I have, so overall, they've seen a lot more patients. I do a mix of jobs. It might not work for everyone, but it suits me. I like having a blend of teaching, administration and research, coupled with patient care. I enjoy teaching and research, but I think it's essential to also be involved in patient care. For me, it's very important to combine research with clinical practice because they inform each other. The ideas come from clinical work and the point of doing research is to make a difference to practice. So I really enjoy the mix and I would really miss my practice if I left it. I haven't minded cutting down to two days a week until my youngest child goes to kindergarten, and once the child care needs go down a little I'll probably increase my practice time again.

It was funny that the Meaning of Life theme was the shortest session. I thought it was perhaps because we were focusing on ideas and concepts, rather than telling our stories. It was

the stories that brought richness to the sessions and it was when people were telling their stories that the sessions ran longer than planned, because we wanted to hear them. After the meaning in life session, I wrote in my journal, *"I was noticing, last night, that the group does not sit well with people's sadness or self criticism. Even the facilitators seemed to feel like they needed to reassure people that anything negative they said about themselves is not true."*

That felt like a bit of an imbalance to me, because we would never tell someone that something positive they said about themselves wasn't true. I don't know that anyone else felt the same way, but to me, the feedback was almost too overwhelmingly affirming. I felt that it would've absolutely been taboo to validate someone's negative feelings about themselves. It made me wonder why it's not OK to have bad feelings about yourself, or talk about areas that you would like to improve. I talked about wanting to figure out how to leave behind some of the fears and anxieties that I have. The sense I got from the feedback I received was that people were pretty sure the group process was helping me with that, allowing me to air them out, so I could begin to let them go. It's not that simple. We're talking about my personality, not just an inaccurate idea that I have about myself. The ideas I shared are not new to me, it's just writing them down and speaking about them that was new. I feel it's important not to be afraid of the negative. I'm OK embracing the negative aspects of my character. I know that having them doesn't make me a bad person. It just makes me human and complex like everyone else.

I think there is a natural desire to want to thank people for sharing their stories and to say something comforting when it is a hard story. So there was a group momentum to being very nice. I don't mind that, and in fact I wouldn't ever have wanted to be the one person who wasn't. But when it was about me, my stories, it felt nice but it didn't feel true. There are definitely nice things about me, but there are also not nice things about me - and I'm OK with both. So when people were giving me feedback in the session and implying that sharing some of my fears was helping me to leave them behind, I wanted to say, "No, they are still there! Knowing that they are there and what they are about is where I am right now, and that's OK. Perhaps I may figure out a way to get rid of them at some point, but I may not, and that's OK too."

I felt in the Meaning in Life session that along with other things, people were taking the risk to talk about things that were heavy in their heart, and I think it is more helpful to allow people to sit with those things. The Life Review process didn't solve or fix anything for me and I wasn't expecting it to, I think that would be an unrealistic expectation. I didn't think of it as some kind of intensive therapy where you might dig in and discover a major new insight. For me this process was not about discovering huge new insights. It was an opportunity to review the things that are there, put the different pieces into a more integrated and comprehensive form, and make more sense of them. That's an important and useful thing to do. Even just talking about and sharing some of my problems is a little step toward understanding them more clearly. So it's not that I didn't gain things from this process, just that I didn't fix anything and I didn't expect to.

I think maybe it's a doctor thing to want to wrap things up and fix them at the end. We are used to interviewing people for 15 minutes and having them leave with something fixed. Sometimes I find that my patients get really annoyed with me if I try to fix things. If they want to come in and talk about their doubts and worries and I start to reassure them that they are really OK, I get the message right away that that is not what they want to hear from me. They just want me to sit with their suffering or the complexity of the issues.

It was important to me that this was a group of family doctors - that felt good. Even though we all have different issues that are important to us, we have such a shared, common experience. When you are with a group of others doctors, it's a given that they understand the level of responsibility that we share. Being a doctor is such a big part of our lives, even our personal lives. For every one of us, I'm sure that becoming a doctor was a major branching point in our life. It's a common thread that makes the rest of our varied experiences make sense.

I really liked meeting the people in the group and hearing their stories. There is something very important about sharing one's own story and hearing other people's stories on the same topic. The other stories provide a context for your own and there is a richness that happens as you blend all the stories together. The emotion in each story and the message it brings are more important than the content. I learned something from listening to all the stories. There is at least one story from each person in the group, and a couple from several people, that I get to share now forever. I will use those stories to help me in my life. Some of the stories that Vanessa and Chantal and Robin shared are really important to me because they have experienced some things in their lives as women doctors and mothers that I haven't yet. Knowing their stories helps me to feel prepared for things that may happen in my life. That's a real plus for me. Some of the stories I will carry forever. They were very meaningful and poignant, and I will never forget them.

It was a plus for me having Ray in the group. The process allowed us to create a deeper understanding of each other and that shift in our friendship will have a long-term effect. Because we have been friends for many years, I have a context for some of the events that Ray spoke about, but hearing him speak about them in the group setting was really useful. I learned things about him that I didn't know before and I think it was the same for him in hearing my stories. Whereas I may not see some of the other group members that often, Ray and I do see each other regularly. That deepening of our friendship is one of the most valuable things for me in terms of the outcomes of this group. It was a really positive outcome.

When I think about what I may carry forward from this group experience, I feel it's almost to soon to tell. I think possibly one significant impact may be starting to keep a journal again. Overall, this process has led to a gelling of my story so far, pulling the threads together and making sense of it. The story is still going on, always evolving, but it was useful to sit down as I did and spend literally hours and hours thinking about my life and actually putting it into words. It was interesting for me to be in this group as I'm turning 40 and starting to think ahead about what

I want out of the next decade and where I see things going. I think looking at how you got to where you are at now, is always the first step in deciding where you see things going and what the plan is from here on in. In that sense, it was a useful time for me to be in the Life Review group because it feels like something of a life transition time, a naturally reflective time in my life. At a transition time of any kind, you tend to reflect informally somehow, but this is a more formalized way of doing that reflection and puts some structure to it.

As I said in the Meaning in Life session, John and I do this kind of reflection informally and have for 20 years. We have an hour-long conversation every night when we review what's happening in our lives, what life is about, and where we are going with it. Occasionally, we sit down and set out our goals on paper, because otherwise I think you talk about ideas, but they just blow in the wind. So a number of times we've done an overhaul to try to make sure we are putting our time on what we actually think is important to us. I think sometimes people live their lives and then as they retire, they start to have regrets about what they wish they had done. I just don't want to do that. I don't think anyone is right on track all the time, but it helps a little bit to stop sometimes and look at where you are trying, and wanting, to be. So Life Review is a little bit similar to what John and I do together naturally, except that this process was more personal. This was about me, rather than us. A way for me to reflect personally on my life and then think a bit about future goals that I have.

The process was very affirming for me because I realized I am more or less doing what I want to do. At the end of the group I didn't leave with a sense of dissatisfaction about my life, or a feeling that I need to fix or change things in any major way. There are lots of things in my life that haven't necessarily all been happy and I know where I carry the pain associated with those things. I haven't really worked on them yet and I may someday, or I may not. But I know they are there. There are also some really positive things in my life that I reflected on and wrote about and shared in the group. When I think about what the meaning of life is, and what it means to do what I do, to be a doctor, and reflect on the good parts and the hard parts of my work, I think that the balance I have found is OK. Nothing is ever perfect, but my life is good enough. I feel I am spending the time with my kids that I want to spend, which is really important to me, and I also have this very rich career that I enjoy. Part of being able to have this balance of family and career is because John is a really supportive partner, and part of it relies on my Mom who comes one day a week and baby-sits for us. I feel really lucky.

It was very confirming for me to do the Life Review process and know this is where I want to be, this is how I want to spend my time, and the things I think are important, the values I hold, are actually reflected in the things that I do. Where I got to at 40 is not too bad! I feel good about that. I can make some changes I want to make now and in the future, but they're minor tinkering. Shifting this, or that, as my children get older - the little shifts as my life unfolds. I know the things I'm not doing too, and I'm okay with that, that may happen someday. It's just maybe this isn't the

right time, or I haven't found the right place, or I haven't yet felt pressed to make it a priority to work on some of the difficult things I've experienced in life. Overall, after these hours of reflecting and writing, I have a very positive feeling about where I am at in my life.

I don't know if going through this process will lead to any other major changes for me, other than just affirming that I feel I'm on the right track. I'll probably know better in six months when I look back and see how things have settled out. I see this as a very positive experience for me and I'm glad I joined the group. The only negative piece at all in this process, was having to figure out how to juggle time and pull the time out of each week to do the reflecting and writing. But I think it is a worthwhile thing to do with one's time. If it hadn't taken a lot of time, it would be a no-brainer. It was great, and while I can't do it every week, the whole group experience has been special for me.

Feedback on structure, facilitation, and future directions.

I wasn't bothered by the fact that the sessions ran late. I know that was a big theme in the group, but for me carrying on until 11:00 PM wasn't a problem. Once the kids are in bed around 9:00 PM no one is covering for me - it's free time! I often had to teach early the next day, so that wasn't perfect, but I think it was important to hear people's stories. For myself, I liked the way Daniel timed the group and made space for the stories.

As I said earlier, I felt the one weakness in the process was around feedback. What I found most useful were the times when people would talk about how the story that had been shared made them feel, or reminded them of their own story. But I felt there were a lot of times when people were told they were courageous, or wonderful, or something like that. Maybe other people found that really supportive and validating, so I don't want to be too negative about it. I don't think I ever told anyone that they were courageous or anything like that and afterwards, I worried a little bit that perhaps I was out of synch with the group on this. That in talking about how people's stories affected me every time I gave feedback, I was maybe the only one being, or seeming, somehow selfish.

It's just that I didn't want to receive what I experienced as judgments and I got a fair number of them. I know they were given with the very best of intentions and were well meaning, but personally I didn't find that useful. Sometimes it can give you an insight if people say they see you in a certain way and you've never thought of yourself being that way before. But in general, I don't feel that it's up to me to decide how someone is and I feel uncomfortable telling people what they are. So, for me, some of the feedback didn't feel as helpful as telling the stories and listening to other people's stories.

I think this type of group could be very effective in terms of helping to sustain doctors. I have two other groups that I belong to, and in the Practice-Based Learning group we do share some things in an informal way, although not nearly to the same depth as in this group. I think a lot of family doctors are more isolated than I am. Many of them don't meet with other doctors at

all. So I think this process is really valuable and has the power to be able to let people connect with colleagues and explore their suffering and concerns in a safe and supportive way. I think that if someone has a really in-depth personal issue, a Life Review group is not necessarily the place to work on that, because this isn't therapy. But it provides an opportunity to explore issues with people who understand your professional experiences and create a sense of community.

I think it would be particularly useful for certain types of issues, such as doctors who are going through lawsuits. I don't know if you'd be able to work on that issue in the same way in individual therapy because it's an issue that is intrinsic to our profession. I think it would be really helpful for a doctor who was going through that kind of experience, or who had been through that, to be in a group like ours. To be able to sit with colleagues who understand and know that the same kind of thing could happen to them, and have them validate your feelings and confirm that you are not a failure or a bad person. I'm sure there are doctors all over Vancouver getting sued. It would be an awesome thing to have a group like ours for doctors who are being sued, so that they could come together and talk about it.

As a family doctor, even if your receptionist makes a mistake and misfiles something, it's your fault. You are the one that's going to go to court - it's you, not them! There are maybe 150 pieces of paper a day that get processed in the office and you just know some of them are not going to go where they are supposed to go. It's your job, as a doctor to try to minimize any potential errors and you hope that you can, but I think an unspoken thing that we all know is that in everybody's office there's going to be some error. There are just too many decisions in a day, too many people doing too many things, and if your regular receptionist is off sick and a temporary replacement shows up, you just keep your fingers crossed that they won't misfile a critical piece of paper. Sometimes we do find a lab result in somebody's chart that was meant to be put in somebody else's, and so far, for me, there has never been an error that had a huge impact on anyone's health. But that doesn't mean that it couldn't happen to me. So you are not only responsible for your own actions as a family doctor, but for other people's actions that you actually can't control in any way. I think things like that weigh heavily on GPs.

When one of our patients goes to a walk-in clinic to get treated we are sent a copy of any lab results that may have been ordered by the doctor at the clinic. If the blood test or chest x-ray is normal, you just usually sign it off and put in the chart and you know your patient has been to a walk-in clinic – it happens all the time. The other day we got a letter from our College saying that if, for example, one of your patients had gone to a walk-in clinic in for a chest infection and you signed off the copy of the normal x-ray you received, and then subsequently something else went wrong with their chest infection, you're now involved and responsible, even though you've never seen the patient. There is the implication that as a family doctor you should have seen the x-ray, known something was wrong with your patient, been prompted to phone them find out why they went to the walk-in clinic, and made sure that everything was now okay. And you wouldn't get

paid anything for that, because we only get paid for seeing someone face to face. To me that seemed so weird, and such an unreasonable expectation. If I am not the doctor in charge, why does this x-ray have anything to do with me, I just got a copy. It's not within our control whether patients choose to see us, or go to walk-in clinic doctors, so it just doesn't make sense that we should be the one's who are held responsible just because we are family doctors. Things like that are unreasonable and stressful.

There is, I believe, a difference between a sloppy or malicious error and a simple error. There are so many decisions and so many things being processed each day, that it is unreasonable to think that nothing will ever go wrong, even when people are trying their very hardest to make sure nothing does. I think the kind of clerical errors that could occur in anyone's practice need to be differentiated from sloppy or serious errors that happen if doctors don't know what they are doing, or do something wrong.

Ray was the only person I knew before the group started on anything other that a professional level. The process is very workable among strangers and it was an interesting added dimension to have had a friend in the group. It was a bonus for me to have Ray there, but I think it might be very complicated to do this kind of Life Review with a whole group of people that knew each other well. I think it could backfire depending on the relationships among people. Even though there would be a lot of history that wouldn't need to be explained, there would be so many other dynamics in the group that it might interfere with the process.

I think it would be very hard to do Life Review with your direct work colleagues. That wouldn't be somewhere where I would want to go! I like a little bit of separation between work and this more personal self-exploration. For me, it wouldn't feel comfortable to do this level of personal and professional sharing with my closest work colleagues.

It was good to have Daniel leading the group. He's skilled at group facilitation and because he is a family doctor, he's also part of our professional community. But the most important things about having him as the facilitator were his skills in this kind of group leadership and who he is as a person. I think it's mostly personal skills that count. Anyone leading this type of group would need to have those facilitation skills, but I don't think that they would have to be a doctor. I think you could have led our group and I don't think it would have been entirely different. I think it would have been a very similar process.

The whole group was aware that this was your research project. In the beginning, when I was feeling very apprehensive about the writing and personal disclosure, John would joke with me and say, "Kate you're going to ruin Hilary's PhD!" That was a standing joke between us for the first couple of weeks! I do think at some unspoken level there was a group spirit of wanting the process to be good, not just for ourselves, but because it is somebody's project. With regard to your presence in the group, there's the impact of having you there as a person. I think you were a valuable group member and I think your presence in the group was positive. I don't think there

was any sort of a doctor, non-doctor issue. I don't think that had any effect on the group. At the last session people were talking about how it worked well because so much didn't need to be said or explained because we were all doctors - there was an underlying, shared understanding among us. But it didn't seem like a problem that you don't share the same profession. It seemed that you had chosen this project because you knew there were problems and that it wasn't all great, so that didn't need to be explained. You assumed that people experienced stressful things in their work as doctors that they needed to share and you knew that there was suffering. Having that basic assumption and knowledge put you in the exact same playing field as everyone else in the room. I didn't have any kind of feeling that you were an outsider. Our group became very cohesive. After a few sessions, there didn't seem to be anyone who didn't feel comfortable in the group. It was hard when someone was away, like the one session that Eric couldn't be there, because you missed him, you wanted everyone to be there.

Vanessa's Story

The reason I responded to the information that was given at the Family Practice Rounds about this research project was because of how I am feeling about being a full-service family physician. For several years now I've been feeling very dissatisfied and disaffected and often, at the end of a work day, I feel angry and put upon. I just didn't want to feel that way any longer. It's not a productive feeling. I saw this group as an opportunity to explore my sense of disaffection and see if there was any way of moving on from it. It's a feeling that has been going on for quite some time and I've really felt trapped by it – unable to solve or shift it. So that was why I left the rounds and called that same afternoon to say I was interested in joining the life review group.

First meeting.

After our first meeting I wrote, *"It started late, which was a bit irritating, and it finished too late. By the end of the time I felt a bit headachy."* I had been up most of the previous night delivering babies and then had a full day at the office. The meeting was scheduled to end at 10.30pm but we were there quite a bit longer and by the time we ended I was really feeling tired.

I was interested in the process among the group members but I was really feeling somewhat on the fringe of the group. Not excluded by any group dynamic, but just looking around and trying to see how this fit for me and who I was in this group. That's a theme that runs through most of the notes I wrote about my experiences in the various sessions - that sense of feeling somewhat on the edge of the group.

As I re-read my notes, I see that I was concerned about being a *"boring contributor!"* I felt that I was going to be boring participant during the session and that was one of my worries at the time. I was also worried because of a feeling that my sibling's death was the big defining moment in my life. I was feeling that I should have moved on from that. Concerned that if I got stuck there, it might at some level cause me to not fully participate, or to somehow feel apart from the others. Her death was something that I had struggled through. It is something that was difficult and it certainly still causes me moments of loss, but I didn't want it to be the big thing in this group. Her death has consumed a lot of stuff in the past and I didn't want that personal tragedy to be the defining part of my experience in this group. I didn't want it to be the focus because it's not the reason I feel disconnected from practicing medicine. It is absolutely not why I am unhappy about being a family doctor at this point in time - it has nothing to do with that. I didn't want the emotional content of her death to hijack the time and opportunity to explore what is going on for me in my professional life.

I experienced the session as significant because of the Life Line exercise where we looked at what we would do if the dot of our lives moved closer to death. That exercise really focused that what I wanted was more genuine relationships with my children and my husband – especially with my youngest child as we are currently struggling with a problematic

adolescent/mother relationship. It brought home for me that these relationships are probably not getting enough attention in my life right now.

I also reflected on the conversation I had with my partner when we were paired off to talk about how we came to be family doctors. First of all my partner told me his story, and then I told him my story about feeling that I ended up in family medicine as a default position, because my sister's death had hijacked my plans to go to England and Europe. I got the feeling that he was very disturbed by me telling him that family medicine was my default position. He kept going back to those words 'by default' and started talking about how he felt about me telling him that. As I sat there listening to what he was saying, I started reflecting his feelings back to him – although it was supposed to be the other way around! I was saying things like, "Uh huh; Oh yes; I can see how that's difficult for you." And I thought to myself – "Well Vanessa, that's very good! You've managed to get yourself off the hook for talking about what's real for you. How ironic this is. I've now got myself off the hook for self-disclosure. I've done it before - and I can do it again!!" I don't remember in any way feeling that I'd been hijacked or that my story had been taken over by his reactions to it. It was more a sense that I'd probably gone as far as I wanted to go at that point and didn't want to go any further because the process was new.

It felt important after that first session to figure out for myself what I hoped to get out of the life review experience. So I made some notes about my goals: *"Acknowledge being a disaffected GP. Find insight into myself, and what I can do next in my life to be happier with it. I feel that I have a lot of issues around security and money and that these keep me doing full service family practice when, in fact, I don't feel very happy about it anymore. Trying to understand why I've got to a point where I don't like it, but I'm not doing anything to leave. So many of my colleagues have left full service family practice - it's not rewarding, so they are out of there. But even though I feel that way, I still keep doing this job. I want to come to an understanding. What is it? What is the pull is that just makes me not simply walk out of the door and walk into the first walk-in clinic that I see?"*

As I thought about the coming session on the branching points theme, I was struggling between two conflicting emotions: On the one hand a desire to be genuine and on the other, fears about how others might perceive me. *"I feel I have no branches and only buds that were nipped and I am worried about how to present this to the group. I don't want to seem pathetic, but neither do I want to feel that I'm not being genuine. I don't want to present things in an unreal light."*

I ended up my journaling about that first session with this reminiscence: *"I'm feeling hopeful that this process will get me to focus more on what I can do to find more satisfaction with the things that aren't making me satisfied."* The session also led to a conversation with my husband about some possible long term plans and things that we might do in the future, and I felt quite positive about that.

Branching points.

In the second meeting on Branching Points I was presenting towards the end of the evening. I think I was the second to last presenter and we were already close to the scheduled ending when it was time for me to share my reflections on the theme. A lot of the other group members had spoken about many branching points that had happened at different times their lives. When it came time for me to speak, I remember making a very conscious decision that I was going to leave out a whole bunch of the things I had reflected on and written about, because we were in a time crunch again. I decided that I would just speak to one branching point and edit everything else out of my story because the meeting was just too long, and I wasn't prepared to stay until midnight.

So I focused my presentation on the branch not taken: the inability to follow through on my plans to go to Europe and England at the end of medical school because of the death of my younger sister. I've often wondered over the years how my life may have unfolded differently if I hadn't felt the need to abandon my plans and dreams of branching out and exploring other worlds when my sister died. In preparing for the meeting, I reflected on that particular branching point quite a bit over the weekend and I came to a feeling of peace about it. A sense that any regrets about roads not taken have been replaced with feeling that I am on the right path for myself. The path I have chosen to walk has brought many good things into my life.

The meeting was significant because I haven't met very many people in my life who have lost two siblings like I have. When Ray talked about two of his siblings dying it caught my attention. I really felt connected with that, knowing that Ray and I shared those similar experiences of loss and grief.

There were other things I'd written about and would have liked to share if we hadn't ended up in a time lock. So I did feel somewhat annoyed that the group time hadn't been managed more equitably. Obviously at times each of us may need a bit longer to share a particular story, so there has to be some flexibility. But it was my understanding that there was going to be pretty much equal time for each of us in the group to speak and receive feedback. I didn't write a lot in my journal after that session - just that the meeting was too long and I felt I had to edit my contribution because of that.

Family.

After the third meeting on the family theme, I wrote down, *"people's journeys are all very different."* This was the session when one of the group members spoke so powerfully about her experience of family. Something she had said the week before had made it sound as if there were certain things, like family experiences, that she found were just too private to discuss. So she had obviously thought about that, and come to a decision about sharing these things with us. I found it interesting to listen to her story and to think about her choice of sharing that with us in this group.

I thought it was very courageous of her to do that. I didn't write a lot in my journal after that session just a short note about the impact of hearing that particular story

That was the time when things were pretty hectic for me both before and after the group meeting so that's probably why I didn't write much. I'd been up much of the night before delivering a baby and spent the day seeing patients as usual. Then, just as the group was closing I got a page to say that I needed to head immediately to the hospital for a delivery and I knew that part of my schedule the following day included a caesarean delivery in the morning. Of course, this isn't anything unusual when you do obstetrical care - it naturally has random, unpredictable hours. It can make you tired at times and it robs you of some of the other things in your life, but it's just what you do.

I remember that some people had a lot to say about family of origin things, and I can't actually remember how much I presented of what I had written about my family. I think there was probably a reasonable discrepancy between them. I think I began by talking about my roots, the heritage of my grandmother, and ended by talking about my relationships with my children and their different personalities. So I think that was fine, and doing the exercise was interesting.

At the end of my notes for that session I've written – *"How I came to be the person I am: The history of the family ...... the losses ...... the hardworking ethic of my grandparents and parents ...... coming from a family that had ongoing losses and depression."* So I guess I must have spent some time reflecting on those things. But thinking about the family history, and who they were, and what they lost, and their stories, was not something new. I've reflected on those things in the past. So the exercise was interesting but on the other hand that meeting felt more like just a sort of a historical review. It didn't lead to any new learning or 'ah ha' moments for me.

I know where my work ethic comes from. I think there probably haven't been a lot of boundaries in my life around work, such as me saying, "This is more than I can give. Getting up at 3 AM in the morning two or three nights in a row is more than I can give". I don't ever remember feeling that way. I've I felt tired, and I've felt, "Oh, gee, I wish they weren't going into labour right now," but I've never felt that this wasn't part of what I signed up for when I became a family physician.

When I think about how I feel when I am in my office and I am with the 35th patient I've seen that day and I'm starting to feel angry because this person is now asking me to deal with a third problem, I'm not feeling angry because I don't want to deal with a third problem. I'm feeling angry because the fee that I am getting paid for the time I need, and want, to spend with this patient is so inadequate. I have all these visions of walk-in clinic doctors spending three minutes for the same fee, whereas I have chosen to not put limits on what I do for my patients. So there is this huge conflict about how the system has valued what I do. I feel very let down that how I have chosen to be a family physician is not valued by the system.

The system values the quick, dirty, in out, throw a prescription at you and forget it. At least that's my perception. It may not be how those walk-in clinics work, but that's what I feel the current system values. I know that's the basis of a lot of my irritation, as opposed to what patients request of me. It isn't what my patients ask of me that makes me irritated.

Career.

The fourth meeting was when we focused on our experiences in becoming and being family physicians. In that session I talked about the slide from having a sense of great commitment and dedication to my work, and experiencing deep enjoyment and satisfaction in what I did as a family doctor, to these current feelings of disillusionment and anger at how changes in the system have eroded the satisfaction of the work and the time to be with patients. I think I presented at the beginning of this meeting and I remember being surprised as I was listening to the other peoples' stories and realizing that they weren't as angry as I was. They certainly had their issues, but they didn't seem as disaffected or as irritated as I was. My sense of irritation seemed somehow to be more deeply ingrained!

Among the notes I made afterwards, I wrote, *"It confirms my sense of burnout .... I don't feel particularly hopeful about my future in full- service family practice after this session .... I need to get in touch with the positive to see if I am able to re-create what I remember feeling as a family physician ...... What does it take to do that?"*

So those were the conflicting feelings that I was thinking about after that meeting. Thinking that comprehensive health care and being a full-service physician probably doesn't have a future unless there are some significant systemic changes. And thinking it probably isn't fixable. Yet I sure remember liking being a full-service family physician when it was more of a balance.

I can remember, when my children were little, going home at around 4.30 PM and feeling like I had done a good day's work – the work in itself was rewarding and it was financially rewarding. But in the full-service, fee-for-service system that exists right now, it has got to the point where if you don't see twice as many patients a day as you used to, you don't have an adequate income. And increasing the volume of people you have to look after each day increases the dissatisfaction. It robs you of your ability to connect with people, and that is the core of what I do as a family physician. As a family physician it's not writing out the prescription that is important, it's the relationships that I have with my patients - relationships that the current system doesn't allow me to pursue other than in the tiniest, most minute, dollops of time. It's a big loss.

I go back and forth thinking to myself I can either choose to see a lot less patients and end up earning nothing because by the time I pay my staff and all the other expenses, I'll barely be able to cover the overheads. Or, maybe, if that's the case, I just shouldn't work at all!! Those are the kind of struggles I experience: On the one hand knowing that I value being a family physician and how enjoyable and satisfying that has been in the past; and on the other knowing

that like everyone else I have to work to support myself and my family and that working in the way I have to now is exhausting and dissatisfying. I'm left wondering how to find a balance with that.

I made a note that the meeting was too long and I was too tired by the end of it because I think we ran quite late again that evening. I also wrote that while the stories were interesting to listen to, I felt that there should be more feedback from the facilitators. That was a recurrent theme for me throughout the group. I guess my sense of how it would work was that people would present their stories and then there would be time to learn from those stories with the help of the experts. That someone would help us see what these stories could mean or how they might be interpreted, and that just didn't happen. The feedback from you and Daniel was very, very short. As you are sitting there experiencing the story, you experience it and react to it in your own way, but I think the role of the discussion and a facilitator is to broaden that experience. For example, when you read a book, you think about it for a while after you put it down. But when you go to your book club meeting and you sit there and talk about it, people give you new ways of looking at things and you take more out of the experience. So, as I said at our final meeting, I felt that it was quite a loss that you and Daniel didn't take more time to offer that kind of input.

Stress and Distress.

I wrote a lot down in my journal about the fifth meeting – it obviously got me going! That was the session in which we talked about the pain associated with being a family physician and I remember that again, that evening, we were into time issues and feeling pressured for time.

I remember presenting my long list of crosses to bear - the many losses of patients, deaths of young children, suffering that I'd seen in my work - and becoming very upset, and being very annoyed at myself about that. It isn't that I was afraid of seeming pathetic – it wasn't that at all. I just didn't want to cry. I wanted to be stronger than that somehow. I felt that somehow in becoming so deeply emotional and starting to sob, I lost the ability to really convey what it was I was trying to say. I was unable to move beyond experiencing the emotions, when what I wanted to do was somehow get to what this emotional content actually does to me as a physician. In this group setting, it wasn't the emotional content that I wanted to share or live. I realize the impact of such distressing things is originally emotional, but time goes by and you can carry on. I wanted to be able to look at things in a slightly more distant way - I don't know if it is a cool and collected, or a clinical way - to be able to understand and talk about the actual impact that seeing all this suffering has had on me, rather than getting overwhelmed and stuck in the sadness that came up as I recalled these events. It may be difficult for people to understand that discrepancy, but for me it was clear that I was unable to move beyond the emotion of the events, and I didn't want that to happen. So I did feel very annoyed with myself about that.

When I look at what I wrote in my journal I've got, *"sad, overwhelmed, tired, burdened. What a difficult job family practice is. How do I find a balance? I need to feel caring and*

connected, compassionate ……. Need to make a good income ….. Sense of exhaustion, disinterest." Those are the sorts of things I wrote about.

I see that I said I wasn't happy with what happened. I didn't prepare my presentation until the night before and it was a difficult ending for me. I wrote down afterwards that I felt, *"exhausted, exposed and inept! I wanted to take it all back and be more composed, analytical and detached. A sense of being a failure during the session and it just left me feeling like I just wanted to leave, and I felt very disconnected."*

I think saying that I was 'one tough lady despite the tears' after I'd spoken in the group, was an attempt to sort of salvage whatever it is that I felt needed salvaging. It's not that I have any issues about being tearful in the group – that wasn't the issue. It's just that it wasn't where I wanted to get stuck in the discussion. Because of the emotions I was never able to get on to what I really wanted to talk about. As I was speaking, I remember thinking this is tedious - this long list of this person dying, and this person experiencing this suffering, and on and on. Thinking that this long list would be so tedious to other people, especially to a group of physicians who also do all the stuff that I do. Thinking to myself that it's normal for doctors to experience these things, so why am I so upset?

I remember saying that how I coped with all this loss and suffering was that I just sucked it up and carried on. That was what I was taught to do in medical school and residency. I don't ever remember anyone asking how we felt about things when a critical event happened. You were just expected to suck it up and carry on. So I wrote about those feelings in my journal, and how I don't expect support or understanding from my patients or family members – it's my job to be supportive to them. Some support may come from family and friends but basically what helps is spending time mulling over things. Time moves on, the pain gets less, and you become a little more distant from the pain.

I felt that I never did get to really talk about all the negative consequences of absorbing this much suffering. I wrote some notes about how I felt that sucking up all of these sad and difficult events in my patient's lives has had fairly negative consequences on my life. I've often felt isolated. A lot of the other group members talked about sharing these things with their spouses and family, but generally I don't tend to do that. I don't want them to be the sponges for all this trauma.

It's not that I don't share anything with them. If one of my patients dies I will come home and say, "Someone I've known for 20 years died today. And what's for dinner? Who's going to help?" So it isn't that I don't say anything, but I don't want to burden them with the things I experience in my work. Sometimes I feel that all of this has left me somewhat exhausted. There isn't a lot of time for social or spiritual connections. What time off I get is sometimes spent just staring at the ocean or reading a book. And that's fine. There's nothing wrong with that. But it would be good to have some energy (any energy!) left for family time especially and for my

personal interests. I guess it's just the cost of doing business in family medicine, but I often wonder at the cost of it all.

I wonder if part of the reason that my youngest child and I are experiencing a difficult relationship is because I'm just not around enough spiritually. That in giving all my care to my patients, my daughter has sensed my exhaustion and, ironically, because I don't share my trauma with her, she isn't going to share her traumas with me! We talked about this kind of thing in the last session. How, if you don't have the opportunity to acknowledge your feelings and share them with others who understand in a confidential, safe setting, then there is a real danger that the walls you put up to stop yourself from burning out on the job can spill over into your personal life and become walls that prevent connection with the people who are important to you.

I also made some notes after this meeting about the impact of hearing a story that one of the group members shared - my reflections about hearing the struggles she shared with us that evening and how they had affected her. Before then, she had largely spoken to her sense that her life had been relatively easy, smooth and trouble free – which she seemed to very genuinely feel. So to hear this story of very difficult events that she had struggled through, and to see the emotional impact of those events in her life, got me thinking about surface cracks. Reflecting on how we all deal with our surface and the cracks. How each of us, in our own way, seal the cracks up and keep it together.

Meaning in life.

The sixth meeting was the meeting when I had laryngitis. I could hardly say anything, and that was very frustrating. I talked about how difficult that was for me in our final meeting and still, to this moment, I'm not sure how best to have dealt with it. I really was feeling quite out of it at that meeting.

The theme of the meeting was Meaning in Life. I do remember that I found it interesting to reflect on that theme and to go back through some of the things that I found from my University days - like the journal I brought in and the picture from my early days as a physician when I was working in a rural practice. I'd had that day off work and I remember going to the beach and chatting with a woman that I bumped into about the assignment and coming home and writing quite a lot about it. Of course I couldn't share most of what I'd written on the theme. In my journal I put down, *"laryngitis, very peripheral to the group, unable to fully participate not only in my presentation but in reflections back to people which was all too difficult."*

So it was an interesting theme to think about but it wasn't one that was loaded with emotional content for me. I made a note in my journal that it was somewhat uninspiring to hear us all talk about our goals and values. All of us in the group seemed to echo very similar basic principles and values and goals. I guess that's why we were all there!

I remember Daniel's comments about his unconditional love for his children and I made a note about it in my journal. It led me to think about my love for my youngest child; to think about

why, these days, it seems that we often end up being irritated by each other; to wonder how she must perceive my caring - probably very badly. One of the main things that came out of this session for me was realizing the importance of having time for quiet reflection. Knowing that I need to have more time for reflecting on what is important to me in my life and create the space I need to do that.

General Reflections.

"Enjoy spending time in personal reflection, thought and review and discussions with my husband who is always very interested, asks me what I was thinking about, and that was very good for us."

I found it was valuable to listen to others. It lessens the sense of isolation and the sense of burden. In essence, as family physicians we practice by ourselves because we aren't in teams and we don't share responsibilities. As several of us in the group said there used to be more opportunities to connect in the past when we were more involved in the hospital and there was a doctor's lounge and there was actually time to have a cup of coffee with colleagues. But that doesn't exist any more. Family practice has now become quite isolating.

Even if you share an office with another doctor there is only so much time in a day and there is hardly any time to connect because you are just both so busy seeing all these patients in a very short time frame. For example, both the physician who shares my office and I work together on Tuesdays. So that's a time when we often have little, minute chats about things. But by the time we get to do that it's 6 pm and I'm thinking "OK so I've got to get these charts done. I've got to get home." So there are lots of things we would want to talk about, but it's just the whole time thing! How are we going to do all this??

That's why it was so very valuable to have this dedicated time set aside to be in the group and be able to spend these hours together. And quite remarkably, nobody ever got called out of this time.

It was very good to be in a group with other family doctors - very helpful to connect with other people who do the same work. Being able to share with other people who understood allowed me to have a sense that I was not alone in experiencing some parts of the work as very stressful and others as rewarding. Also, as I said in the final meeting, I found it very valuable to be able to be real in this group – not needing to pretend that things are going OK and put on a forced smile when they aren't.

The group confirmed for me the importance of having some kind of structure or process in place for doctor's to debrief stressful and critical events. The group was a place to begin doing this, but as I said in our feedback session I felt we'd only just begun to prick the scabs of our wounds. When the group ends, there isn't something in place where we can continue to find connection and support, although that is so needed.

My last comment is that the group was too short! I thought we were just sort of settling into a comfortable group dynamic and it was over. I can actually only think of one group thing that I have ever done in my life, which would have been 25 years ago so I don't have much experience with groups, and I certainly don't facilitate them. This was pretty much a new experience for me and I found that the journey of how a group forms, how it connects, and how it creates an identity for itself, was an interesting phenomena. I really felt that we were just sort of cozying up into the group, and it was over, it was gone.

I think what I will certainly try to do following this experience is to take more time to be reflective. What I really need to do is to figure out what I have to do to make this job do-able. I have another ten or fifteen years work ahead of me and I don't like feeling annoyed about it. There are parts of my work that bring me joy and energy and parts that drain my energy. So in the future, I want to do more of the things that energize me and cut back on those that don't. And I want to create more time for myself and for enjoying my family. At the last meeting, I said that I'd come to a realization that the answers lie within myself. I guess there are two sides to that.

There is the whole aspect of how do you find satisfaction in life and where do you put your energies. That is a very personal process. Nobody can do that for you. And then there is the aspect of how does one find professional satisfaction.

I think that there should be something in place within the system, and the people who fund it, to help you find that professional satisfaction. As an experienced, trained, working physician you have some value to the system in terms of looking after people and knowing what to do. I really think the system should look into that when so many people are just crawling away - packing up and leaving because they don't feel supported. When you get to the point where you just can't do it anymore, then the bottom line is, you are out of here. And this situation is happening at a time when there are not enough physicians in this Province to look after patients. I think the system should look into that and say, "What needs to happen here? We value you in this job. How do we do that?" Rather than just saying, "We have no feedback. These are the facts. Go figure it out on your own!"

As a family physician you're part of a system that you have no control over. You are an independent practitioner, but you are still part of the government run system. We don't officially work for anybody - the hospital has no official relationship with us and the government couldn't care less. We do work for the people of this Province, but it's on a one to one basis, and they don't pay us. It is such a bizarre way that this whole system works. You're not truly independent, you don't have an employer, you have no benefits and there is nobody who is really looking at this and saying, this is what needs to happen here. I actually think that it has only occurred to the system very recently that they should try and help their doctors. For many years now, we've been made to feel that we are the bad guys - because we're looking after patients and costing the

system money!! If we weren't doing our jobs, if we weren't looking after people, it would be cheaper!!

I'm at a crossroads in my life. In fact, as of yesterday, I'm more at a crossroads than I realized. I have been part of a group of physicians looking into getting funding to change the model of how we practice. We really didn't expect the funding to come through, so I haven't paid a lot of attention to it. Now all of a sudden this could become very much a reality, and I have to decide whether I am actually going to go forward with this group. It would be a complete change in how I do things. I would move into an office with six other physicians, the system would be fully computerized, and the payment model is quite different. It's a population-based funding model where rather than being paid per visit you receive a global budget for the number of people you care for. So you don't have the same pressures that you do in a fee-for-service model of feeling like you have to see more and more patients, and not talk to people on the phone, and not do prescription refills on the phone, because you simply don't get paid for any of those things. In this model, you can talk to people on the phone and not feel annoyed when people ask you to do that! However, it's not a system without problems. The understanding I have so far is that every time one of your patients uses a walk-in clinic you get deducted, and you have to pay the walk-in clinic from your budget. I'm sure that causes some irritation! Anyway this opportunity has suddenly reared its head and now is the big choice point - I have to decide how I want to move ahead. I think something is going to change for me in a very dramatic way.

Feedback on structure, facilitation, and future directions.

I realize that this was not meant to be a psychotherapy group but on the other hand, as far as I was concerned, the purpose of being there was to be in a therapeutic process where I could examine my role as a physician, what effect that was having on me, and be able to do that with a group of colleagues. Maybe some of the themes such as branching points and family of origin could have been done as exercises that weren't necessarily brought into the group, or somehow given less time. Those themes were interesting in allowing us to know the other people, and the contexts in which they work, and who they are as individuals - so I don't think you can completely eliminate them, because it does help to know those things about each other. But I think in these kinds of groups you need more time to explore issues like: What does it mean to be a family physician? What are the stresses? How do you deal with them? Those issues warranted longer time. I think it would be valuable to either expand the number of sessions so that there is more time to discuss these topics, or reduce the amount of time spent on other things in the initial sessions. For instance, when Daniel talked about the life review process and you went over the research component of the group in the first session, I felt that was redundant, because you had already explained all of that to us in our individual meetings before the group started.

As I said in the last meeting I also think it would be valuable to see how this kind of process could evolve into something more ongoing. My sense is that some kind of counselling or

critical incident debriefing is available to a lot of people in the workplace, but I don't think it's ever occurred to people that maybe physicians need that too. So that if you had some horrible thing that happened, you could book an appointment and discuss with a counsellor. Talk through how it was for you, rather than sucking it up, not burdening your family with it or pretending that it really doesn't matter.

Of course we can avail ourselves of those things. We can set up our own appointments, and we can get ourselves therapists, and we can do all of that - but physicians don't. Physicians simply don't do it - it's not the role model. Doctors don't make good patients. Even if it's a physical problem, and not an emotional one, they are too busy being doctors and not patients. Doctors are notorious for that. When it involves emotional issues, I think the reasons that doctors don't seek support is multi-factorial: It's availability; it's embarrassment; it's the sense that nobody else needs to do this - so what's wrong with you?

I think it's how we have created this image of what, and who, doctors are and sold it to the doctors and to the medical students. Perhaps the current day medical students aren't so much sold the same bill of goods, or maybe at least they don't buy into it in the same way. But certainly my generation of physicians were sold it and bought into it. So it's different, more difficult, to think about going to some sort of actual therapist, as opposed to being able to get together with a congenial group of supportive colleagues, and be able to enter into a space of personal reflection and sharing, and know that it is helpful to do that. Kate and Ray talked about the Practice-Based Learning group they belong to, and I think those sorts of things are helpful but it's not the norm. Most physicians don't belong to those kinds of groups.

In terms of Daniel's and your roles in the group, the fact that you are a non-doctor was absolutely not an issue. I saw you in your role as a facilitator of the group. I never perceived you in the role of an observer or peripheral researcher. The research was why this group was happening, but it wasn't part of the structure of the group.

As I said earlier, I thought that you and Daniel should have had more time to use your skills as facilitators of groups. That was missed – it was a loss. I honestly felt that there were times when you were reflecting back to people on their stories that your responses were very restrained and restricted. I had the feeling that you were searching for things to say that were genuine but somewhat tightly packaged. My sense was that both of you were restrained in the things you said, and how you chose to say them, because if you opened things up there wouldn't be enough time to deal with them. Most of the comments you made were basically reflecting the situation back to people. Which was fine, and it's good to hear those things, but it felt superficial and compressed. Just some reflecting and now it's time to move on – let's have the next story please! It made me feel like, "Where is the beef??"

The fact that the participants were all physicians was very key because that's what this group was all about. How you are living your life as a physician. But you don't necessarily need to

be a physician to facilitate the group. You need to have the skills to run a group, to know how to make that group work, but you don't need to be a physician. I had a sense of connection to Daniel as one physician to another, but I don't think the dynamic of the group was affected by whether he was, or wasn't, a doctor. It's certainly affected by who he is as a person, but that is different than who he is as a physician.

I definitely think the concept of the group we were in is very valuable in terms of sustainability. It's important to explore these issues and frustrations together. One of the things that I really worry about though, is that I don't know if there are many years left for full-service family practice in an urban setting. Maybe it is too late to sustain this model of care in the current climate. There are very few young physicians coming into this model of full-service care and you can't sustain a system that doesn't have young people coming into it. So I wonder about the people in this group who, like me, are full-service family physicians. Maybe their days are numbered? Where do those people go? How do they continue to practice in a system that is exhausting and doesn't value them?

We are not here to fix the system, but if family physicians didn't feel so isolated, or so exhausted, and more supported both emotionally and financially, then perhaps some of the young physicians could see that they didn't need to be so afraid of being isolated and overwhelmed by demands that they are not prepared to take on. I think that if young physicians knew this kind of group process for sharing with colleagues was available, and if they could see it as a part of how they wouldn't be isolated, it would be very helpful.

It's actually quite funny at times to wonder how other people perceive what we do as family doctors. One of my colleagues is an obstetrician so she only sees people for their pregnancies and to deliver their babies - she doesn't know them before that, and she doesn't know them after. She is constantly being given presents by the patients she sees. Yet here I am, with people who I have looked after for ever, gotten up at three in the morning to deliver their babies, looked after their postpartum depressions and everything else, continue to look after them and the baby, and I can't actually remember in the last five years getting anything more than the very rarest thank-you card! I just don't understand the discrepancy. It's a bit similar to when the nurses in the case room say, "Oh your patient, so and so, gave us these chocolates and this wonderful thank-you card for all our fine care and nursing", and I laugh to myself and think oh well, guess I missed out on the chocolates!!

It isn't to do with the cards and the presents – that isn't the issue at all. It's more wondering how, as family doctors, we are perceived in society. The ongoing care doesn't seem to have the same value for people in some ways, or doesn't seem to warrant acknowledgement. I really don't understand that. It's odd. Maybe it's somehow just taken for granted that that is the way it is:

Thisismydoctor

        shelooksaftermeandwritesprescriptions

            andgetsupatthreeinthemorning

              andspendsfivehoursdeliveringmybaby

and

   then

     Iseeher

       twodayslater

          andonwego ....

Ray's Story

I can't really remember if I'd heard anything about this project, or about life review, prior to hearing you and Daniel speak at Family Practice Rounds. I don't think so. At this point, it all kind of blurs, timing wise, because subsequent to the presentation I talked to a couple of people who had done life review before and found it very valuable. So really, for myself, it was just the presentation at rounds that made me think about joining the group.

I have an interest in issues like vicarious trauma, care for the caregivers, and sustainability for family doctors. So the presentation rang close to home. Although I didn't know much about life review, it sounded like something that might be valuable. In the profession, we aren't really taught to spend time on self-reflection or self-care – the reverse is often true. In general, as doctors, it becomes more familiar for us to live in our heads, rather than spend time being aware of our own feelings. I think it's important for doctors, myself included, to pay more attention to issues of vicarious trauma and self-care. We know the statistics that speak to high levels of distress among physicians, and we all know examples of the toll that being a doctor has taken on colleagues.

Part of the work that I'm currently involved in has to do with working with family doctors who teach residents. Looking at issues such as: What makes a good teacher? How do we sustain both teachers and residents? How do we inspire residents to become family doctors? So I was also interested in exploring and learning more about life review from that educational perspective. To see if, or how, it might inform work with residents.

But apart from these interests, probably the biggest factor in deciding to join the group was that I knew both you and Daniel. I knew that whatever both of you would be involved in would be very high calibre and valuable. So to be honest, it was probably the credibility issue that was the deciding factor for me.

Even though the name, life review, is somewhat self-explanatory, and you and I had talked about the concept and the structure in our initial meeting, it's not necessarily easy to really understand what the process will be like. I remember talking with Kate before the meetings started. She is very organized and more detail oriented than I am – I'm more oriented toward concepts. She said, "I don't know exactly what we are going to do, or really what the process will entail, or what the details of the topics are". And I responded that I didn't know either but, "Let's just go with it, it'll be interesting!"

In our final session, some of us talked about the fact that it might be helpful in the future for people to have a more detailed outline about the various topics ahead of time. I know that some people felt, in retrospect, that they would have liked to spend more of our time on themes specifically focused around work and life as a family doctor and less on the personal themes. That wasn't necessarily, or specifically, my focus. Of course, the general understanding of the group was that we were looking at our lives as family physicians. Nevertheless, I think that any

work that any of us do affects both our careers and our personal lives. You can't completely detach your career, your life as a family doctor, from your personal life. Ultimately, I think, what any of us as human beings often get in trouble with is unresolved personal issues, and how they carry over into our work and personal lives.

For me, it was very important that there was a balance of looking at career themes and personal themes and I think it is important to have both in a group like this. For myself, I found the personal themes were the most interesting, because they are more intimate and allow you to delve into yourself more. The themes around career and work trauma were interesting, but for me, they were less intense than the personal themes. That's probably because the bigger issues in my life, the things that affect me more closely at this time, are not work related.

One of the things that drew me to this group was the desire, on some level, to engage in self-exploration and have a structure that would help me to do that. I don't know if it's partially my personality, but practically speaking, there are so many distractions and other demands that I just don't make the space for personal reflection unless there is some kind of structure or facilitated process in place. It's like needing a deadline, or a book club, to get motivated. You want to read the book but you don't have the time to do it. But you know you need to read the book because you're going to a meeting to talk about the book. So you read the book! From that perspective, the group worked well for me.

I found the whole process interesting. It's interesting just to read back through my journal. When you're no longer involved in the reflecting and writing your impressions and memories start to blur. That's where it is actually neat having the journal. You can go back and read a little bit and it really does stimulate memories about the experience and what was significant for you at the time. I actually enjoyed the writing process - being forced to take the time to consider the bigger picture issues that we don't usually do, and certainly don't take the time to reflect on. That was very valuable.

In general, though, I found the process frustrating because it was too rushed. That really compromised the whole experience for me. It certainly wasn't the time between meetings that was rushed, because that was at our own pace, but I found the sessions challenging because we were trying to get so much information packed into each one. Three and a half hours is a significant length of time, but it is amazing how quickly it goes. And even though we went over time most evenings, I felt there wasn't enough time to delve into issues in significant depth on any of the topics.

Initially it takes a while for the group just to get to know each other and to come to an understanding of the process. I think that we worked well as a group, but the whole group building process takes time. There is always some initial hesitancy or anxiety in any group when you first come together and that's probably especially true with doctors. My impression is that we tend to be a pretty guarded group. We are guarded and we tend to intellectualize, as opposed to showing

or talking about our feelings. It's just part of the nature of our profession and our built in defense mechanisms. We probably bring that to anything we are involved in, and it takes a while to get beyond that.

I was a bit surprised at the anxiety I personally felt in initially settling into the group. I've been involved in therapeutic group work before and I'm not exactly a shy person -- usually, in fact, quite the opposite! I guess it was just the heightened anxiety of exposing myself among colleagues as opposed to an unknown group of people. I wrote about that in my journal after our first evening together: My sense of going to the group with mostly positive anticipation and slight anxiety; the heightened anxiety I felt in actually meeting the other group members; the challenge of being in a group of physician colleagues with whom we are supposed to be scientific and stoic, not touchy-feely. I was surprised to meet some of the people who were there and happy that you and Daniel and Kate and Eric were in the group - people that I'd known before. So just generally feeling some apprehension about how we would get along together and how comfortable I was going to be in a group of professional colleagues.

The first evening, when we paired off to talk about a branching point that was significant in choosing to become a family doctor, I was aware of feeling anxious about speaking and being listened to, even though it was just to one other person. It made me realize that in my work I'm more used to being the one who is listening and asking the questions -- being the one who is more in control of the interaction. Initially, it felt unnatural to speak and be listened to by the other group members. I felt vulnerable exposing myself, especially in front of colleagues. I suspect it's pretty common for people to have that sense of initial anxiety when they first join a group.

Most good things that come out of any kind of growth process involve exposing yourself to some degree. It's a vulnerable process, but it is also an exciting and valuable process. It just naturally takes some time to develop trust and a sense of safety and gradually feel comfortable about exposing more of yourself. Certainly, I think the biggest thing that I get out of listening to other people's stories is an understanding of them. It's a learning process - just adding layers and layers of knowledge, and understanding, and a depth of history with somebody.

I think one of the reasons that our group came together well and the process worked so effectively was the group facilitation that you and Daniel provided: The sense of safety that was created; the trust in the confidentiality of what we shared; the climate of respect and mutual support among us. I think that we really settled in as a group, and started feeling very comfortable and safe after about three sessions.

I find it quite fascinating to think that we had perfect attendance - with the exception of Eric who had to miss one session because he was in the hospital being operated on. That is just unbelievable for a group of six physicians over seven weeks! It is quite phenomenal. What that speaks to is the sense of commitment that people felt to the group and to the process. Realizing how valuable and necessary it was that everybody be there every time. Because ultimately there

is no reason that you can't do that – it is just prioritization. You decide, "This is important. I am going to shift my other commitments and work my life around it."

I think it would be beneficial to expand the life review process over a longer time frame and meet for at least eight or ten sessions. I realize it's easy to say that in retrospect after you've had a positive experience, but ultimately, I feel that six weeks is just too rushed. While you get a taste of things, you can't really explore them in adequate depth and, for me, the sessions themselves felt very time-pressured.

It takes a while to get to know what the process will be like. We'd talked about the idea of presenting about a maximum of two typed pages on each of the themes. I found that helpful in initially thinking about writing on the various topics. It felt like a realistic amount of writing to do – not too overwhelming. I found the writing process was enjoyable and not nearly as onerous as I'd thought it might be. In fact, it turned out that the problem was trying to keep it to just a few pages! It's easy to get going and write a lot more, but then the challenge comes when you have to pare that down and decide what you are going to share in the group. Initially, I didn't really pick up specifically on the idea of only having fifteen minutes to present on a theme. The sense of how much you can actually present in fifteen minutes, and just how quickly fifteen minutes goes when you are speaking, is hard to grasp at first.

For instance, I decided to present the major branching points in my life in a chronological way – starting in my childhood and moving toward the present. A major branching point that happened recently in my life was the death of my brother a couple of years ago. I was planning to speak about that, but just chronologically, I didn't get there. I remember running out of time and making the conscious decision to not bring up my brother's death. So even when Daniel asked if I wanted to take a few more minutes, or if there was anything more I wanted to add before ending, I left it unspoken. It isn't the kind of thing that you can just throw in, or mention in passing. You need to have adequate time to discuss or explain important events like that, especially when you are in a group of people that you don't yet know, other than perhaps peripherally or professionally. Later that evening, I resonated with the story that Vanessa told, and I spoke about my brother's death in response to her story – our shared experience of losing siblings.

I think the handout you gave us on branching points talked about maybe looking at our lives as a branching tree or flowing river. Those metaphors didn't click for me when I was doing my own reflections and writing. But when we were in the session and people were sharing different analogies and stories, the image came to me of a tree with several main branches - each branch representing a different theme in my life. I'm not an artist, but after the group I sketched out a little schematic of that tree in my journal. It was kind of neat, and actually very helpful to do that. I'd written about my branching points as more of a chronology whereas the drawing pulled things together in a more integrated way. Having that conceptual framework made it easier to see and understand the significant themes in my life and how they relate to one another.

There was some talk in the feedback session that for some people the branching points theme wasn't as relevant, or as valuable, as the topics that were directly focused on life as a family doctor. I actually found it very interesting. But it's a big topic and I think you need time to really explore what those turning points are ultimately about. You can't adequately explain all the major branching points in your life in fifteen or twenty minutes. You can really only give an encapsulation, maybe highlight a couple, one or two of the major branching points.

I found the reflection process was very helpful and journaling was very effective and useful. I was surprised by how much I enjoyed the journaling when I got into it and scheduled the time to do it. Generally, I would reflect back on the previous session and journal about that, and then get into writing about the next theme that was coming up. So I sort of linked the two kinds of writing together. In some respects, I found reflecting on my experiences in the group and journaling about things that were significant for me, was as valuable for my own learning as writing about the various themes.

The sensitizing questions that you gave us on each theme were very helpful. They take you into reflecting on a lot of different aspects of the topic, which is valuable and interesting. But they were quite extensive, and although the handout said we didn't have to answer all or any of them, I think most people did reflect on all of them, and then felt they wanted to share a lot of what they had thought, or written, about in the group.

For me, I was constantly aware of feeling tense about the time-pressures. The sessions continually ran overtime, and often it was ultimately very late by the time we ended. I experienced that as fairly anxiety provoking - which I found surprising. I chronically run late in my life and I have to be continually watching the clock in my office because I am chronically running behind. So I was actually very surprised that I reacted so strongly against the time pressures in the group and going over time. This whole issue has been a learning process for me. I still don't completely understand it. But I think part of the reason for my anxiety is that because I am so chronically aware of time pressure in my life in general, I don't want to have to deal with that issue in a therapeutic setting like the group.

It has been interesting to reflect on my reactions and try to figure out what it means. I know that I wasn't the only group member who found it stressful that we weren't sticking to agreed time limits. In fact Daniel shared with us that he experienced a lot of anxiety about time constraints and found it very challenging to struggle with that issue. I don't think it should just fall to the facilitator to handle things like that, because it's obviously a group issue too, but it does need to be addressed.

Certainly, in our daily work as family doctors, one of our issues is a constant struggle with time, or rather lack of time - worrying about whether we are running on time, or running behind. Usually, I believe, people will talk for as long as you let them. Even patients who say they are going to be very quick, or that they don't have anything much to say this visit, will generally talk

for as long as you will listen to them. And inevitably there is always going to be one more issue they want to bring up at the end of the appointment. So I think it is important for people to know the ground rules, and that's one thing we don't do well in medicine, is set up the ground rules so that people understand how much time they have. I believe it's no different in the group. If people know the ground rules, they will respect them, and even if they are into an intense story, they will understand and accept that you say, "OK, we've reached the time limit." And if I need to say a little bit more, I can say, "I just need to finish up this thought, or this part of the story," or I can choose to explore it further at another time.

It's an anxiety provoking position to have to be the person that does the limiting. But if those are the ground rules, I think that everybody would be fine with being cut off. Because that's the structure of the group, and it's been spoken to, and agreed to. Ultimately, if that doesn't happen, the ground rules become kind of blurry. We say we're going to have fifteen minutes to speak, but sometimes it stretches to twenty, or twenty-five, or thirty. Then, as a group member, it becomes a bit confusing. I'm no longer clear what the actual limits are because they seem kind of loose. I don't want to cut myself short, but I'm not quite sure how long I've got. I think the bigger issue is probably whether three and a half hours is adequate time. The real issue is that we just had so much material to cover each session that it really put pressure on the whole evening, and we realized that we probably just couldn't cover everything we wanted to in the time frame.

When we moved into career and talking about life as a family doctor, an interesting and very positive thing that I got out of the group was the recurrent theme about the importance of relationships with patients. When we were talking about what keeps us in family medicine, the significance of relationships with patients kept coming up, again and again, in all the stories. Every one was speaking to the fact that being a family doctor is not just about making a diagnosis, and treating somebody, and prescribing the right drug. It's really about the enduring relationships you build with someone and their family members, and how that affects somebody's health. That certainly rang home with me. What I really enjoy in my work are the relational and psychological and emotional aspects of the job, as opposed to the mechanics of medicine. Connecting with patients and building strong relationships with them is very important to me.

It was nice to hear the importance of those relationships articulated by other colleagues. To hear the other doctors in the group saying that what keeps them in the work, and what they enjoy, are the relationships with their patients. It was not only confirming for me personally, to hear that, it also brought me some enlightenment. In terms of our discipline, I just hadn't really thought of that issue in that way before. That this is really so much what family medicine is about. Even for people who are really busy and seeing high volumes of patients, it's all still very much about building that sense of connection and relationship with patients and their families. That is the core of what is important to family doctors, and what is rewarding and sustaining for them professionally.

In the current structure, the continual time pressure around getting people in and out of the office as quickly as you can, is big hit, a huge assault, on the sustainability of full-service family practice. That is why I have personally made conscious decisions, in both of my practices, to not remain in fee-for-service any longer. In one practice, I have just switched over to a population-based funding model. I'm not sure how that is going to work out financially, but there is less pressure in terms of the number of people I need to see each day, so more opportunity to connect with patients in a meaningful way. At my other job, I am on salary, so there's no question that it is basically a very different experience with regard to the kind of time I can spend with patients.

In the group, there was a fair bit of frustration expressed about the state of family medicine these days. How difficult it has become to sustain yourself as a full-service family doctor and maintain your career in the current climate and structure. It is something of a pervasive feeling right now in our field, which is frustrating. I found it interesting to hear that articulated and explore it more together. I think that was one of the important things about this group. It was a valuable process to just get together and voice the frustrations and challenges and know that you are not the only one who feels that way. It was also valuable to share different ways of coping or dealing with these challenges - to hear what people are doing about it, what kinds of different career choices they have made, or are considering, in terms of their own sustainability.

I think it was also very useful to explore some other aspects of the job – what we found enjoyable, rewarding, energizing. To take time to focus on some of the positive benefits we experience in the work, so that the negative things don't become all consuming or overwhelming. For example, I had the sense that one member of our group was feeling very pressured in her career right now because of the current way health care is structured. By the end of the group, I got the sense that she had shifted her perspective a little, was seeing some of the more positive aspects of family medicine that she really values, and thinking about how she can change things to find a better balance for herself.

Without the safety of the structure and the process, I doubt that we would have been able to share what we did in this group. For example, the whole issue around mistakes in medicine. Medicine is not a culture that really shares mistakes very openly, although it is so important to learn from them. But there is this whole pressure within society and within the profession that doctors should be perfect, or that medicine should be perfect. And if you are not perfect you will get sued and all that kind of stuff. But I think there is a need and also a desire, even if it that desire is subconscious and not verbalized, to be able share concerns about mistakes or possible mistakes. So it is very valuable to have a forum, like we did, where you can talk about those kinds of things in a confidential, safe environment.

Sometimes in society there is still this whole idea of looking up to doctors as somewhat superhuman, some how infallible, not able to make mistakes. And I wonder how much the

profession perpetuates that? How much do we self-perpetuate that? I don't find that attitude very helpful. On the whole, it perpetuates a lack of self-reflection and a lack of sustainability among doctors. Sometimes in other groups people will say things like, "How can you continue to be on call and deliver babies all night? Oh, you must be so altruistic." Words to that effect. Well, whatever! It's our job, it's something you get used to, it's what we've chosen to do, it can be positive or negative, there can be fallout from that, and you can debate the merits of that. I think it is very important to get beyond the 'superhuman' image that some people still project on doctors, and not buy into that. Because in the end, that leaves us very vulnerable to not being allowed to make mistakes, to not being allowed to be human.

So the advantage of being in a group of colleagues who understand the experience of being a family doctor, is that it makes it much more realistic. And at the same time, you can also explore whether the way we are doing things is healthy. Is it sustainable? Does it make sense? Do we have to do it this way? That's where having someone like Daniel, who is also a family doctor, was very helpful. But even if the facilitator isn't a doctor, I think you can also get into those questions just within the group itself when you are among colleagues.

What I wrote in my journal about this group process after our final session was, *"Anti-isolation. Anti-burnout. Anti-insulation."* I think that being able to reflect, and recognize your feelings, and share those with others in a safe and confidential setting is very important in preventing disconnection, burnout, relationship difficulties, or many of the other problems that we know colleagues have struggled with and suffer from. Being able to share common themes and experiences, and even just give voice to common challenges and frustrations is a beneficial and supportive process. I think, as doctors, we can become emotionally detached. Part of that ability to detach emotionally is imperative. If you are too sensitive to all the trauma, and life pain, and suffering that surrounds you in your work, you couldn't do the job. But if you totally block out your feelings, that's not healthy either.

I think it would be fascinating to study how to manage to keep a balance – to let enough emotion in, without becoming overwhelmed by it – the whole issue of vicarious traumatic stress. I think when we start to get overwhelmed and burnt out, the walls go up, and you really try to protect yourself. But it backfires somehow, because you don't get any emotional release either. The walls keep the suffering in, as well as keeping it out. That prevents you from being able to recognize, or deal with your own feelings. So the natural osmosis of emotion gets plugged - the dynamic flow is blocked. Your emotional filter is plugged up. It's dirty. You need to get your filter cleaned out! This group is a kind of therapeutic process to keep the filter clean.

A huge part of our job is therapeutic listening. But that's something that's probably just really starting be talked about in medicine, or just realized. People who are good doctors naturally do that, and can understand that. But there is such a counter-culture to that as well. The whole rigid scientific, academic, didactic culture that says it's got to be by the book, and you have to be

in your head, and not your heart. I believe it takes space to have the kind of empathetic capacity that is needed to connect to patients with your heart. When we are healthy and taking care of ourselves, we can remain more open to other people's pain and suffering, we can be more helpful and effective.

As I said at the last meeting, my thoughts were, and still are, that it might be more valuable to do this kind of life review process with a group of people who work together in some other capacity, or who already have an existing relationship - for example a group practice, or a department, or a Practice-Based Learning group. I can see that people might have greater concerns about exposing themselves to colleagues they work with, and will maybe feel more vulnerable, or that they have more to lose. But, I think already having some existing knowledge of people could be an advantage. Your preconceptions may be right or wrong, but you have some kind of understanding of each other, some background context. There may be less initial anxiety about joining the group, so building a sense of group cohesion may come a little faster.

Even more importantly, if there were some other binding force apart from being in the life review group together, it would work to sustain lasting relationships among the group members. There was a fair amount of talk at our last meeting about how to continue on this process and retain the experience of feeling supported and connected once the group ended. If we are ultimately trying to facilitate sustainability, engender a sense of collegiality and community, and promote connectedness as opposed to isolation, then it is important to have a way to maintain the relationships that have been built through the process.

I think the kind of group format that we had is very important as a means for giving doctors an opportunity to connect - especially for people who are not connected to colleagues in other groups. So it is very important to have groups like this available. But personally, I think I would have found it more valuable to do this in a group of colleagues with whom I work more closely and have a continuing relationship with. I think it just would add a whole other level.

For example, Kate and I have known each other for more than fifteen years, since being in residency. We have worked together a bit, and share a friendship and group of friends in common. But I gained a huge amount of insight and closeness with her through this group process that we haven't gained in fifteen years of knowing each other and working together. Being in the group together deepened our relationship in a very positive way. I think it will really help in terms of the ongoing support that we can give to each other.

With the other members in the group, there isn't a structure in place or natural opportunities to connect that will allow us to sustain the relationships we've built. We have gone through an intense process together, got to know each other, and exposed ourselves to varying degrees, but then it just kind of ends. In some respects it feels like the experience we had together hangs out there in the ether a little bit. So I feel strongly that the process would continue to be of benefit, or be of more benefit, if it were embedded within a group of people who naturally

meet anyway in some kind of group context. I suspect that once people had experienced this kind of group process together, they would automatically continue to share more with each other than they did before, because they would know more about each other and feel a greater sense of comfort.

The biggest thing I got out of this for myself is probably the knowledge that I am interested in doing more self-exploration. I also realized that I want, or need, to do that in a venue that has the capacity to get into more depth around challenging personal issues. Having been exposed to more intensive therapeutic group processes in the past, I realized that I'm ready for a more intensive depth of self-exploration than life review is designed to provide. During our sessions, I often felt that I wanted to push the process further and get into the issues at a deeper level than we were able to do in the life review structure.

So at a personal level, the group experience didn't have a dramatic impact on my life. I found it interesting and valuable, but not earth shattering by any means. That may also be partly due to the fact that I don't feel a burning desire, or heightened sense of need, to do major work around career or personal issues at this time in my life. My impression was that some of the other group members found the process extremely valuable and moving, and I know that for some of them it was the first time they had done this kind of work in a group. Overall, I think life review provides a valuable introduction to self-exploration in a group context and the impact of the process on people's lives, or the significance of what they take from it, probably depends on individual people's readiness and where they are at in their lives.

At a professional level, what I took from it was a heightened awareness of the benefits of learning and sharing among colleagues as ways to promote sustainability and self-care. The necessity, although we are not used to doing that in our culture, of staying in touch with our own feelings so that we don't become burnt out, or emotionally shut down, and end up jeopardizing important relationships in our lives, or self-soothing in ways that are harmful.

The group certainly reinforced for me that there is a need and a strong desire on the part of people in our field to have this kind of opportunity to connect with colleagues, and be able to explore their feelings and experiences in a safe and confidential environment. It also reinforced my feeling that we need to encourage family doctors, and doctors in general, to do more of these kinds of self-reflective processes. One of the main things I have taken from this experience is the feeling that it is important to keep looking for ways to offer similar kinds of groups for family doctors and potentially for residents. There is a need for it, and a desire on the part of family doctors to go there.

Feedback on structure, facilitation, and future directions.

In our final session, when we were giving feedback on our experiences, there were a lot of different suggestions about how to solve the time pressure problems or have something like this process available on an ongoing basis for doctors. I think someone suggested doubling the

length of the group and spending two sessions on each theme, so that only half the group would present each evening. There was also a suggestion that maybe not everybody needs to present on each topic. I don't know about that. I think if everybody had prepared their story they might feel really short changed if they didn't get to tell it in the group. Also, if you thought you weren't going to present on a certain topic, I wonder how much of the reflecting and writing you would actually do! I think it's valuable to hear all the stories because it is a learning process – learning more about each other and learning from the stories that people tell.

I think somebody suggested having a drop-in group where people would be able to debrief stressful or critical events. I think, practically speaking, it would be very challenging if the make-up of the group was always changing. I don't think people would feel safe enough to share, because part of the process is developing comfort, and confidence, and safety within the group. I think if you wanted to have some kind of ongoing process in place to debrief critical events, it would have to be piggybacked on to an existing structure where people had already established trust and a history together.

That's where my thoughts around building this process into an existing team come in. If people had experienced this life review process together, they would have established a level of trust and connection that would allow them to debrief critical events among themselves. The group would have an ongoing natural life, and people would have developed the capacity and safety to share at a deeper level. So the opportunity would be there to share difficult experiences with colleagues when they came up, or you could make it into a more formal structure - meet once a month to discuss challenging issues.

I guess the down side of doing a process like this with a team that works together is that you have to deal with the existing group dynamics. If there are tensions in the group or personalities that tend to dominate, people may not feel comfortable speaking. But I don't see that as insurmountable by any means. I think it's the role of a good facilitator to ensure those kind of dynamics don't derail the process – make sure that everybody does get time and space, and is listened to in a respectful way. Which certainly doesn't necessarily always happen at the work place or in committee meetings! I think a well facilitated group might also really help to improve existing group dynamics, and there could be a huge spin off benefit in terms of team building.

Another thing that Kate and I brought up is that we are involved in a study group that almost acts as an informal professional support group. We have been together for about ten years now and it has evolved into that over time. There has been some change in the group membership, but actually a lot of the core people have been there from the start. The reason we've continued to meet for so long is because of the supportive nature of the group. We often end up talking about challenging cases or events that may be related to the topic of the evening – or may not! I could certainly see that work around sustainability or critical events could be built into groups like ours in a more formal, or acknowledged, way.

In fact, Daniel came and talked to us several years ago around palliative care issues and talking to people about death and dying. One of the exercises he had us do that evening was to pair off and share a personal experience with just one other colleague. I can't remember what the topic was, but I just remember it was neat, a very valuable experience. It was a little bit new territory for us, but it was in an existing structure and related to an educational topic - although it was really more about personal development. So another potential model could be to build the kind of process we experienced in life review into an existing Practice-Based Learning group. Generally, at our meetings, one of the group members functions as a facilitator, but I think if we were going to move into sharing at a deeper level, or look at more personal issues, it would be important to have an experienced group facilitator to lead the process. One of the strengths of our group was the facilitation that allowed us to create a safe environment. I think it would be essential to have that available in the future when people are doing this kind of work together.

I think you could probably offer this kind of group to allied health care professionals, but the focus and the issues would likely be very different around the career themes, if not the general themes. When you are looking at the personal themes in life review, I don't think it matters as much what the make-up of the group is. But if you are looking at career issues, career decisions, work-related trauma, and sustainability among family physicians it's important that all the group members are family doctors and have an intimate knowledge of what it's like to be a family doctor. Personally, as I said before, I think it is important to have a blend of personal and career themes as part of the process and not break those apart. The combination builds a more solid group connection and depth of interpersonal trust.

I think the fact that Daniel is an experienced family doctor and also has skills in counselling and facilitating groups was a very significant factor with regard to the initial buy-in and legitimacy of this process. But extrapolating beyond this first group, I don't think that the facilitator would need to be a family doctor. I really don't think that would be a critical factor, because it's the group members who are doing the work, and most of the sharing is among the group. The person leading the group needs to have good group facilitation skills and an understanding of the issues that face family doctors, but they don't necessarily have to be a doctor. Daniel's insights were very helpful because of his combined skills, but I think the biggest insights come from really reflecting back to somebody what they are actually saying themselves, what you are hearing from them, as opposed to whether you have a knowledge of the professional field.

I don't think your presence in the group as a researcher and non-doctor had any effect on the process – certainly no negative impact. At times, I was aware that we needed to explain to you what the medical language meant, or clarify the meaning of a particular issue to us as doctors. There is something of a different language that we use and understand among ourselves. However, I don't think that would prevent someone who isn't a doctor from facilitating

this kind of group. As long as they had enough of an understanding of the culture, they could simply do what you did occasionally and very artfully ask for clarification when that was needed.

In some respects, because you aren't part of our professional culture, you were able to reflect back to us that what we are dealing with is sometimes more unique than we may have realized, or paid attention to. I appreciated your insights and ability to challenge us at times to really hear what we were saying. You get so wrapped up in your own world that you just take things for granted and accept that it's part of the deal. You just take it for granted that you are on call every night during the week; or that you are up half the night delivering a baby; or that outside of work, many people assume that because you're a doctor, it's all right to approach you in all sorts of social situations and start asking you for medical advice. So having an outside perspective, someone who reminds you that some of the things you take for granted are not actually normal, can be valuable. In some ways, it is actually quite grounding.

Chantal's Story

I think part of the drawing card for many of us to join the group was that we knew Daniel. A couple of the people in the group had met you before. I hadn't, but I had met Daniel previously. I knew that he had written a book and was very knowledgeable and that he was also skilled in facilitating groups. I was intrigued by the way he talked about reflection, the idea that taking time for self-reflection is a healthy thing to do, and that it had been helpful in his own life. In the hurly burly of life and all the time pressures we are under, part of you does think that you should be making time to reflect, but it's hard to do that.

When you come to a group like this, you don't really understand what it is going to be like until you are in it. You explained the process very accurately when we met for our first interview, but you still can't really understand it. It's like telling a little kid that there is going to be a newborn in the family and what the newborn is going to look like. But they can't really know. They don't really have a sense of the impact they'll feel when they see the newborn. So in some ways I was coming into this process relatively blankly, but it felt like the right time to do it.

My life was thrown into turmoil a few years ago when my marriage ended and lots of things in my life are in a state of flux right now. This is a time of change for me: I'm 55 and getting divorced, my children are growing up, I'm involved in furthering my education, and I'm starting to think about what it will be like to be retired and my fears about how I can achieve the financial readiness I need for that. I thought this would be a perfect time to do life review, a real celebration of turning 55 and taking time to reflect on future goals.

I found the process of writing on the life review themes and journaling my experiences really unblocked me. I used to do some journaling of my thoughts years ago when I lived away from home and knew that no one else could read it. In fact, like Vanessa did, I went back and found some journaling that I did when I was 17. It was quite humorous to see my idealism. The idealism was definitely there! At the beginning of the dissolution of my marriage someone suggested that it might be helpful to write a divorce journal. I didn't do it because at the time I was too upset and I couldn't imagine wanting to re-read such painful things. I also think part of what held me back was the fear that someone would read my very private thoughts. I have four children at home and I wouldn't have wanted to risk them reading about the pain I was experiencing. Today, when I'm not feeling the same way, I wish that I had documented that experience. It would be interesting to go back and notice all the subtle shades of difference that occurred as I went through that process.

Life review precipitated getting back to writing and the flow has started again, which is a good thing for me. The discipline of having to reflect and write before each group session ties in with the commitment you feel to the group. You'd feel poorly if you arrived at a session without doing the preparation because there would be a sense of letting the group down when it came to your turn to share. That sense of group commitment is part of making time to reflect and write.

Since our group ended, I've actually continued to do some writing as a way of exploring and evaluating who I am and why I'm the way I am. In the last session, I mentioned that I was going to give myself the gift of some individual psychotherapy. Now, before I meet my therapist, I collect my thoughts and do some writing, although not in as disciplined a fashion as we had to in the group.

I'll never forget coming to the group on that first evening. I came straight from seeing patients and my daughter dropped me off because she needed the car. I didn't have the information you'd sent us with me, and I'd noted the address down wrongly. I was searching up and down the street in all the slushy snow and pouring rain and I didn't have a cell phone number to call you because we didn't arrange that until the first meeting. Daniel had called and left a message wondering where I was, but he didn't leave a number to call back! I'd found out by chance that Vanessa was also going to be in the group, so I called the case room to get her cell phone number. I was standing in the rain trying to call Vanessa but getting no answer. She was probably sitting in the group thinking, "Oh hell, I'm already being called to go somewhere!" Then I looked across the street and remembered that the building had something to do with the hospital. When I walked over, I noticed there was a piece of white paper fluttering on the door. It had my name on it and your cell number to call so that you could let me in. I was so relieved to find that note! What if you hadn't put it there? I was soaked to the skin by the time I arrived, but just delighted that I'd made it to the meeting.

The life line exercise we did that first evening was significant for me. I'd written down a number of future goals I wanted to accomplish, but when we were asked to think about moving the point of our lives closer to death, I realized that what was important to me was cementing the relationships with people I care about in my life. It got me thinking about reflecting back on your life if you were close to death. Would you think that a lot of the things you'd committed time and energy to were superfluous or unimportant? As I thought about my own life, I had a sense that the choices I've made about where to dedicate my time and energy have been worthwhile.

Many of the ways in which I am wounded come from the dissolution of my marriage and the ways in which I was treated in the later years when my husband was trying to justify why he did not want to be in a committed relationship with me anymore. There was a point at which my husband said that I had mismanaged my life. By that he meant that in my choice to put the children first, foster their development, and continue to be a working mother, I had not spent enough time and resources on my appearance. He had shared the same goals for the children earlier in our life and he was actually the one who wanted them to be in private schools and wanted us to move to Vancouver to make that easier. Now he was telling me that I had made the wrong choices in not making my appearance my first priority. Personally, I do not I feel I neglected my appearance during the years we were together. Certainly supporting my husband's goal of owning his own business took precedence over spending excessive amounts of money so

I could be dressed in the latest fashions. It seemed like a mature and strong thing to do – the opposite of some of the caricatures we see on various shows where a foolish wife is always shopping on her husband's plastic and leaving him discouraged because he can't avoid being in debt.

As I reflected on the life line, I recognized that in terms of my values and what is important to me, I have done what feels right. I imagine the kind of regrets that a woman might feel if she was older and had not spent time fostering relationships with her children. She might feel lonely and disconnected and wish she could relive the earlier years. Whereas if you are doing the best you can and cherishing every minute while you have it, then that's what you want to be doing.

I have a sense of being blessed in my life. Such blessings and the values I learned in my family about always being willing to try, make your best effort, and work hard have helped me achieve many goals in my life. Perhaps the one area where that isn't true is in my marriage where I maybe tried too hard for too long. Family and relationships have always been important in my life. My marriage was the cornerstone of my life, our lives, for twenty years. I thought about that recently when I read in the newspaper about the local doctor whose lovely wife was murdered. He used the same word I had used in the group. He described her as the cornerstone of their lives, the person who was always there for him and the children, and talked of how much he valued and would miss that. At the end of my marriage, those sentiments were not there for me. You can't change somebody else's behaviour, even if you want things to be different. But just because someone doesn't value what you gave, it doesn't mean it wasn't real or worthwhile. It's very dangerous to accept someone else's evaluation of us. We need to have our own internal sense of values. If I died a year from now, I would not feel that I had mismanaged my life.

Because of the change in my family circumstances, the reality of retirement is on my mind a lot more than I would have imagined. My Mom is ninety-three years old. When I looked at the lifeline, I was thinking I may have another forty years to live. As a self-employed single woman, I have to get very focused on how I am going to survive financially and have to hurry up and save. But of course I'm still supporting the children and it's a tad late in the game to start saving for your retirement when your friends are already retiring! Twenty-five years ago when I started a medical practice, I would never have thought that at this point in my life I would ever be worried about finances. I would have laughed my head off if someone had suggested that! I was actually planning to retire at 55. I didn't want to be a 65 year-old physician who someone might look at and wonder if I still knew anything. Just as Eric said, you worry about being devalued as an older doctor, or worry about not being as knowledgeable or cutting edge as you used to be. We can put ourselves down quickly as we get older because you run into some perceptions that wound you. I certainly won't get to do the "Freedom 55" thing! I may have to work for another

fifteen years and I want to make sure I stay current so that I'm not some sort of negative caricature.

All these concerns and goals were on my mind as I was reflecting on the life line. But when I moved the X up to a year before I died, then did it really matter that I didn't have savings to take me through to 95? What if I had neglected the children and wasted the time I could have spent listening to them? What if I'd said I have to work way more shifts so I can get more money and save for my retirement? The only time I have with my children is this time. Most of us as parents have to work these days, but you try to titrate it so that you are spending enough time on your highest priorities. I don't think I blew it with my priorities. Maybe, in some strange way, it's a good that I am no longer with my spouse. He was not the greatest when it came to managing money! Now I can collect my wits, find out where I am, and plan ahead.

As I said in Branching Points, I had no sense earlier in my life that I would become a doctor. That seemed like something that was out of the realm of expectations in the social world I grew up in. I'm not sure what led me to set goals beyond the scope of most of the people I grew up with. Maybe it was the values I received from my parents. Maybe it is simply just a gift, a blessing I have been given in my life. My parents didn't have an easy life, but there was tremendous loyalty between them and love for their children. I really don't know how my mother did it. How she learned to be such a nurturing and caring person when she didn't get much of that in her young life. My parents always stressed the importance of being willing to try something and not back off from challenges because you are afraid you won't be "the" best at something. They encouraged all of their seven children to fulfill their own individual gifts, make their best effort, and give to others - especially those who are less fortunate in life.

I was studying fashion design in Paris when I met a young woman who was very lost in her life and pretty much homeless at the time. She would hang out around the university residences and try to make a little money in the day selling little wool dogs she made in the Metro. I used to spend time talking to her and somewhere out of that experience was born the realization of wanting to become a doctor. I don't know whether it was seeing how her life might go and being grateful that I'd been given more of an emphasis on education, or whether it was her sense that our conversations were meaningful and she felt that I could really see her and relate to her. I had an epiphany that I could be a doctor and returned to Canada with full determination to remove the obstacles that stood in the way of achieving that goal. It took me a while to get into medical school but I persevered and was accepted as a mature student. Unlike the experiences some of the other group members described, I was lucky to be in a medical school that had a very supportive learning climate. I had the great good fortune to have a wonderful mentor, someone who is highly respected and well known in medical circles. I learned from him how to be with patients and the importance of fostering and cherishing those relationships.

I think it was in the last session that I talked about learning in life the importance of speaking what is dancing between your eyes when you are with patients and other people – both recognizing and acknowledging the thoughts and feelings that are present between you. For example, I'm thinking of some of the extra shifts I do in a walk-in clinic besides having my own full service practice. When someone comes in for a one-off visit you could easily just scratch the surface with that person and get on to the next room as fast as possible. You could treat the work as just a job, knowing that the more patients you see the more money you make - that's how you are paid, it's all piece work.

Many patients don't know what to expect and are a little bit intimidated when they visit a doctor they don't know. It's a complete crapshoot in a walk-in clinic as to how they will be treated and how much time a doctor will spend trying to understand their problem. They could easily end up feeling that their concerns really haven't been answered or that they didn't express them well enough. If they felt brushed off, or that you didn't really hear them, they probably leave frustrated and just think they'll try somewhere else.

For myself, I think you get out of something what you put into it. When you can actually take the opportunity to unlock what the real issue is and get to the heart of the matter it is a very special thing. It's such a gift that sometimes patients are astounded when they get more than they came for and maybe didn't even know that's what they needed. If it gives meaning in your life to do this for patients and see the effect that you can have in a tiny encounter that stands out in their day, then you know you are in the right profession. It's very rewarding to be able to give this kind of service to patients. I told the story in the group about offering to fill out a tax form for a single parent at a walk-in clinic. I related to her as a woman who, like myself, had been left with the challenge of caring for a child with a pervasive developmental delay. Of course she didn't know this was part of what inspired me to do that for her. At the time, it felt satisfying to help this woman in a way that she wouldn't have expected. It was my choosing, my gift to her.

However, it can feel quite different when you are working with patients who are unreasonably demanding and seem to want to extract every ounce out of you. Two days after I'd helped this single parent, one of my own patients turned up wanting me to deal with four different health issues and also wanting a pap test done in the same visit. I talked to her about what we could reasonably accomplish in this visit and that'd we'd need a second appointment to cover all of her concerns. I thought she'd agreed and chosen to talk through the health problems and re-book another appointment for the pap test. Once she had her various prescriptions and referrals in hand, she was insistent that the pap test was a priority and it would be hard for her to get time off work and come back to see me. So I did the pap test for her, but I felt browbeaten, manipulated and unappreciated. I also felt hostile toward the medical services commission who will neither create a category for a multiple problem visit, nor advise patients that they only allow doctors to bill for a single issue. We are the ones who are left trying to explain this to patients who

think we are being cheap and not giving them what they want. Patients don't understand that we are only paid for a ten-minute visit or that spending twenty minutes with a patient who is distressed and in need of counselling is limited to four visits a year. In most offices these days, six appointments are booked each hour and in walk-in clinics it is typically eight.

Many patients find it hard to take time off work and it's cost-effective for them to want to talk about several issues at once. That should be recognized and the government should be accountable for the regulations they place on us. For example, other than providing some posters for our waiting room, they don't take responsibility for advising people that check-ups are not an insured service. So patients keep booking physicals and have the expectation that we will provide that service without being able to bill for it. We keep asking the government to create expanded categories and offer for them to audit our charts if they have concerns. They won't go near that! They can audit us anyway and we risk being docked if we bill for any services beyond what is allowed under the current regulations, even if we have duly spent the time. It is very frustrating and really undermines the satisfaction of providing the kind of care I want to for my patients.

As a family doctor you come to know your patients' life worlds as well as their medical problems. There is great enjoyment in knowing patients over many years and helping people to cope with the complexities of various life transitions. I feel very privileged to be a part of people's lives, share their struggles, and learn with them. Yet in recent years, the current system leaves me sometimes feeling very frustrated and dispirited. The heavy patient loads, increased paperwork and unmanageable expectations can be exhausting. Some days it can feel like being constantly pecked at - someone always wanting or needing something more when you only have so much time and energy to give. When I choose to freely give my time because that is what a patient needs, it is personally satisfying and reflects my values around the kind of relationships I believe are important between a patient and their family doctor. But when I feel caught between what the system will allow and patients that are unreasonably demanding I feel taken advantage of. I sometimes feel that I end up with the short end of the stick because I tend to be gentle and accommodating. And who really cares if I am up until 3 A.M charting and finishing paperwork!

In the group, we also talked about the challenge of dealing with very demanding and sometimes aggressive patients. I think the ability to set boundaries with patients or other people comes easier to some people than others. It's hard to intrinsically have that ability if you have not been brought up to do that or haven't seen it modeled. When I think of the different personalities in our group, I imagine some people would be more capable of being very assertive with patients about the kind of behaviours they will, and will not, accept. In our call group, I've always experienced Vanessa as someone who is very assertive. It is an area where she has strength and she is not shy about saying difficult things. In this group process, it was a revelation to also experience the gentle, caring side of who she is as a person and come to know her more closely.

We all have our different strengths and different styles and it was valuable to learn from each other and get different perspectives on handling challenging situations.

I feel that one of the things I want to work on in the future is being more assertive. In addition to saying I'd mismanaged my life, my husband said that I was incapable of punishing a flea. I could walk away from that statement thinking I am totally inadequate when it comes down to setting boundaries with people or providing the children with discipline. But on further reflection, it's maybe just that I have a different style than he has. Being an enforcer is not a place where I would want to be. I would wish for discernment, to know the right way to handle things. Parenting is such a complex job and you always worry about not doing it well enough. If you are too strict or overbearing the kids feel stifled and can't wait to get away. You don't end up with love from that. Some of the stories that were shared in our group spoke poignantly to that issue.

I remember when I first came to the practice where I work now. It was owned by an older couple who were waiting to retire. They were trying to find someone to take over the practice when many doctors don't want to do that anymore. Dr. Sarah, whose practice I took over when I moved to Vancouver, was a very conscientious and competent physician. She was also quite soft-spoken. Once when I was meeting with her, Dr. Sarah recounted a story about a time when her son was waiting for her in the chart area while she was seeing her last patient of the day. Because she was unwilling or unable to give that patient everything he was demanding, he began to raise his voice and verbally abuse her. When she came out of the room and the patient left, her son told her, "Mother, you must never let anyone talk to you that way!" He said that if he had been spoken to in that fashion he would have exercised his moral authority and said, "This visit is over. Get out of the room". Before you do that, I think you have to be sure of your moral authority and maybe it comes down to just holding your self-esteem. It doesn't matter how much education you have, or even how much credit you get for doing a great job, you can still have holes in your self-esteem.

I'm not sure if people comprehend how devalued an older woman can feel in this society. I was reading an article in a magazine about the fears that women have about ageing in a culture that is so focused on youth and beauty. Over and above any worries we shared in the group about becoming older as a professional, this article talked about the fear of becoming invisible as an older woman. I think if to 'older' and 'female' you add 'poor' then very few people have the time of day for you. If you've got money and command some authority on the basis of income and status then they will at least pretend to be interested and serve you. I find in my practice that if you accord someone who is older, female, and low income the full respect of shining your attention and care on them, they just come alive because they rarely have that experience.

I wonder if ageing isn't even harder for women who were fantastically beautiful when they were younger and received a ton of positive feedback because of that. If your looks are average, you learn perhaps more easily that the way you will earn someone's love is to work on the person

you are. You want to become someone who is accomplished; someone who has developed their own values and thought about how they want to be in the world. It goes back to some of the things I said in my stories about branching points and family. Obviously I'm disappointed that my husband seemed to care more about appearance than everything that I thought would have been important and easily dumped me for a younger woman. The magazine article said, "When you are older, the beauty steals inside". When I hope for love for myself in the future, I guess I wonder if anyone will see me. If they did, I would want them to see the beauty that is inside and care about who I am as a person.

In this group I felt truly seen and heard. I don't think any of us could have known in advance how nice it feels to receive people's undivided attention and give that to others in return. Each of us were honoured and there was a bounty of acknowledgement for the gifts we bring and the challenges we've faced. It felt like a very safe place to be. In this life review program all secrets were respected and all emotions, some of which were unexpected, were welcomed.

I was thinking about Robin a couple of days ago and the story she shared about the test result that was misfiled. About a year ago we went through the nightmare of having a series of temporary receptionists and it was scary. We had three different temps in a four-week period and one of them was completely out of her depth. She was misfiling things and had little pieces of paper everywhere about things she planned to do later. I had to let her go pretty fast. This week a patient brought his wife and children in for a visit. While he was there, he asked me what was happening with the referral I'd initiated for him to go to the Sports Medicine clinic almost a year previously. I got my current receptionist to call the clinic and checked his file. It turns out that one of the temps, probably the one who was completely overwhelmed, had simply put the 'request for consultation' that I had completed into his chart rather than faxing it to the clinic before she filed it. So it was just sitting in his chart and it wasn't stamped 'faxed'. That is exactly the kind of thing that happened to Robin even though she is so conscientious.

I handle a thousand bits of information a day, and the same the next day, and the day after that. I would have no way of remembering this patient's particular referral. Once I complete my paperwork I have to rely on the office staff processing it correctly. In the case of this man, I apologized and explained what had happened. He was minimally irked because he wasn't sure he still needed any treatment. So there were no serious repercussions as there were for Robin. As a family doctor, you can't afford to keep inefficient staff because you are the one who is held responsible for any errors that occur even if you can't really control the whole situation. If at times you are forced to rely on temps who are not up to speed, it's very stressful. Potentially, there may be other balls that were dropped while that young woman was with us and I just hope none of them are serious. All of us in the group resonated with Robin's story because as family doctors we all live with that stress and concern. It reminded me of a story that I shared later that same

evening about a colleague who was completely broken by a very publicized malpractice suit and can no longer take the stress of full service work.

Moving my practice to Vancouver after 18 years of being in the same town was challenging. Not only did I have to get to know all my new patients, I needed to start building a network of colleagues, and that takes time, you can't rush it. One of the things that was very beneficial in making connections was being asked to take on a leadership role for a new division of Family Practice. The position had been advertised but nobody had applied. I guess they'd read the job description and seen all the things you were supposed to do for a modest honorarium each month! Anyway, I was persuaded to take on the job because I had previous experience in this kind of role. I'll never forget the day that I took on that position. It was an amazing day: It began by being introduced as the new leader and ended with discovering that my husband was having an affair! If I hadn't already been introduced, I wouldn't have taken on the job because I was too upset. Initially I thought about quitting. I just didn't think I could handle anything more. But actually, as I look back, I realize it was a blessing. Around that time I was talking on the phone to a good friend who lives in Calgary. She has become quite religious and is very comfortable with the concept of prayer. She asked if she could pray for me and when I said, "Sure," she launched right into a prayer. She said something like, " Lord, I would like you to send Chantal many gifts. If you can't give her the gift of her husband's love, then give her many other gifts so that she has what she needs to get through this time, get her life back on track, and the strength to be able to give the children what they need." In retrospect, I think being asked to take on that leadership role was one of those gifts. It helped me to make connections and build a network of colleagues.

In the earlier years of being a family physician I had the good fortune to have a very supportive practice partner and a wonderful nurse who worked with us. There was also a great spirit of teamwork in the local hospital. As many of us said, it's much harder to have those kind of collegial connections now, even though they are so important. Time, or rather lack of time is such a huge issue for all of us. Even if you have a practice partner you are pretty much operating 'solo'. You get very little opportunity to connect because you are so busy seeing patients all day. I'm often up very late, charting or doing paperwork and because I'm involved in obstetrics I'm on call all week and some weekends for deliveries. It can be a struggle at times to juggle all the responsibilities and try to figure out having enough time with my children, especially now that I'm a single parent.

Many younger doctors don't want to take on the complexities and overload of being a family physician. They prefer to work in walk-in clinics rather than be the 'point person' you are as a family doctor. As we were all saying, it's very hard these days to find a locum who will come in so that you can take a break, have a vacation or keep up your education. Even if you can find someone, it is complex under the current system of remuneration to work out the financial side of things. Some patients prefer to wait until their own doctor returns rather than seeing someone

new, so by the time you've paid the locum and covered the office overhead you can end up with a net loss. Obviously, because we are self-employed, we don't have access to the kinds of benefits that some jobs provide such as sick leave or paid vacation time. Even if you are feeling really tired or stressed, you expect yourself to just push on and be available for your patients. If the government wants to attract more family doctors, I think that one area they need to look into is how to create a better system for having locums available so that family physicians can plan a couple of weeks vacation each year and not get burnt out.

When I think about this program, I was actually just amazed that all these doctors who are so busy came enthusiastically for a series of seven sessions that lasted three or four hours each. Typically what happens with doctors is that a conflict comes up and something has to give. So you end up missing a meeting because you decide the other thing has compelling importance. It was amazing that none of us missed a single meeting except Eric, who was forced to, and I know how much he really wanted to be part of that session when we talked about mistakes and distress. I think part of the commitment we felt was that we didn't want to let the group down and we realized the importance of everyone being there. The other part was really wanting to hear all the different stories and wanting to know what other people would say about each topic.

When it came to the last session, I didn't understand that we weren't going to have to read something we'd prepared ahead of time. So while I was reflecting on my feelings about the process, I had made some notes in my journal that I was planning to read at the wrap-up session. These are some of the things I wrote about: *"I consider myself very lucky to have fallen into this seven-week engagement with these people at this specific time. I like the term engagement for its image of the cross-connecting with our stories and experiences that have happened here. In each of our cases we have appeared to have successfully left behind our agendas and our other obligations of the day and really focused our undivided attention on the speaker and the feedback. It was like a cross-pollination. A very healthy process. The antithesis of isolation and it was pro-wellness.*

There are these ads for teens and the quotation is, "What is your anti-drug?" For some it's soccer, working with the school yearbook or other school activities. Some have community involvement. But the common theme is actually being connected. From a physician wellness theme you could call a forum such as this an anti-burnout activity. For me professionally it was fascinating to see the wealth of common ground in our life philosophies. One after another, on the same night, we also share many of the same frustrations - the common theme being the time famine. And we truly reinforced the need to have boundaries to protect some of our own time for ourselves and for our families."

Sharing mutual frustrations with peers felt great. We all know how absolutely little sympathy you get from anyone else if you talk to them about the difficulties of being a doctor. They think you've got it made and probably earn a lot, and just don't manage it

right. When you are meeting with peers in the cross-pollination and even the ventilation of these frustrations it has served a huge purpose already. If ideas are born to help us to hold our ground, maintain healthy boundaries with our patients and with the number of committees we are asked to go on, that's another big thing. And if in our group we are inspired to care for ourselves and foster our relationships, then we really do come away with having experienced support on a level that will help us to nurture ourselves.

This group has been a precious experience in my life and a special opportunity. I think we all drew a great deal of support from being able to connect with colleagues and get to know each other at a much deeper level in a way that felt both safe and honouring. For me personally, the timing of the group was perfect. Being able to review my life and renew my plans was a meaningful part of moving on from the pain of my marriage break-up and reclaiming my life.

Feedback on structure, facilitation, and future directions.

In terms of leading the group, I don't think it was important that Daniel was himself a family doctor. He wasn't there to tell his own life story and his skill in facilitating the group didn't in any way depend on him sharing the experience of being a family physician. I think the common ingredient that is needed to make any group work well is to be able to tap the resources among the people who are there. So it wasn't important that Daniel was a doctor, or that you weren't. What matters is helping to create a climate in which people can tell their stories.

In our group, the facilitation skills that you and Daniel provided and the structure of the process allowed us to really connect and learn from each other. It was a safe and supportive place to be. We knew that what we said would be held in confidence and that allowed us to share stories that we couldn't have otherwise.

Your own excitement about life review was probably a significant factor in reinforcing our sense of the importance the work we were doing together. Not the importance of this as a research project, but the significance of engaging in a process that had potential value for everyone. I think this life review process really did have value for all of us. There was so much learning in the cross-pollination among our stories and coming together like this with colleagues is sustaining – it really works against isolation and burnout. I imagine that all of us are probably feeling more unplugged as a result of this and continuing on a little with the reflective process.

I think I could have gotten even more out of this process if I'd been able to step away from my family and work responsibilities for a while, but that isn't really practical. The process starts you thinking about things that you could easily get into in more depth. But meanwhile life goes on full tilt! For myself, having seven sessions was pretty close to the ballpark. I know that some people felt it should have been longer. If we had continued on for bit longer that would have been fine, but it is also a big time commitment to make each week. If I end up having meetings or late office hours two or three nights in a row, that just feels like too much time to be away from the

children. So for me, the time frame worked well because there is only so much time week after week that I can be away from home in the evenings.

Themes

The ten conceptual groupings that emerged from a thematic analysis of the research findings are now described along with illustrative quotations from the doctors' stories. Readers are reminded that Table 1 presents an overview of these groupings and can be found at the end of chapter 4.

Theme 1: Struggling with Constraints to Self-care and Professional Support

1A: Lack of time for self-reflection and connection.

All the participants viewed self-reflection as a healthy thing to do, but in their stories we see how infrequently they feel able to create opportunities for this in their lives. Ray speaks to part of the difficulty: "In the profession, we aren't really taught to spend time on self-reflection or self care – the reverse is often true. In general, as doctors, it becomes more familiar for us to live in our heads, rather than spend time being aware of our own feelings." Robin comments that making time for self reflection and self care usually gets pushed aside in the face of time pressures: "So you never actually have the time to really reflect on, or deal with, your own feelings – you just put them to one side and carry on. I think we get very good at doing that as doctors and we probably do that a lot in terms of our personal life as well. And eventually that is not very healthy."

Participants in group-based life review are expected to spend time outside of group meetings in personal reflection and writing. For the doctors in this program their commitment to the process provided a means to structure and legitimize making time for personal reflection. Robin remarks: "In this life review process, having a specific time where it was your job to sit down and reflect was invaluable. To have time where you knew that you were going to sit down and just think about what you were doing and incorporate that into your daily life, or certainly into your weekly life, was so valuable when most of the time you are running really hard just to do what you are doing."

Time pressures and what Chantal named as "time famine" recurred as a constant and consistent theme in the group member's lives. In this context, the life review program was experienced as a meaningful way to address their struggle with finding time to reflect and connect with colleagues. In each narrative we read how amazed the participants were that six busy physicians were not only able, but also dedicated to attending all of the group sessions. Ray describes their attendance as "just unbelievable" and "quite phenomenal" in a profession where competing demands and requirements to be available for patients frequently result in time conflicts and missed meetings. He attributes this to the "sense of commitment that people felt to the group and to the process." Eric's thoughts reflect this commonly shared experience:

That's what was so incredible about this process. I was the only person who missed a session and that's because I had to have surgery. Just think of that! I can't imagine a doctor's group being so faithful to a process. It was so

oxymoronic I remember at the beginning. We were all bitching about time and all the logistics around time. And yet the proof was in the pudding, we all turned up for what were some brutally long nights. That was the measure of it as far as I'm concerned."

1B: The need to create non-stigmatizing collegial support groups.

The group members spoke about the toll that being a doctor had taken on significant numbers of their colleagues and emphasized the importance of physicians having opportunities to talk about issues that were troubling them. At the same time, they recognized that cultural norms inhibit many physicians in their age group from seeking support unless the situation is deemed critical. Eric comments: "Of course we have a Physicians Support program and a Physicians Health Program but they are things that people go to, I think, in more extreme situations, or only under duress. They aren't places where functional, sometimes distressed, reasonably normal people can sit down together and talk, in an existential sense, about having more ease with their lives as doctors." Vanessa addressed the stigma that can be associated with seeking emotional support when there is a perception that, "nobody else needs to do this – so what's wrong with you?" In her experience it was, "different, more difficult, to think about going to some sort of actual therapist, as opposed to being able to get together with a congenial group of colleagues, and be able to enter into a space of personal reflection and sharing, and know it is helpful to do that."

Group members felt that the life review program precluded the stigma that some physicians might associate with seeking help or disclosing difficulties. The educational focus of life review distinguished it from engaging in therapy. In contrast to therapy, life review was experienced as fitting more closely within the realm of proactive professional development and providing a culturally acceptable way for family doctors to engage with colleagues in self-exploration and the provision of mutual support. Life review was not seen as replacing or meeting the need for more intensive therapeutic work but as opening a space for collegial connection and interpersonal learning. Kate remarks:

> I think this process is really valuable and has the power to be able to let people connect with colleagues and explore their suffering and concerns in a safe and supportive way. I think that if someone has a really in-depth personal issue, a Life Review group is not necessarily the place to explore that, because this isn't therapy. But it provides an opportunity to explore issues with people who understand your professional experiences and create a sense of community.

Based on their experiences in the group, all the participants wanted to see more opportunities of this kind offered to others in their profession. Given the prevailing hesitancy about self-disclosure in the medical culture, participants commented on the importance of having physicians understand the nature of the program and recognize it as an opportunity for proactive professional development rather than a remedial intervention. For example, Eric wanted to

reassure others that, "this is not some kind of T group. This is a professional development program that has been extremely valuable. But it is on a personal level. It isn't about learning to do some particular medical procedure better. This is about your own personal and professional development." Similarly Robin wanted other colleagues to know that, "this process isn't just to keep you going in times when family practice is getting increasingly rougher, this is to your advantage personally."

Theme 2: Experimenting Safely with Self-disclosure among Colleagues

2A: Concerns about professional norms.

For the doctors in this program, engaging in life review with colleagues presented the additional challenge of contravening an implicit norm in the medical culture that promotes maintaining a certain level of professional distance. Five of the six group members had learned early in their medical training that disclosing personal feelings was neither encouraged nor validated. All of them described medicine as a culture that places a high value on appearing self reliant and stoic. They had learned the importance of having the 'right' answer and seen from experience that expressing uncertainty or vulnerability was at best, risky, and at worst invited direct exposure to being shamed or blamed. In this climate, they felt that the desire for more authentic collegial relationships was often counterbalanced by caution and fears of being negatively evaluated. Ray addresses this issue in his story: "My impression is that we tend to be a pretty guarded group. We are guarded and we tend to intellectualize, as opposed to showing or talking about our feelings. It's just part of the nature of our profession and our built in defense mechanisms. We probably bring that to anything we are involved in, and it takes a while to get beyond that."

It was not surprising to hear that natural anxieties about self-disclosure were heightened for four of the participants when they initially joined with a group of colleagues in life review. Eric, for example, craved the opportunity to explore the experience of being a doctor with colleagues but since medical school had learned to play his cards close to his chest and avoid disclosing any kind of professional vulnerability in the medical community. He remarks: "I was worried prior to the group starting and on the first evening. I didn't know where we were going to need to go. How far we were going to need to disclose. What kind of personal work we might be doing in a group context – so it was a little frightening." Comments by Ray describe his experience of this theme:

> I was a bit surprised by the anxiety I personally felt in initially settling into the
> group. I've been involved in therapeutic group work before and I'm not exactly a
> shy person – usually, in fact, quite the opposite! I guess it was just the
> heightened anxiety of exposing myself among colleagues as opposed to an
> unknown group of people. I wrote about that in my journal after our first evening
> together: My sense of going to the group with mostly positive anticipation and
> slight anxiety; the heightened anxiety I felt in actually meeting the other group

members; the challenge of being in a group of physician colleagues with whom we are supposed to be scientific and stoic, not touchy feely.

2B: Personal control about the degree of self-disclosure.

All the participants expressed some initial hesitancy as they approached writing and sharing on the first life review theme. Several of the stories provide valuable insights into the initial struggle people experienced in deciding how much of themselves they wished to reveal. Vanessa spoke of trying to balance her desire to be genuine with worries about being seen as pathetic. In a similar vein, Robin didn't want to burden the other group members with unresolved issues and was afraid of being judged as more distressed than she felt she was. Kate's words describe the anxiety of trying to find a balance that feels personally comfortable and interpersonally appropriate:

> Initially, for the first week or two, I had difficulty deciding what to write on the
> themes. I was trying to find the balance between telling a completely boring story
> or disclosing things that I didn't want to disclose. Anything interesting felt too
> private, they were things I didn't really want to share. Anything not private felt
> boring, and I couldn't imagine people wanting to hear that stuff. So I was trying to
> take the temperature of the group without knowing what people were going to
> talk about. Knowing very well that everyone has a story, but knowing that people
> may or may not decide to share it with the group, and deciding that I would only
> share my more private stories if other people did.

The structure of the life review process was experienced as providing a high degree of personal control as group members experimented with self-disclosure. Participants valued knowing what would be discussed ahead of time and appreciated having an opportunity to reflect on their writing before coming to the group. They felt that they were in control of how much they chose to share and would not be coerced into disclosing more than felt comfortable. Eric comments:

> I was quite struck by the degree of disclosure in our group, but there was a real
> safety to it, it was never out of control. It was clear that we could disclose, and
> that we would not have to disclose too much. You can go to a certain level, and
> you're still keeping some things inside you and that's OK – that doesn't disqualify
> you from the process.

2C: Witnessing others risk self-disclosure.

For Eric, one of the important ingredients in the life review process was "that after you'd shared your story, you very quickly heard the others' stories. So you didn't feel personally exposed – you weren't the only one sharing something." As the group members saw others risk personal disclosure they in turn felt able to be more personally revealing. Robin's comments speak to this theme:

I wasn't ever the first speaker in those initial sessions and hearing how open
everybody else was made it a lot easier to say, "This is where my family is.
These are where my branching points were. These are the things that were
stressful for me." Because every other person in the group was very open about
the things they discussed, it made me feel much more comfortable discussing
those things too.

In her story, Vanessa speaks to not only being moved by the power of what another
group member shared during the family theme but also by seeing this person take the risk to
entrust the group with her story:

Something she had said the week before had made it sound as if there were
certain things, like family experiences, that she found were just too private to
discuss. So she had obviously thought about that, and come to decision about
sharing these things with us. I found it interesting to listen to her story and to
think about her choice of sharing that with us in this group. I thought it was very
courageous of her to do that.

Seeing other members risk sharing vulnerabilities and witnessing that the group received
and responded to these disclosures in a respectful and supportive way allowed participants to
disclose things that they would not typically have shared. In her story Robin describes the
incremental trust and disclosure that unfolded among the group members:

With branching points, we could sort of test the waters, decide how comfortable
we felt and how much we wanted to share. Then as the comfort level grew, we
could approach topics that were more intense. So that by the time we came to
the session on stress and distress, it was so much easier for me to talk about
things that were really difficult for me. It was a time when all of us were feeling so
well supported that we could bring up those very difficult issues and try to
describe them as best we could, when we probably hadn't really ever done that
before. Certainly I hadn't really looked at them carefully. They were such very
sore issues that they had to be put on the back burner in order to get on with life
and what I had to do day by day.

Theme 3: Expert Group Facilitation

Without exception, the participants remarked on the importance of having this kind of
process led by people who have expertise as group facilitators. All of them spoke about the
importance of establishing group agreements to promote a safe, respectful and inclusive learning
climate. Having the agreements in place and feeling that they could rely on the leader's skill to
bring forward and address issues that had the potential to undermine interpersonal trust was
identified as a key component in enhancing a sense of personal safety and willingness to risk
self-disclosure. For example, Eric commented: "I believe people took the risk to be real because

of the process. The facilitation was incredibly important. Also having ground rules, the structure, and the understanding that they were in place made it work."

Knowing that Daniel was both an experienced family physician and skilled group facilitator contributed significantly to the participants' initial interest in joining the life review program. However, in their feedback on the process, all of them remarked that what they valued about his leadership were his skills in counselling psychology and group facilitation, rather than the fact that he was a family doctor. Kate commented; "It was good to have Daniel leading the group. He's skilled at facilitation and because he is a family doctor, he's part of our professional community. But the most important things about having him as a facilitator were his skills in this kind of group leadership and who he is as a person."

The participants appreciated the group leading and processing skills that Daniel and I used to enhance group development, promote individual members ability to integrate the emotional experience of sharing their stories, and ensure that feedback and reactions to the stories did not inadvertently detract from the process. My primary role in the group was as a participant/inquirer. However, there were times when it felt important and ethically responsible to use my skills as a counsellor and group facilitator to move into a co-facilitation role. Feedback from the participants indicated that during the group process, the majority of them identified more closely with my presence as a participant/facilitator than as a participant/inquirer.

In individual stories it is interesting to note that some of the participants had different expectations about the way in which the facilitators might help to enhance their learning in the group. For example, Robin had expected Daniel's role to be that of a moderator and was pleasantly surprised that his counselling skills helped group members to identify strengths. On the other hand, Vanessa experienced it as a big loss that Daniel and I did not provide more feedback and observations about the stories. Overall, what group members expressed was their sense that the combined structure of the program and expert facilitation allowed them to create a cohesive and productive learning environment. Chantal remarked:

> I think the common ingredient that is needed to make any group work well is to
> be able to tap into the resources among the people who are there. So it wasn't
> important that Daniel was a doctor, or that you weren't. What matters is helping
> people to create a climate in which people can tell their stories. In our group, the
> facilitation skills that you and Daniel provided and the structure of the process
> allowed us to really connect and learn from each other. It was a safe and
> supportive place to be. We knew that what we said would be held in confidence
> and that allowed us to share stories that we couldn't have otherwise.

As they discussed expanding opportunities of this kind to other physicians, the participants deemed that it was essential that future programs were facilitated by people who combined an adequate understanding of the medical culture with expertise in group leadership.

Ray stated: "One of the strengths of our group was the facilitation that allowed us to create a safe environment. I think it would be essential to have that available in the future when people are doing this kind of work together." Eric expressed the concern in this way:

> One of the big mistakes that is often made in medicine is that doctors think they can do everything, so I would worry about a situation where this whole program would begin to be done by well-meaning doctors who weren't necessarily trained in counselling and facilitation. That would be a concern for me because I could see this derailing because there wouldn't be enough attention to the process and to maintaining safety in the group. Doctors who wanted to lead groups like this would need to have an additional qualification, like Daniel has.

Theme 4: Isolation, Relationship, and Collegial Support

A strong theme in the group discussion revolved around the risks that family doctors run of becoming professionally isolated in today's health care structure and current fee-for-service model of remuneration. Vanessa, Robin, Chantal and Eric's stories provide insights into this issue. Robin comments:

> We lead very fiercely private, and pretty lonely, professional lives. The medical system has become so frantically busy that I can't remember the last time I ate in the hospital. I don't go to the cafeteria, ever. We don't have the doctor's coffee lounges any more. There used to be a time when you would be able to get together at early morning rounds and sit and have a coffee before the guest speakers talked, or you would be taking a break at lunch, and you'd meet up in the hospital. That just doesn't happen now with family physicians. You're physically not even close to each other. Generally our paths are leave home, go to the office, go to the hospital, come home.

Several group members coined the term "anti-isolation" to describe the life review process. The opportunity to connect with colleagues and build a community of support was seen by all of them as an important way to reduce professional isolation and enhance sustainability and self-care among family doctors. Those who met regularly with colleagues in other professional groups commented that the life review program greatly expanded the ability to share with other doctors at a personal level and legitimized the importance of doing this. As Eric said, it allowed them to "do directly what we have only been able to do secondarily until now."

In the participant's individual stories they relate how the process provided the means to develop closer relationships with other group members and form the beginnings of an expanded collegial support network. Ray and Kate had been friends for many years and in their stories we hear how participating in life review together impacted their relationship in positive ways. Ray commented:

> I gained a huge amount of insight and closeness with her through this group
> process that we haven't gained in fifteen years of knowing each other and
> working together. Being in the group together deepened our relationship in a very
> positive way. I think it will really help in terms of the ongoing support that we can
> give to each other.

Similarly, Robin expressed that the relationships that she had built with Chantal and Vanessa in the group would likely be an ongoing source of support and that they all now felt more comfortable talking at a personal level and making time to see each other. In Robin's story we witness the strength she drew from feeling that she was in a community of supportive colleagues as she faced a painful experience in her personal life:

> I felt a sense of strength in being with the group. I felt that I could come home
> after that and deal with this sad situation, because I knew that there was that
> support there. It was interesting to think that out of six sessions that we'd had up
> to then, I already had a real sense of strength from being with this group.

For Eric, the process resulted in a dramatic shift in his perceptions of the medical culture and allowed him to connect with colleagues in way that he had yearned for, but doubted was possible:

> In seven weeks we built a community of doctor-friends in a way that was safe,
> and worked, and had some parameters around it – and there was a reality there.
> It was possible again for me to be a colleague in a way that allowed me some
> vulnerability and safety. That's a big accomplishment.

Theme 5: Normalizing Concerns and Frustrations

A universal theme that emerged in the group process was the benefit participants attributed to being able to share professional concerns and frustrations with colleagues. The realization that others shared similar challenges normalized experiences and promoted self-acceptance. For example, in Eric's story we read that, "simply being able to talk about feelings of uncertainty in the group was very important because those thoughts and feelings are almost never shared among colleagues." Knowing that others shared his experience was reassuring and led to greater self-confidence: "A sense that I can go back out there and work away and know that I'm not losing it. The feelings I have are normal – they go with the territory." Similarly, for Vanessa the interpersonal sharing, "allowed me to feel that I was not alone in experiencing some parts of the work as very stressful and others as rewarding." She valued the opportunity "to be able to be real in this group – not needing to pretend that things are going OK and put on a forced smile when they aren't."

The significant level of frustration that participants were experiencing about the current state of family practice medicine was palpable in the group. It threads throughout the narratives as we hear about the various ways in which the current structure was experienced as eroding

professional satisfaction, diminishing financial reward, exacerbating time pressures, and threatening the sustainability of full-service practice. Ray's comments speak to the value that participants expressed about being able to explore these concerns together:

> I think that was one of the important things about this group. It was a valuable process to just get together and voice the frustrations and challenges and know that you are not the only one who feels that way. It was also valuable to share different ways of coping or dealing with these challenges – to hear what other people are doing about it, what kinds of different career choices they have made, or are considering, in terms of their own sustainability.

Chantal's words illustrate the importance members placed on being able to share their concerns and frustrations with peers who could understand the issues and validate their experiences:

> One after another, on the same night, we also share many of the same frustrations – the common theme being the time famine. And we truly reinforced the need to have boundaries to protect some of our own time for ourselves and for our families. Sharing mutual frustrations with peers felt great. We all know how little sympathy you get from anyone else if you talk to them about the difficulties of being a doctor. They think you've got it made and probably earn a lot, and just don't manage it right. When you are meeting with peers in the cross-pollination and even the ventilation of these frustrations it has served a huge purpose already.

Theme 6: Affirming Vocational Commitment and Esteem

Many of the frustrations the doctors expressed centred on how the current system negatively impacted relationships with patients and undermined the quality of care they wanted to provide. Vanessa speaks evocatively to this struggle:

> In the full-service, fee-for-service system that exists right now, it has got to the point where if you don't see twice as many patients a day as you used to, you don't have adequate income. And increasing the volume of people you have to look after each day increases the dissatisfaction. It robs you of your ability to connect with people, and that is the core of what I do as a family physician. As a family physician it's not writing out the prescription that is important, it's the relationships that I have with my patients – relationships that the current system doesn't allow me to pursue other than in the tiniest, most minute, dollops of time. It's a big loss.

In sharing what they found rewarding and sustaining, a consistent theme across all the stories was the importance of relationships with patients and their families. Chantal's words epitomize the general feeling that was expressed in the group: "There is great enjoyment in

knowing patients over many years and helping people cope with the complexities of various life transitions. I feel very privileged to be a part of people's lives, share their struggles, and learn with them." Ray expressed that hearing this recurring theme was not only personally confirming but also enlightening in terms of the discipline of family practice:

> In terms of our discipline I just hadn't really thought of that issue in that way before. That this is really so much what family medicine is about. Even for people who are really busy and seeing high volumes of patients, it's all still very much about building that sense of connection and relationship with patients and their families. That is the core of what is important to family doctors, and what is rewarding and sustaining for them professionally.

In a political climate and health care system that sometimes left them feeling dispirited or under-valued, affirming the fundamental values that informed their sense of vocation was experienced as professionally renewing. It allowed the participants to tap into and celebrate the worth of what they did as family doctors and enhanced feelings of mutual respect and professional esteem. We hear this theme expressed clearly in Eric's narrative:

> A key thing in this process was the intense respect that I was able to feel for the other physicians in the group. Feeling that respect, and then coming to the understanding that mutual respect recursively requires self-respect. What came out of it for me was a whole new sense of my worth as a physician. And that, almost immediately, had a material effect in my professional life.

At the follow up meeting, several of the participants commented that the group process had strengthened their commitment to recognize what they experienced as personally satisfying in their work and either explore or consolidate ways to reduce negative impacts on their professional sustainability. For example, Robin expressed that one of the important things she was carrying forward from the group process was recognizing that although there were very stressful things about being a family doctor, there were also many enjoyable parts. Since being in the group, she felt that she could more easily flow with the challenges and focus on the good things that each day brought her in her work.

Theme 7: Sharing the Burden of Painful Events and Witnessing Trauma

During the life review process participants told and bore witness to some very poignant and sacred stories. Group members commented on the value of creating a protected space in which they could safely share some of the painful events they had experienced in their personal and professional lives. Chantal remarked in her narrative:

> In this group I felt truly seen and heard. I don't think any of us could have known in advance how nice it feels to receive people's undivided attention and give that to others in return. Each of us were honoured and there was a bounty of acknowledgement for the gifts we bring and the challenges we've faced. It felt

like a very safe place to be. In this life review program all secrets were respected and all emotions, some of which were unexpected, were welcomed.

All the participants spoke about how rare it was for doctors to share either personal or professional distress with colleagues. Professional expectations that they would remain stalwart in the face of exposure to suffering compounded any hesitancy that individuals may have learned about disclosing personal distress prior to entering medical training. Without opportunities to express their feelings about painful events, the participants felt that the emotional detachment that at times served them well in the face of trauma easily turned into shutting down emotionally, risking burnout, and putting up walls that undermined relationships with patients, family and friends. Ray's words speak to this issue:

I think when we start to get overwhelmed and burnt out, the walls go up, and you really try to protect yourself. But it backfires somehow, because you don't get any release either. The walls keep the suffering in, as well as keeping it out. That prevents you from being able to recognize, or deal with your own feelings. So the natural osmosis of emotion gets plugged – the dynamic flow is blocked. Your emotional filter is plugged up. It's dirty. You need to get your filter cleaned out! This group is a kind of therapeutic process to keep the filter clean.

Vanessa's story illustrates the difficulties that family doctors can experience when they are not provided with consistent opportunities to talk about critical events in their work lives and struggle with professional norms that inhibit the expression of feelings:

I remember saying that how I coped with all this loss and suffering was that I just sucked it up and carried on. That was what I was taught to do in medical school and residency. I don't ever remember anyone asking how we felt about things when a critical event happened. You were just expected to suck it up and carry on ... I wrote some notes about how I felt that sucking up all of these sad and difficult events in my patients' lives has had fairly negative consequences on my life. I've often felt isolated. A lot of the other group members talked about sharing things with their spouses and family, but generally I don't tend to do that. I don't want them to be the sponges for all this trauma.

In the group, Vanessa wanted to be able to explore the impact of vicarious traumatic stress in her life in a relatively dispassionate way and not get stuck in her feelings. However, as she began to speak about the layers of grief that she had carried in silence for so many years she was overwhelmed by the sorrow that welled up. She was also concerned that describing some of the painful events she had witnessed "would be so tedious to other people, especially to a group of physicians who also do all the stuff I do. Thinking to myself that it's normal for doctors to experience these things, so why am I so upset." For Vanessa, the life review program was a place to begin sharing some of the pain she carried from bearing witness to unfixable suffering.

However she expressed feeling that, "we'd only just begun to prick the scabs of our wounds. When the group ends there isn't something in place where we can continue to find connection and support, although that is so needed." Four of the group members wanted to have more time in the life review sessions to talk about professional distress and all of them emphasized the vital importance of having a process in place that would allow and encourage doctors to release the emotional impact of exposure to loss and suffering.

Robin's narrative illuminates the transformative potential of being able to share a very painful experience in her professional life with a group of supportive colleagues. Robin was surprised to realize the depth of emotion and distress that she was still carrying about an incident that had occurred several years previously. The opportunity to acknowledge and express these feelings brought her a sense of emotional release and closure:

> I had left the session feeling very supported, very thankful too of being able to talk about the issue, and somehow lighter for doing that. The responses from each of the people in the group were only supportive. What came in the following days was the feeling that I was allowed to be human. I had made an error and finally I had a sense of reprieve – a sense that I could begin to forgive myself for being human. So it was a very cathartic week for me.

Being able to openly share her emotions and have her story witnessed by a non-judgmental and supportive group of colleagues allowed Robin to move beyond feelings of self-blame and shame. It opened the doorway for her to integrate the experience at a cognitive level and understand more fully how it had impacted her life. Robin realized not only the extent to which this particular event had continued to surreptitiously cloud her professional life on a daily basis but also how accustomed she had become in general to choking back her tears. These insights translated into becoming more comfortable with expressing sadness and affirmed Robin's intention to create time and space to acknowledge and honour her feelings.

Kate's story provides another important perspective on what it was like for group members to disclose some of the struggles they had experienced in their lives. Kate was uncomfortable with receiving feedback that she experienced as overly reassuring. She did not expect life review to help her resolve personal issues and did not want others to imply that it would:

> I talked about wanting to leave behind some of the fears and anxieties that I have. The sense I got from the feedback I received was that people were pretty sure that the group process was helping me with that, allowing me to air them out, so I could begin to let them go. It's not that simple.

Kate expressed that what was new for her in the life review process was taking the risk to write down and speak about some of the challenges she had faced. While she felt that sharing some of her problems was "a little step toward understanding them more clearly" what was more

important to Kate was knowing herself what these difficult issues were about and embracing them as part of the complex story of her life.

Theme 8: Sharing the Distress of Potential or Perceived Mistakes

The story that Robin shared about the lawsuit surrounding the loss of her long time patient had a powerful impact on the other five group members. Each of them resonated deeply with her story and felt they could very easily have found themselves in the same situation. Kate remarks: "As she was sharing her story, there was a really clear understanding in the room that she was carrying the burden for all of us this time. She was the unlucky one, but it could have been any of us."

Worry about making mistakes and being sued was experienced as a constant source of stress. As we hear in several of the stories, they all knew that errors were an inevitable and sometimes unavoidable part of medical practice. However, they commented that this whole issue generally remained unspoken and all of them lived with the angst of feeling that doctors were expected by society and by their professional culture to be infallible. Being sued was seen as a humiliating and isolating experience. The participants remarked that most doctors who were being sued tended to suffer the ordeal in silence with few, if any, opportunities for support from colleagues.

In the group, participants talked about the stress of not being allowed to be human and the weight they experienced as family doctors of being held responsible for things that were beyond their control. They felt that not being able to openly share the stress associated with potential or perceived mistakes took a significant toll on the emotional well being of physicians. In this context, the life review program was experienced as a rare opportunity to address these issues with colleagues. Ray's comments illustrate this theme:

> Without the safety of the structure and the process, I doubt that we would have been able to share what we did in this group. For example, the whole issue of mistakes in medicine. Medicine is not a culture that really shares mistakes very openly, although it is so important to learn from them. But there is this whole pressure within society and within the profession that doctors should be perfect, or that medicine should be perfect. And if you are not perfect you will get sued and all that kind of stuff. But I think there is a need and also a desire, even if that desire is subconscious and not verbalized, to be able to share concerns about mistakes or possible mistakes. So it's very valuable to have a forum, like we did, where you can talk about those kinds of things in a confidential, safe environment.

Theme 9: Personal and Interpersonal Learning

    9A: Integrating life experiences and expanding self-understanding.

    Life review enhanced self-understanding, allowed participants to feel some resolution about issues they had struggled with, and expanded appreciation of personal values, accomplishments and goals.

    Participants commented that the life review process provided them with an opportunity to make more sense of how various experiences and events in their lives fit together. They felt that being able to see things from a more integrated perspective highlighted some of the significant themes and patterns in their life stories and deepened their personal understanding of what had contributed to shaping their lives and ways of being in the world. For example, Eric became aware of the significant impact of a pattern of achievement and reward in his life. Chantal spoke about having more insight into issues around establishing boundaries in her life. Robin realized how feeling responsible for being, or appearing to be, in control of situations had negatively impacted interpersonal relationships in her life and felt that gaining a deeper level of self-understanding about this issue would enhance her ability to create closer relationships in her personal life in the future.

    Several participants expressed that the group experience helped them to reframe and integrate difficult issues or events in their personal lives more positively. Vanessa commented that reflecting on her branching points helped her to come to a sense of resolution about missed opportunities earlier in her life:

        I've often wondered over the years how my life may have unfolded differently if I hadn't felt the need to abandon my plans of branching out and exploring other worlds when my sister died. In preparing for the meeting, I reflected on that particular branching point quite a bit over the weekend and came to a feeling of peace about it. A sense that any regrets about roads not taken have been replaced with feeling that I am on the right path for myself. The path I have chosen to walk has brought many good things in my life.

    Robin was surprised to recognize the extent to which childhood experiences influenced interactions in her current family relationships. This new awareness allowed her to experience a change in perspective which enhanced self acceptance and some reconciliation with past events: "So I feel a little more forgiving of myself, and it's also allowed me to be a little more forgiving of my parents, in terms of some of the things I would have wished they had done differently."

    A number of the group members experienced life review as a means to affirm their personal values and accomplishments and celebrate where they had come to at that point in their lives. They commented that the process left them feeling encouraged and validated about choices they had made and how their lives were evolving. Kate remarks:

It was very confirming for me to do the life review process and know this is where
I want to be, and this is how I want to spend my time, and the things I think are
important, the values I hold, are actually reflected in the things that I do. Where I
got to at 40 is not bad! I feel good about that. I can make some changes I want to
make now and in the future, but they're minor tinkering.

For Chantal, life review allowed her to situate the painful loss of her marriage and the
difficult period of transition she was experiencing within the context of her broader life story.
During the group process Chantal re-affirmed her personal values, celebrated the blessings she
had received in her life, and validated her accomplishments and strengths. In her narrative we
hear her confirm that she can move ahead in her life knowing that she has done what feels right.
Life review did not diminish the pain of losing a relationship that had been the cornerstone of her
life for twenty years but it provided Chantal with a sense of continuity and the knowledge that she
will carry forward the values and sense of purpose that bring meaning to her life. In describing her
experience in the program Chantal comments:

This group has been a precious experience in my life and a special opportunity. I
think we all drew a great deal of support from being able to connect with
colleagues and get to know each other at a much deeper level in a way that felt
both safe and honouring. Being able to review my life and renew my plans was a
meaningful part of moving on from the pain of my marriage break up and
reclaiming my life.

In terms of their future goals, participants expressed that life review provided them with
an opportunity to pause and take stock of what was personally meaningful. All of them
commented that the process brought clearly into focus the significance of creating and
maintaining a satisfactory balance between their personal and professional commitments. As they
reflected on the future, a commonly shared goal was the desire to create more time for
themselves and for nurturing relationships with the people who were important in their lives. For
example, Vanessa recognized that one of her priorities was to carve out the space she needed
for quiet reflection and enjoying her family relationships. Similarly, Chantal realized that she had
learned very well how to care for others and was now committed to giving more of her energies to
self-care.

9B: Learning from other's experiences and life stories.

All the participants commented on how much they valued the interpersonal learning that
the group experience provided. Although the life review process had been described in detail
before the program started, many of them related that they had no way of knowing beforehand
how many layers of learning would evolve from sharing their life stories in the group.

At a professional level, being in a life review group with colleagues was experienced as
particularly beneficial in terms of learning how they each coped with various challenges in their

work as family physicians. Group members spoke about the value of learning a variety of individual approaches to handling complex situations and appreciated being able to share their own learning and insights with colleagues. Chantal comments: "We each have our different strengths and different styles and it was valuable to learn from each other and get different perspectives on handling challenging situations."

At a personal level, participants commented that in listening to other people's stories they not only learned more about each other but also more about themselves in the process. Hearing all the different stories around each life review theme evoked memories, insights and further reflection about their own lives. Chantal described the process as an opportunity to learn from "the cross-pollination among our stories." Group members connected with some of their colleague's stories at a deeply emotional level. They spoke of how much they valued being entrusted with stories that they experienced as memorable gifts that they could use as touchstones in their own lives. Kate's words illustrate this theme:

> There is something very important about sharing one's own story and hearing other people's stories on the same topic. The other stories provide a context for your own and there is a richness that happens as you blend all the stories together. The emotion in the story and the message it brings are more important than the content. I learned something from listening to all the stories. There is at least one story from each person in the group, and a couple from several people, that I get to share now forever. I will use those stories to help me in my life.

9C: Keeping a journal amplified personal learning.

Eric was unable to continue journaling or writing on the themes following his injury. Each of the other five group members experienced keeping a personal journal as a helpful way to extend their learning and self-understanding.

Participants felt that journaling provided a means to more fully integrate experiences that emerged during the group process or express thoughts and feelings that were not shared in the group. For example, in Ray's story he describes the value he found in using the journal to sketch the metaphor of his branching points that had come to him in the group meeting: "The drawing pulled things together in a more integrated way. Having that conceptual framework made it easier to see and understand the significant themes in my life and how they relate to one another." During the session on stress and distress Vanessa did not have the opportunity to talk about the impact of witnessing so much loss and suffering in the way she wanted to. Her journal became the place where she could write more fully about the things she had been unable to share in the group. In Kate's narrative, we see how the journal provided a means to express and reflect on the discomfort she felt at times in receiving feedback that she experienced as too overwhelmingly positive or affirming.

Journaling was also experienced as a valuable way to enhance self-reflection and expand personal learning. Chantal expressed that writing on the themes and journaling "really unblocked me" and she was continuing to journal "as a way of exploring who I am and why I'm the way I am." Kate re-connected to the enjoyment of keeping a personal journal earlier in her life and found journaling very helpful as a way to expand her learning: "In some ways, for me, the process of writing and thinking things through was maybe even more useful than telling my story in the group. It's hard though to weigh the value of those things because hearing other people's stories in the sessions was so valuable." Ray was surprised by how much he enjoyed journaling and how useful it was in terms of his personal learning: "In some respects, I found reflecting on my experiences in the group and journaling about things that were significant for me, was as valuable for my learning as writing about the various themes." In their stories, both Ray and Robin comment on the value of being able to re-read their journals, recall significant events and appreciate how their experiences and feelings were evolving. As Robin said: "Even now, when I go back to reading what I was writing in early January, it's sort of a different me than is here today."

For Robin, being invited to keep a journal during the life review program led her to discover a technique that she experienced as a very useful way to acknowledge her personal feelings and deal with challenging issues in a positive way:

> The journaling is a skill that I've come to use just since joining the group, it's not something that I did before. I've found it very helpful as a way to acknowledge and express my feelings and somehow, in doing that, in taking the time to reflect on what is going on for me, feel a sense of resolution.

Theme 10: Promoting Professional Sustainability and Self-care

The opportunity to engage in self-reflection, share and learn with colleagues in a confidential and supportive environment, and create a sense of community was experienced by the six doctors in this program as personally meaningful and professionally rewarding. In her narrative, Chantal described the group-based life review program as: "A very healthy process. It was the antithesis of isolation and it was pro-wellness." All the participants endorsed the program as a valuable means to promote professional sustainability and personal well being among physicians.

Group members expressed that this type of professional development activity filled a significant gap in efforts to sustain family doctors in the workplace. The program was seen as a viable way to reduce anxieties about self-disclosure that were inherent in the medical culture and empower doctors to build supportive collegial communities. The participants strongly recommended offering similar groups for other practicing physicians and exploring ways to incorporate this type of experience into medical training. Robin remarks:

> I think that having the time to reflect and talk about things is something that is very necessary for professional as well as personal health. Since the group I've been thinking about how one could incorporate the kind of experience we've had into training. To use it as a way to teach physicians how to wrestle with some of the difficult issues that come up – to give them the time and space to wrestle with those things. At what stage in one's career does one start insisting on this?

Apart from family physicians, the participants felt that many doctors could benefit greatly from being able to explore their concerns with colleagues in a safe and supportive group climate as they had done in the life review program. They suggested the importance of looking at how more opportunities of this kind could be created within medicine at large to enhance self-care and sustainability. Eric commented:

> If the word got out in the medical community that you can go to these groups, and it feels really good to be there, and all of a sudden there's more people you know and can connect with in a real way – if that word got around, it would be very transformative. It would be a wonderful outcome of the process – very healing to a professional.

Participants unanimously reported that their experiences in the program expanded their appreciation of the benefits of learning and sharing among colleagues and confirmed the importance of providing others in their field with similar professional development opportunities. Ray's words illustrate this theme:

> At a professional level what I took from it was a heightened awareness of the benefits of learning and sharing among colleagues as ways to promote sustainability and self-care. The necessity, although we are not used to doing that in our culture, of staying in touch with our feelings so that we don't become burnt out, or emotionally shut down, and end up jeopardizing important relationships in our lives, or self-soothing in ways that are harmful. The group certainly reinforced for me that there is a need and a desire on the part of people in our field to have this kind of opportunity to connect with colleagues, and be able to explore their feelings and experiences in a safe and confidential environment. It also reinforced my feeling that we need to encourage family doctors, and doctors in general, to do more of these kinds of self-reflective processes. One of the main things I have taken from this experience is the feeling that it is important to keep looking for ways to offer similar kinds of groups for family doctors and potentially for residents. There is a need for it, and a desire on the part of family doctors to go there.

CHAPTER 6

Discussion

Introduction

The individual narratives that were constructed in this exploratory study provide richly textured accounts of how each participant experienced the group-based program and form the core findings that were generated in this inquiry. Birren and Deutchman (1991) describe life review as allowing participants to look at their lives through the prism of various life themes. In a similar way, the narratives presented here allow readers to gain a prismatic perspective of the process. Each story re-presents a different angle of vision and provides insights into what each doctor experienced as significant, healing, frustrating and sometimes stressful as they engaged in the life review program.

The narratives are also revealing of the cultural and social discourses within which the doctors' lives are situated and provide a deeper context for understanding their experiences in the program (Bruner, 1991; Mishler, 1999). Woven through the narratives we hear how prevailing professional norms and practices constrain opportunities for self-reflection and collegial support. We gain insights into the perceptions they have as family doctors about what is valued socially and politically in the current health care climate and learn how this affects them personally and professionally. We see how a confluence of personal, professional and social expectations about what it means to be a doctor can both inhibit seeking support and mask the need to develop resources to sustain physicians in their work.

In this chapter I will first highlight some of my own reflections on the process and findings of this inquiry. I will then discuss the theoretical implications of the findings and implications for future research and practice.

Time in Context

It was striking to hear so many of the challenges to collegial connection and sustainability that are referred to in the literature embodied in the doctors' experiences. Lack of time, in particular, was a recurrent theme in the group. In choosing to become family doctors the participants had all expected to work long hours, lead very busy professional lives, and be consistently available to their patients. They did not appear to regret or question the need to do whatever was needed to promote patient care and well-being. However the current structure of health care was experienced as increasing workloads, undermining their vocational commitment, and exacerbating time pressures in ways that were often dissatisfying and sometimes exhausting and unbearable. They struggled with finding time for self-reflection; adequate time to build the relationships with their patients that was so central to their professional ethics and satisfaction; time to balance their professional and personal lives; time to connect with family practice colleagues; and the time and opportunities that were needed to maintain networks with other medical specialists. Understanding this systemic problem more fully is significant given concerns

about the need to enhance sustainability among family physicians. It is apparent how easily family doctors can become isolated, distressed and demoralized in the current health care climate.

Struggles with time certainly spilled over into the group process. It was as if we were mirroring this more systemic problem in our work together; the desire and deep appreciation for connection held in a delicate and sometimes discomforting sense of being pressured for time. As the group leader, Daniel faced the challenge of trying to balance making space for the rich stories that people wanted to share with respecting the agreed-upon time limits. It was a tension that was never fully resolved in the group and our meetings frequently ran well over time. Both Daniel and I knew that when facilitators do not consistently respect and reinforce guidelines around issues such as the time for meetings to start and end it can adversely effect the group dynamics. After the second session we talked as a group about the frustration and tiredness that running late was causing for some of the members. We revisited our agreements around time limits for sharing reflections on each theme and Daniel spoke to the dilemma he was experiencing as the time keeper. We decided to add a seventh session and agreed that while the process required some flexibility we would strive to work within the time constraints that each session provided. Nevertheless we continued to struggle with the issue. The importance of having an opportunity to tell and hear stories that were so rarely shared among colleagues took precedence over ending the meetings on time. Daniel reflected afterwards that perhaps his own experience of working as a family doctor added to his hesitancy to impose time limits. He could relate at an embodied level to the desire for connection that was so clearly present among the group members and knew from his own experience the value of spending time with colleagues in this way.

Part of my own anxiety about the struggles with time constraints was related to feeling hampered in my role as a participant inquirer to share the responsibility for time keeping with Daniel as I usually did when we co-led workshops. Part of it was regret that I had not adequately addressed the need for longer, and more, sessions ahead of time. In designing the program, Daniel and I had discussed the benefits of meeting for eight to ten sessions. We decided on six, believing that more than this might deter physicians from joining the program given how pressured their lives were. It was ironic, in retrospect, to think that our concerns about their lack of time had resulted in a time crunch in the program. I was relieved when the group decided to add a seventh session and in their feedback the majority of the participants recommended that future life review groups for physicians be expanded to at least eight sessions. The time difficulties did not prevent the group from building a strong sense of cohesiveness but we hear in both Vanessa and Ray's stories how time constraints impacted their experiences in the program. These findings raise issues that need to be considered in planning future life review groups and I will discuss some of these in the section on implications for practice.

Building Relationships and Creating Community

The fact that all the doctors were so dedicated to attending the seven life review sessions was experienced as an extremely unusual phenomenon in this profession. They attributed their commitment as speaking to the importance they placed on having an opportunity to connect with colleagues in an authentic way, reduce a sense of isolation and learn with, and from, each other. The group members pointed out that life review provided an exceptional opportunity to talk about themselves as individuals and as family doctors. In other professional meetings or groups the focus was either on gaining information (e.g. new treatment modalities or case review) or on issues about the doctor-patient relationship. For instance, Practice-Based Learning groups were cited by some of the members as providing a venue for collegial support but only secondarily allowing them to broach their personal experiences.

In the narratives we hear how connection and help seeking among physicians is impeded by norms in the medical culture that promote confidentiality, self-reliance, and fears of being stigmatized if they expose vulnerability or distress. Not surprisingly, the anxiety that most people experience when they join a new group was heightened for a number of the doctors when they thought about engaging in self-disclosure in front of colleagues. Their professional training had taught them to avoid negative evaluation by responding in terms of scientific and evidence based knowledge and they were generally more guarded when it came to talking about or showing their feelings around other medical professionals. Initially they expressed some hesitancy about being invited to tell their stories in whatever way felt most meaningful for them. They joked about the fact that in medicine they were expected to have the right answer to questions and consequently there was an ingrained sense of needing to figure out the right way to do life review. Some of them commented that in the beginning it felt somewhat awkward to be in the role of the speaker while other people listened to them. It was a strange role reversal after spending fifteen to thirty years as family doctors. Usually they were the ones listening to their patient's stories. While there was a desire to share their own stories, they realized that they were far more accustomed to getting information about other people's lives than they were in speaking about themselves. As they spoke, I found myself reflecting on the literature that that points out how rarely we get to hear doctors stories (Holland, 1995; Kleinman, 1998; Montgomery Hunter, 1991) and knowing in a deeper way what a loss that is for those of us outside of the profession and especially for the doctors themselves.

As we see in the narratives, their initial ambivalence quite quickly shifted to experiencing the pleasure of having people's undivided attention as they told their stories. They expressed great satisfaction about feeling heard and understood by their colleagues and appreciated the opportunity to listen to the stories that were shared without any of the usual pressures of needing to document the facts, diagnose the problem, and prescribe a solution. The benefits that the participants experienced as a result of building deeper relationships with colleagues are revealed

strongly in the thematic results: the value of normalizing concerns and frustrations and learning how others are coping with challenging situations; the opportunity to affirm vocational commitment and professional worth; the relief of being able to talk about painful events and worries about making mistakes; the chance to learn from other people's life stories. At an individual level, the participants valued gaining a more integrated perspective on their own life stories and enhancing their self-understanding. For several of them the process allowed them to feel some resolution about issues they had struggled with in their lives. For others it was an opportunity to affirm their values and accomplishments and celebrate where they were in their lives. They all appreciated the opportunity to look more closely at what was personally meaningful to them as they thought about their future goals.

All the doctors experienced the life review program as counteracting their anxiety about self-disclosure. The structure and group guidelines allowed them to experience a strong degree of personal control over what they chose to share and permitted them to risk self-disclosure at a pace that fit with a growing sense of personal safety and interpersonal trust. A significant finding in this inquiry was the fact that the participants felt that the educational focus of life review precluded the stigma that can be attached to seeking emotional support in the medical culture. They saw it as a culturally acceptable and proactive way for doctors to engage in self-exploration and mutual support. This finding confirmed my hope that the life review model might be one that is valued as culturally sensitive and therefore appropriate to professional development amongst physicians.

Montgomery Hunter (1991) suggested that reading stories about what it is like to work in the trenches of medicine offers physicians the potential for psychic refreshment and moral encouragement. The results of this study suggest that it is even more refreshing and encouraging when doctors are provided with a means to sit together and share their stories. By far the most encompassing finding in this inquiry is the depth of interpersonal trust and cohesiveness that developed among the group. Yalom (1998) notes that a sense of group cohesiveness is more than a therapeutic force in its own right. It creates the conditions in which other healing factors and intra-personal and interpersonal learning can optimally occur. Similarly both Mezirow (1997) and Randall (1995) speak about the importance of creating safe and democratic spaces for birthing stories and unleashing the potential for integrative and emancipatory learning.

In the narratives we hear how much the participants valued the group, felt a sense of belonging and wanted everyone to be present. They experienced feeling valued, supported and unconditionally accepted by the other group members. Being able to disclose one's self to others and feel validated while doing this is essential for the creation of authentic relationships and an enhanced sense of personal authenticity. These six doctors felt that the safety that was built into the life review program (through the structure, confidentiality, guidelines and facilitation) allowed them to talk about themselves and share their experiences in ways they had not previously felt

they could do with professional colleagues. The process worked against powerful norms in the medical culture that limit the fullness of the stories that doctors can share with each other. It allowed them to create a sense of community and experience the value of being in community with their colleagues.

The community-building aspect of life review (Birren & Cochran, 2001) was experienced as powerful and much needed way to move physicians out of isolation and into connection. Mezirow (1994, 1998) points out that the establishment of democratic, collaborative learning climates can open up the potential for emancipatory learning and emancipatory action at both individual and societal levels. At the follow up meeting, the participants in this study decided that they wanted to continue working together as a group and we set a future meeting date in the early fall to explore how we could proceed with this. They also decided to advocate to the regional health authority that this program (led by skilled facilitators) be made available to all primary care physicians in their region.

Group Facilitation

Another significant finding was the importance the doctors placed on the expert group leadership that allowed them to create and maintain a safe and supportive group climate. According to Birren and Deutchman (1991) and de Vries et al. (1995), leaders of life review groups do not need to be health care professionals or therapists because life review is not problem centred or designed to be group psychotherapy. Birren and Cochran (2001) address the importance of group leaders having some training in teaching or leading small groups and prior experience as participants in life review. These authors provide guidelines for leaders in terms of managing time, creating and maintaining a non-judgmental environment, and addressing issues of concern that might arise for the participants during the process. They recognize that people with extensive experience as group leaders may not always be available and that paying for the assistance of highly skilled facilitators may be too costly in some situations and limit the use of this valuable model. However, Westwood et al. (2002) and Westwood and McClean (in press) suggest that skilled group facilitation is essential to helping group members build, maintain and deepen group cohesion in populations who are wary of self-disclosure and where there is a high risk of potential shaming, embarrassment or re-traumatization. The results of this inquiry support the findings of these authors and indicate that expert leadership is required when implementing a group-based life review program with family physicians.

Initially, as I felt my way into being a participant-inquirer in this group process, I found myself frequently standing on shifting ground. I was struggling with what felt like an ambiguous, complex role and embodying the awareness that in engaging in collaborative narrative research it was impossible to bracket out parts of myself if I wanted to be authentic and spontaneous in my relationships with the co-researchers in this inquiry. Previously I had co-led a variety of groups with Daniel. All the participants were aware of this and knew that I had training and experience as

a group facilitator. On the one hand, as a researcher in the group, I felt that I needed to restrain myself from moving into a co-leadership role. On many occasions however, I felt compelled, both ethically and pragmatically, to assume a role of co-facilitation. Journaling and having opportunities to struggle with the tension I was experiencing in conversations with Daniel and my committee members allowed me to more fully embrace the multiple positions I was negotiating. While Daniel retained primary leadership for the group, in their narratives the participants reflect that during the life review process both Daniel and I provided group facilitation.

This life review program for family physicians was situated in a group based counselling model to enhance the benefits of the life review process. The facilitators employed both individual and group counselling skills (for example, empathic reflection, immediacy, strength confrontation, clarifying, summarizing, moderating, supporting, linking, limiting and process observing) to enhance inclusion, interpersonal trust, and group cohesion.[3] For life review to have optimal therapeutic benefits, it is imperative that facilitators be closely attuned to the levels of personal safety and interpersonal trust that are present as the process unfolds over time. The participants in this group expressed appreciation for the way the facilitators provided specific interpersonal skills, reinforced the group guidelines when this was needed, ensured that people were not inadvertently pushed to self-disclose beyond their own comfort levels, and encouraged individuals to take the time they needed to reflect as they were sharing their stories so that they did not risk premature disclosures that might leave them feeling overly exposed.

The six participants stressed that expert facilitation was an essential component of allowing them to move from a place of hesitancy to a strong sense of community. They valued Daniel and I assisting them at times to identify, clarify and express their feelings. This is apparent in Robin's story. Not only did she benefit greatly from the group receiving her painful story with compassion and support, she gained further relief and closure by following Daniel's strategic suggestion that she write a letter to her patient. It was evident that group members trusted that the facilitators had the necessary skills to support both individual members and the group as a whole if strong or unexpected emotions were expressed. For myself, the research conversation with Vanessa following the program clearly reinforced the importance of group leaders having the skills to help group members both express and contain emotions that may catch them by surprise as they tell their stories. As we talked, Vanessa described the depth of frustration and ineptitude that she had experienced following the session in which she was overtaken with grief as she spoke to some of the loss and suffering she had witnessed as a doctor. If the facilitators had not intervened and helped her to contain her emotions (so that she could continue to participate with at least an appearance of equanimity) her felt sense of exposure could well have been even greater and seriously diminished her sense of belonging and interpersonal safety. The findings

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[3] Readers who are interested can find a full reference to these kinds of skills in works by Egan (2002) and Corey (2000) among others.

also highlighted for me the importance of facilitators making themselves available outside of group meetings. Participants valued knowing that they could contact Daniel (or myself if he was not available) outside of the sessions if they were experiencing difficulties and individuals deeply appreciated his care in following up after meetings when they had shared a difficult story.

The role expectations of doctors are such that they are hesitant to disclose, fearful of stigmatization, regularly exposed to the suffering of others in their work, and acutely aware of the public's expectations of them. In this professional context, group members felt that expert facilitation was vital to enhancing their experience of life review and optimizing their ability to create a safe, cohesive, and productive learning environment. Based on their experiences in the program, the six doctors were emphatic that any life review groups for physicians in the future needed to be led by people who combined knowledge of their professional culture with expertise in group counselling and facilitation.

It was a privilege and an honour to be a member of this group and it is an experience that I cherish. The stories that were shared in the sacred space that we created together are ones that I hold in my heart and will never forget. The willingness of the participants to be so open about what had, and had not, worked well for them during our research conversations was invaluable in expanding my own perceptions and awareness as a participant inquirer during the group process. For example, in the group Kate was reticent to voice her discomfort with feedback that she had experienced as too overwhelmingly positive. Learning about her feelings highlighted how affirmations given to be supportive can sometimes be experienced as evaluative and overly reassuring. It is a useful reminder that facilitators need to remain sensitive to this potential.

Sharing the Burdens of Care

The consequences of expecting doctors to be more than human and single handedly carry the burden of caring for others can be disastrous to their health and their desire or ability to continue in practice (Myers, 2003, 2004; Remen, 2001). A large body of evidence speaks to the benefits of connection and supportive witnessing in healing trauma and preventing or reducing the impact of secondary traumatic stress reactions (Arvay, 1998; Catherall, 1999; Herman, 1997; McCann & Pearlman, 1990). We know that people who are repeatedly exposed to the suffering of others in their work are at high risk for burnout and compassion fatigue if they do not have opportunities to share these experiences and have them validated. This is especially true for those who have a strong capacity for connecting empathically with others. The very quality that enhances their ability to provide care to others renders them most vulnerable to experiencing vicarious traumatic stress reactions (Pearlman & Saakvitne, 1995). Despite this accumulated evidence, as we hear in these stories and read in the literature, physicians too rarely either have the chance or take the risk to seek emotional support in the current culture of medical practice.

Prior to this study I was well aware that many physicians lack opportunities for receiving adequate emotional support. Nevertheless, as a participant in the program, it was sobering to

witness the degree of loss and suffering that that some of these family doctors had been exposed to in the course of their work without any structured opportunities to safely share their experiences. The participants in this group had been practicing as family doctors for between 15 and 30 years. Apart from being able to talk about some of the distress they might be experiencing with a family member or close friend, they seemed to have been very much alone when it came to finding a way to cope.

The doctors in this study knew the importance of being able to explore and safely express the emotional impact of consistently bearing witness to suffering and loss and talked about the risks of compassion fatigue. They recognized that without emotional support and encouragement to express their feelings there was a real danger that doctors would burn out and put up walls that kept the suffering inside as well as keeping it out. Yet paradoxically, their professional training and dedication to providing care seemed at times to have masked, even from themselves, the importance of having their own suffering heard. They had in some ways become inured to putting their own feelings and needs to one side so that they could get on with caring for other people.

The participants commented that emotional detachment can be a double-edged sword in the medical profession. Being able to detach emotionally was sometimes very necessary in allowing physicians to function competently in the face of critical incidents and unfixable suffering. However, if emotional detachment became a primary way of being in the world, it seriously jeopardized the ability to foster and sustain compassionate professional and personal relationships. The doctors felt that physicians could very easily get stuck in a stance of emotional detachment if they did not have opportunities to safely express their feelings about difficult events they witnessed in their work. At the same time, they recognized how unused to doing this they were in their profession. It would be valuable to conduct further research with physicians to understand more fully how they cope with the tension of moving between emotional detachment and connection.

In the life review group, the participants created a safe and protected space in which they could begin to share the burdens of caring with colleagues who could truly understand and validate their experiences. For Robin, the opportunity to express her feelings about a painful event and be witnessed by a group of supportive colleagues was transformative. She was able to integrate the event into her life, find closure, forgive herself, and feel that she was allowed to be human. In our second research conversation, Robin commented that the group had also provided her with the space and means to acknowledge the sadness of losing a family pet and beloved patient at the same time. Without this opportunity, she felt she would likely have put her sorrow on the back burner and been afraid of ever getting that close to a patient again for fear of the pain she might experience if the person died. Having the means to grieve the loss made her realize

she didn't want to avoid that kind of closeness and miss out on all the other things she gained in a relationship with a patient she cared about deeply.

As human beings, if we do not have opportunities to share our suffering or express our grief with others who can understand and support us we risk losing a part of ourselves. We diminish our capacity to be fully alive, spontaneous, and able to engage authentically in intimate relationships with others (Dayton, 1994; Herman, 1997; Levine, 1997). In the life review group, I saw the restorative power of six family doctors creating a collegial community in which they could start to share the burden of bearing witness to other people's suffering. What occurred in this group is an example of the healing potential that exists when doctors can break through the walls of silence, safely share some of their own suffering, and build a supportive, compassionate community with their colleagues. It was, however, only the beginning of sharing the wounding that some of them had accumulated in their years of practice. As Vanessa pointed out, when the group ended there was nothing in place where they could continue to find this depth of collegial connection and support.

Living with Uncertainty and Ambiguity

Professional and societal expectations that doctors should be perfect or that medicine should be error free weighed heavily on these physicians. Uncertainty is an inherent part medical work and errors are an inevitable part of medical practice. However this is rarely discussed openly in medicine (Clarke, 1996; Holland, 1995; Sotile & Sotile, 2002). In the group the doctors valued having a confidential space in which they could share some of their anxieties about potential or perceived mistakes and the pressure of being held responsible for other people's actions over which they had little, or no, control. In an increasingly litigious culture, worry about making mistakes and being sued was experienced as a constant source of stress for physicians and one that took a significant toll on their emotional well being. Myers (2004) noted that investigation of a physician's medical license strikes at the core of their professional identity and sense of integrity. The doctors in this group saw it as a wrenching and humiliating ordeal that most doctors go through without collegial support. There would be great value in addressing this issue within the medical community and within society as a whole.

The narratives reveal some of the challenges that this group of physicians experience currently in their work and the importance they placed on being able to talk with colleagues about their concerns and frustrations. In a time of rapid technological advance, health care restructuring, increased bureaucracy, and restrictions on health care spending, they faced increasingly complex demands and moral decisions about how to provide their patients with the best possible care. There was no ambiguity among these family doctors about the importance of the doctor-patient relationship and the healing effects of providing patients with personal and continuing care. A consistent theme in the group was their unequivocal dedication to building healing and sustained relationships with their patients and patient's families. In the stories we

hear the depth of frustration they experience about the ways in which the current structure of health care negatively impacts this core aspect of their work. Where the ambiguity lay for these physicians was in questioning how much society values this model of care and the degree to which it is sustainable in today's health care climate.

Many times as I listened to the stories and experiences that were shared in our group meetings I wished that other people could hear the struggles, dedication and courage of these doctors. I sincerely hope that others will read the narratives that were co-constructed in this study and gain insight into the experience of living and working as a family doctor. It is evident that in recent years there has been a decline in morale among family doctors in Canada. It is imperative that if we do want them to continue to provide us with comprehensive and compassionate care, we need as a society to start giving back to them.

Theoretical Implications

This research project illuminated several significant findings for theoretical consideration: (a) the constructs of vicarious traumatization and burnout as aspects of this research; (b) implications for guided autobiographical methods; and (c) expansion of the literature related to family physicians.

Although I reviewed the construct of vicarious trauma (Pearlman & Saakvitne, 1995) in the literature review as a possible theoretical explanation for part of the stress experienced by physicians in their work, the findings do not indicate that vicarious trauma symptoms were present in their narratives. Vanessa spoke of wanting to talk more fully about the impact of vicarious traumatic stress on her life. However, she did not describe her distress as symptoms of vicarious trauma (intrusive imagery, avoidance, hypervigilance, and shattered beliefs) but more in terms of descriptions of burnout (being emotionally exhausted, depersonalization, and a low sense of accomplishment). The majority of the participants in this inquiry recommended having more time in the life review program to talk about professional distress and the effects of bearing witness to suffering. At the conclusion of the group, several doctors commented that in speaking to other doctors about the life review program it would be important to emphasize the risks that physicians run of becoming vicariously traumatized and the benefits of having opportunities to share the impact of stressful events with colleagues. Yet there was no evidence in their narratives that they were themselves experiencing vicarious traumatic stress. The question is raised: Is vicarious trauma a part of their experience? Group-based life review is not designed to be an in-depth therapeutic intervention and perhaps this prevents adequate opportunity to understand the deeper layers of personal experience that may be related to helping or wanting to help a traumatized or suffering person (Figley, 1999). An important issue that needs to be re-examined in future research with physicians is the extent to which they may experience vicarious traumatization.

With regard to the literature on life review, this study confirmed many of the findings of previous research studies on group-based life review (Birren & Deutchman, 1991; de Vries et al., 1995; McClean, 2001). The significant contribution this inquiry makes is knowledge about the use of group-based life review with family doctors. Prior to this study, no research has been conducted to understand how family physicians would experience joining with colleagues in a group-based life review program. In this study, the participants expressed that it was vital for leaders of life review programs for family doctors to have both expertise as group facilitators and an adequate understanding of the medical culture and context. This finding about the importance of expert group leadership is similar to results of research using the life review approach with peacekeeping soldiers (Westwood et al., 2002). The findings also indicate that there may be great value in adding a component of personal journaling to the life review process.

Finally, the findings of this inquiry add to the body of existing knowledge in the literature related to family physicians in terms of providing one potential way to enhance well-being, collegiality and sustainability in this population. The narratives also provide valuable insights into how the participants in this study experience living and working as family doctors and confirm the vital importance of fostering a positive professional climate in which self-care, collegiality and seeking support are more proactively encouraged.

Implications for Research

The findings of this exploratory study suggest several avenues for future research. The number of participants in this study was limited to six people and no criteria were put in place to limit participation on the basis of age, gender, ethnicity, geographic location, or type of family practice. An obvious next step would be to build on this inquiry by conducting a more extensive evaluation of the Life Review Program for Family Doctors and researching how other groups of family physicians in the health care region experience engaging in similar professional development programs. Such studies would yield important comparative data and provide useful information about how effectively and flexibly the program can be refined to meet the needs of family doctors working in a variety of practice settings and at various stages in their career lives. For example, the six physicians in this study were all currently practicing in an urban setting. It would be very worthwhile to change the delivery format of the life review program and carry out research with doctors working in rural practice. Similarly, the participants in the current inquiry had all been practicing for a minimum of 15 years and ranged in age from 39 to 59 years old. It would be valuable to understand how well the model addresses the needs of family physicians who have been in practice for fewer years. Further, the six doctors in this study had all completed their medical training in Canada and were all members of the mainstream culture. Further studies are needed to understand how international medical graduates and physicians from diverse ethnic groups would experience engaging in this type of professional development program.

Future research could also explore the value of offering a range of life review programs for specific populations of family doctors. The changing demographic picture of the Canadian medical profession (Sullivan, 2004) indicates that in the under 35 age group female doctors make up 52% of the profession and that two thirds of young female physicians practice family medicine as opposed to other specialties. It could be interesting to research how younger female physicians might experience joining together in a professional development program grounded in a life review approach. In addition, as one of the doctors in this study suggested, it could be worthwhile to research this approach with late career physicians in terms of its effectiveness in enhancing interpersonal learning, work satisfaction and sustainability.

Expanding on the current findings, it would be important to design longer-term follow-up studies to explore whether physicians who had participated in a life review program experienced this as contributing in an on-going way to a sense of professional sustainability and collegial connection. Following this exploratory research, it would also be very valuable to consider combining quantitative and qualitative methodologies and incorporating relevant outcome measures in a pre-test/post-test design. For example, it might be useful to consider measures such as the Compassion Satisfaction and Fatigue (CSF) Test (Figley & Stamm, 1996), the Self-Esteem Rating Scale (Nugent, 1994; Nugent & Thomas, 1993), and the Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996).

Another desirable initiative would be to research how physicians who work in other specializations would respond to this approach to professional development and explore whether the benefits were similar to those experienced by the participants in this study. Doctors who work in specialties such as intensive care, emergency rooms and palliative care (among others) are repeatedly exposed to trauma and suffering and called upon to make challenging ethical decisions in their work. To what extent do they desire to have a greater sense of collegial community with their colleagues and would they experience a life review program as a meaningful way to enhance a climate of mutual support? Similarly, could this type of program benefit other members of medical teams such as nurses and people involved in attending and debriefing critical incidents? Could working in cross-disciplinary life review groups encourage greater levels of interpersonal understanding and teamwork as long as participants did not feel obliged or subtly pressured into participating?

The participants in this study felt that it was essential to look for ways to incorporate the kind of experience they had had in the group into residency training and more proactively promote self-care and future sustainability. They questioned whether it would be possible to create the time and space for this in current training programs and how ready residents would be to engage in this kind of process when they are under so much pressure to gain clinical knowledge and expertise. These findings and my own experience in working with family practice residents raises a significant question that merits further research. Can the emphasis on gaining

clinical expertise be balanced with increased opportunities for residents to create collaborative learning groups in which they could safely share some of the concerns and difficulties they may be experiencing? How ready would residents be to see the value of such opportunities in terms of their current and future well-being? To what extent do people who are involved in teaching residents see a need to do this?

Implications for Practice

The Life Review Program for Family Doctors appears to offer a viable and effective means to enhance sustainability among family physicians. This is an important finding given the need for, and lack of, resources to support physicians in the workplace. The participants strongly recommended moving as quickly as possible to make this type of professional development program available to family doctors in their health care region. They also recommended exploring how similar opportunities could be offered to residents and physicians working in other specialized areas of practice. Clearly, in following through on these recommendations, research and practice go hand-in-hand: many of the implications for practice are interwoven with the implications for research described previously.

The findings of this exploratory inquiry suggest some pragmatic issues that need to be considered in implementing and delivering future life review programs for family doctors:

- The importance of recognizing that three and a half hours provides little time for six participants to share their stories in any depth. Birren and Cochran (2001) recommend the discipline of participants sharing only two pages of their writing per session. This is to ensure enough time for everyone to share their stories and receive feedback and also as a way to have individuals focus on which details are most essential to telling their stories. While this may work as a general rule of thumb, I believe that applying it in this life review program would have been detrimental to the process and to the significant learning that occurred among the group members. Physicians have very few opportunities to share their stories and experiences. In the future I would recommend planning sessions that are at least four hours in length for a life review group with six doctors. Alternately, if time restrictions prohibit this, then it might be worth considering having only five members in the group. The participants in this program felt that six was an ideal number because it allows for diversity and, as Robin commented, enough people to shoulder the emotions that arise. Based on my own experiences with the life review approach, I have seen it work effectively in groups of five to eight participants depending on the time that is available for meetings.

- The need to explore a variety of formats for offering the program that might avoid having to meet at the end of what, for many doctors, have been long work days. For example, it would be valuable to explore the possibility of meeting for a morning session at the weekend or considering meeting for a full day once every two weeks. In making this type

of program available to family doctors who are working in rural communities the format could be adapted for a weekend workshop. Fortunately, the structure of group-based life review lends itself well to this need for flexible delivery designs.

- Remaining aware that the structure of life review is not designed to provide the depth of therapeutic self-exploration that some participants will desire. In this inquiry, Vanessa wanted the group to be longer and hoped for more in-depth feedback from the group facilitators during the sessions. Ray was aware of feeling that he wanted to push the process further and get into issues at a deeper level than the life review structure allows. Research has shown that life review can provide a useful diagnostic function in allowing group members to identify issues that they may want to explore further (de Vries et al., 1995) and leaders need to be able to recommend appropriate resources. Life review has also been effectively combined with therapeutic enactment as a way for group members to identify and work through critical issues in their life experiences (Brown Shaw et al, 1999; Westwood et al, 2002). I would recommend that post-group resources be developed to allow participants who desire this to have on-going opportunities to meet, expand on their learning, and process issues more deeply.

The participants in this program experienced the life review process as providing a safe and culturally acceptable way to experiment with self-disclosure among colleagues. They felt that the educational focus of the program distinguished it from engaging in therapy and precluded the stigmatization that can often be associated with seeking therapeutic support in this culture. This finding has significant implications for practice when we consider that a major issue that has been identified in the literature is the need to transform the dominant culture of medicine where the personal is often excluded from professional practice.

Further, this finding has implications for other professional groups who may share similar anxieties about self-disclosure and help-seeking. For example, it would be worthwhile investigating the suitability of a group-based life review professional development program among military, law enforcement, and corrections personnel.

Finally, the participants in the study emphasized that people delivering this type of program need to combine expertise as group facilitators with an adequate understanding of the culture and context of medical practice. It is important to consider ways to expand trans-disciplinary professional development opportunities between areas of Counselling Psychology, Medicine and Adult Education. In this way we can draw on combined expertise and mutual learning opportunities as we seek to develop future resources to support physician well-being and sustainability.

Conclusion

In this study a collaborative narrative methodology, coupled with participant inquiry, was adopted to generate an in-depth understanding of how six family physicians experienced joining with colleagues in a group based life review program. The narratives that were co-constructed in this study and the thematic results indicate that the program was experienced as an effective means to promote self-care, the provision of mutual support, a sense of community, and enhanced sustainability among family doctors.

It is rare for doctors to share their stories either with each other or with people outside of the profession. As authors point out, stories about what it is like to be a doctor are few and far between in the literature (Holland, 1995; Kleinman, 1998; Montgomery Hunter, 1991). The narratives that the six doctors in this study have been willing to share with us are precious gifts. They do far more than tell us how the doctors experienced being in a group-based life review program. In their stories, the doctors have taken the risk to share some parts of their personal and professional lives with us so that we can more fully understand the experience of being a family doctor. Since this inquiry their lives have moved on and evolved in ways we cannot know. What they have entrusted us with are their stories.

> The story that comes from the heart stays with the listener the longest. When we "give-away" the stories in our heart, only then do we know how rich we really are. As our story lives on in the hearts of others, love and gratitude for what we have given them grows and expands to yet others. We share the gift of our story not so much for our own purposes but for the greater purpose of the lasting bond between human beings that is created through the sharing. Our story is a gift for the ages. (Atkinson, 1995, p. 137)

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APPENDIXES

Appendix A - Poem

THE MISSING WOMEN   Sunday, February 24, 2002

Fifty women have disappeared from the Downtown East Side. Such a strange word "disappeared". Inconclusive. It holds an endless stream of suffering and faint hope. Killed, murdered, dead – these are words that I can grasp, choke down, swallow whole. Hard, cold, bitter words – words that ring with the finality of an ending - provide the possibility of a beginning.

'Dis-appeared' floats like mist – unattached, detached, unknowable.

Re-cognizing

Fifty names surround a cross in the Peace Chapel of Christchurch Cathedral. Fifty names are spoken in the quiet of candlelight. You have been called the faceless ones, the forgotten ones. Tonight, as you are named, I feel you take your places as daughters, mothers, sisters, aunties, lovers, cousins, friends. No longer simply "missing women" or "sex trade workers". You are remembered, acknowledged, each one of you, as a woman who is missed.

The wax from my candle drips onto the page of names.

I recall the five of you that I met this week. Not on the streets where you lived and worked. Although I may, perhaps, have seen you there before - in the downtown east side - as I made my way to and from my office. Seen you and passed by. Stopping only briefly, occasionally, to give spare change or a cigarette. I would have seen the scabs, the bruises, the needle tracks, your hollow eyes. Seen the misery and not the beauty of your souls. Felt compassion and missed seeing the passion in your hearts.

Re-membering

This week I met you in the frozen agony of a heart that loved you. A heart numbed by unbearable grief. A voice silenced by unfathomed rage. Incomprehension stifling breath.
Tears compacted into stone.
The scar of your loss burned into the fabric of her soul.

She brought you to our circle, held you in sacred space. We faced you – the faceless ones – faced the unfixable suffering of y/our lives, knew the unspeakable terror of evil. Shattered threads of safety and fragile hope.

I met you in grief, wading in leaden pools of overwhelming grief. I met you in peace, in the interweaving conversations of our lives. Voices speaking
of tragedy and triumph, laughter and tears. Storying strength and grace. Dignifying indignity. Re-storing spirit.

She named the gifts embedded in your souls - re-membered them, em-bodied them. Risked holding you, once more, in her caring arms. And you breathed life back into in her aching heart.

Struggle Innocence Flamboyance Calmness Honesty

Gracefully, graciously you entered our circle, embraced her isolation, heard our fears, felt our tears – honoured us with your presence.

Re-turning

Tonight, I see your faces in the flickering flame of a candle. You are etched in my bones –
Struggle, Innocence, Flamboyance, Calmness, Honesty.

Tonight, as the words of Amazing Grace fill this Cathedral, I will sing for you. Push through the clump of grief in my throat, push through dark anger, despair, fear and violence. Sing the song that together we have written in my soul.

Re-connecting
The vigil ends. Fullness and emptiness are braided in the scent of sweeetgrass and blown out candles. Hurts and blessings commingle. I know refuge from isolation in the companionship of friends who stand beside me. Sowing seeds of re-memberance, flames of hope. Re-connecting to the fire of spirit. Resting in the grace of eternal love. Gathering the courage, humility and connection I need - to bear witness, to hold the candle.

A candle is made to become entirely a flame.
In that annihilating moment
it has no shadow.
It is nothing but a tongue of light
describing a refuge.
Look at this
just finishing candle stub
as someone who is finally safe
from virtue and vice,
the pride and the shame
we claim from those.   - Rumi: A Just Finishing Candle

Appendix B – Four Principles of Family Medicine

The family physician is a skilled clinician.

Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

Family medicine is a community-based discipline.

Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex biopsychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.

The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

The family physician is a resource to a defined practice population.

The family physician views his or her practice as a "population at risk", and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients' health.

Family physicians have effective strategies for self-directed, lifelong learning.

Family physicians have the responsibility to advocate public policy that promotes their patients' health.

Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources.

They consider the needs of both the individual and the community.

The patient-physician relationship is central to the role of the family physician.

Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family physicians respect the privacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients' well-being, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.

Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.

*Quoted from The Postgraduate Family Medicine Curriculum: An Integrated Approach

meaningful for you. In the group meetings you will share your reflections with the other group members, either by reading all or part of what you have written or speaking to the theme in a way that is comfortable for you. After you share your story, you have the opportunity to hear how the other group members experienced listening to you and how your story impacted them personally. Similarly, you will have the opportunity to listen to others' stories and talk about your response to hearing them. The facilitator, Dr. Kuhl, will ensure that appropriate group agreements are established in the first meeting to promote confidentiality, respectful communication and a non-judgmental group climate. Each session will focus on a different theme, such as "branching points in your life", and sensitizing questions will be given to help you write your autobiographical essay related to each theme.

To facilitate your own reflections and the research interviews following the program, you will be asked to keep a brief journal of anecdotes or notes to yourself that will remind you of experiences you had during the life review process. The co-investigator will attend the group sessions as a participant-inquirer and will keep a similar journal of her own experiences. Although there is no limit to the amount of time you choose to spend reflecting and writing on each theme or journaling between sessions, you can expect to spend a minimum of 2 hours per week preparing for the group meetings (i.e. at least 18 hours over a six to eight week period).

You understand that no video or audiotapes will be made during the life review group meetings. You know that you are not required to show the co-investigator what you have written on the themes or in your journal as part of the research data, these remain confidential to you. Anything that you have written would only be included in the narrative of your experience in life review if you specifically requested this happen during the research interviews.

2. First Research Interview:

Sometime during the three weeks following the final group session you will be interviewed individually for approximately two hours regarding your experience in the life review program. The purpose of this interview is to create an understanding of what it was like for you to participate in life review and the meanings that the experience has for you personally. The research conversation will be audio-taped and transcribed. The co-investigator will write an initial narrative based on the interview conversation, her understanding of the story of your experiences in life review and her own reflections and interpretations. The narrative will be written in a way that disguises any identifying information and using the pseudonym you have chosen to protect your confidentiality.

This initial narrative will be sent to you for review. A cover letter will invite you to note any editorial suggestions (additions, deletions or amendments) that you feel would enhance how coherently and resonantly the narrative reflects your experiences in life review.

3. Second Research Interview:

You will be interviewed individually for approximately one hour to discuss your suggestions for editorial revisions. With your permission, this interview will be audio-taped to ensure that the co-investigator is being accurate in making the changes you want when the narrative is re-written.

4. Conclusion of the Research:

A final copy of your re-written individual narrative will be sent to you and once the study is completed, you will receive, by mail, a copy of the research findings.

Time Commitment:

The time commitment in this study will vary depending on the amount time that you decide to dedicate to reflecting and writing during the life review program. You can anticipate a maximum

Appendix E – Group Process

Appendix E 1 – Group Guidelines

LIFE REVIEW GROUP:
GUIDELINES FOR THE GROUP PROCESS

Following the initial group meeting, the following five sessions will all be based on a similar format: The group facilitator will provide an opportunity for group members to reconnect with the group (e.g. express any concerns or events that could impact their ability to be as present as they wish during the session) and briefly review the theme assignment for the next session. The remainder of the time will be devoted to sharing the stories and reflections that group members prepared for the current session. To guide this process the facilitator will:

1. Remind group members that the purpose of reading their story into the group is to help them integrate their own experience and benefit from having the story listened to and witnessed by others in the group.

2. Take responsibility for monitoring time and moving the process along to avoid the last speaker being shortchanged. Remind group members that they each have the same air time, that they can read or speak to as much or as little of what they have written (or documented in other ways) as they want to within the time frame allotted, and that, as facilitator, they will provide assistance to ensure that the group member is supported in the telling of their story.

3. After each person has spoken their story into the group, they will be invited to reflect and comment about what they were aware of as they told their story to the group. The facilitator will ask if they wish to hear from others in the group how listening to the story impacted them.

4. If the speaker wishes to hear from others, the facilitator will invite group members to comment on what part of the story impacted them personally or what they took from the story that was most important to them.

5. The facilitator will remind group members that their task is to help amplify and expand awareness for the storyteller (and themselves) by using open-ended questions for clarification if needed, speaking from their own experience using "I" statements, and avoiding advice giving, evaluative statements, or feeling that they 'have' to say something when remaining quiet and absorbing the story is what they want to do.

Appendix E 2 – Guidelines for Writing

Writing Guidelines

Before each group we would like you to spend some time documenting your reflections and experiences about the theme being discussed at the next meeting. Each theme is briefly described in a handout with questions for you to consider as you reflect and write. Don't be put off, or limited, by the questions. They are only suggestions to promote reflection and you may find some, all, or none of them relevant.

We have found that there is a marked difference in the value of life review between people who put something down on paper and those who don't. So, try not to neglect your homework! We know that it will enrich your experience and hope you will find it the most enjoyable homework you've ever done.

You may choose to write short biographical essays or document your experiences in other ways that you prefer - notes, drawings, a collage, poems, photographs or other objects that represent your reflections on the theme. If at any point life takes over and you can't carve out the time you need for homework - just jot down some notes. What is important, in fact essential, is that you have thought about the theme before the meeting. Grammar, spelling, sentence structure and artistic skill are not important or required – no one will be marking your homework. The only thing that counts is that it is meaningful for you. Remember, it's your life story! Your writing is yours to keep. It is completely your choice as to whether you want to share parts of it with family or friends, or keep it private.

The same principles apply to keeping a brief journal of your experiences during the life review process. You are being asked to do this as a way to deepen your own reflections about the process and facilitate our research conversations following the program. There is no 'right' or 'wrong' way to do it – it is simply an invitation to record experiences that struck you as important, interesting or challenging in whatever way is meaningful for you.

As you reflect on, share and compare your life stories with those of others in the group you may come away with a greater appreciation for the life you have lived and are living - with all its ups, downs, joys, sorrows, hopes, fears, questions and anticipated futures. As James Birren (1987) puts it, reviewing our lives can help us to see that "we must have been good travelers to have gotten this far".

Appendix E 3 - Journalling

Journaling Your Life Review Experience

You are not required to show this journal to anyone. So how you choose to journal your experiences in this life review program is entirely up to you – whatever you find to be a meaningful (and not too onerous!) way of recording how your experiences in the life review program are unfolding.

In tracking your experience, consider spending some time shortly after each session to make a note of anything that was significant for you during the group meeting. You may also want to make a note of things that strike you as important, interesting, puzzling or difficult in the time between meetings as you are reflecting on the various themes.

As a general guide to journaling, you may want to think about including:

- Your thinking: (e.g. insights, learning, hopes, questions, anxieties, frustrations). Things that stand out as significant from listening to other's stories or in sharing your own and having them witnessed.

- Your feelings: (e.g. excitement, apprehension, neutrality, anger, sadness, gratitude, anticipation). Any significant dream images, or patterns of feelings that emerge. Perhaps either resistance (to doing homework, journaling, making time to be part of the group) or pleasure in taking time for yourself to reflect and share with others?

- Any physical reactions that you experience as significant and the context in which they arise (e.g. experiences of feeling energized, calm, relieved, anxious, tearful, restless, tired, joyful).

Thanks for agreeing to keep a brief journal during this program. As you know, I will be doing the same thing. I trust that it will enhance our experience of life review and our research conversations following the group.

Appendix E 4 – Group Agreement

LIFE REVIEW FOR FAMILY PHYSICIANS

Draft Group Agreement

Guidelines to make the shared experience rewarding for everyone...

- This group experience will be stronger if everyone attends all the sessions and arrives on time. We will do our best to notify each other in advance if we if unable to attend the group or will be arriving late.

- To help everyone be comfortable in the group, we will keep what is shared during the group sessions confidential. The names of people in the group and the things we talk about will be kept within the group. We are free to talk about our own experiences outside the group, while always being careful not to breach another group member's privacy.

- Each member has the right to privacy within the group too: to choose what they wish to share of their reflections and writing on the life review themes; to "pass" when they choose to rather than feeling obliged to participate or that they 'have' to say something in response to a story they have witnessed; and to ask others to stop if their comments or questions are experienced as discomforting.

- We will try to make sure that everyone has equal time to have their voice heard. The facilitator(s) will take responsibility for monitoring time and moving the process along as needed.

- We welcome different beliefs and values within this group. We can respect and affirm each other by honoring our different viewpoints and not judging each other. We will endeavor to speak only from our own experience, using "I" statements.

- Many of us are used to thinking that the way to support another person is through helpful comments, suggestions and advice. In this group no advice will be given unless specifically requested.

- We welcome the expression of feelings in this group. We will support each other by allowing time and space for expressing feelings that arise and not jumping in too readily with Kleenex or 'soothing' gestures.

Appendix E 5 – Branching Into Medicine

Significant Career Branching Point: Becoming a Family Physician

For this activity you will be assigned into pairs.

1. Recall a significant event or experience that you sense was related to, or in some way led toward, your choice to become a family physician. Was it more externally or internally motivated? Initiated from without or within?

   How did this particular event impact you with respect to:
   - Your thoughts
   - Your feelings
   - Your behaviours
   - Your sense of meaning in life, spiritual beliefs or values

2. Write down a few brief notes to recall this event or experience.

3. Describe the event/experience to your partner.

4. Your partner will actively listen to your story (asking only clarifying questions as needed). They may want to ask your permission to keep a few notes as you are speaking and you can let them know if that would feel OK or if you prefer that they just listen without writing. When you have finished speaking, your partner will paraphrase back to you what she/he heard.

5. As you hear your story reflected back to you, ask yourself if your partner captured the essence of it accurately. If not, help them understand it more fully.

6. Now switch roles and repeat #3, #4 & #5.

7. Having heard each others stories, talk together about the experience:

   - How did it feel being listened to? What was it like to listen? Did you have any new insights as a result of hearing your own story reflected back to you, or in listening to your partner?

We will close this activity by coming together as a whole group and having an opportunity to share insights, learning, questions or challenges that emerged during the exercise.

Appendix F – Life Review Themes

Appendix F 1 – Branching Points

Think of your life as a branching tree, as a flowing river that has many juncture points, or as a trailing plant that puts down roots at various places and then grows on. What is a branching point? Branching points are events, experiences, or happenings in our lives that significantly affect the direction or flow of our life. Branching points are experiences that shape our lives in some important way. Branching points may be big events (e.g., marriage, retirement, geographical move) or they may seem small and apparently inconsequential (e.g., reading a book, going on a hike). Big outcomes may have small beginnings. From your point of view, what were the major branching points in your life? What were the events, experiences, interactions with people and places that had a major influence or impact on the way your life has flowed?

Sensitizing Questions:

- About how old were you at the time of the branching point(s)? The timing of an event is often very important. Did it happen too soon? Were you too young? Did it happen too late? Were you too old?

- Who were the important people involved in the turning point or were you alone? Were the people involved in other major branching points?

- What were the feelings you experienced at the time the branching point occurred? How intense were they? Were your feelings mixed, changeable, seemingly contradictory at times?

- Sometimes our feelings about an experience or event change over time. Something that seemed a disaster when it happened may turn out to be a positive event later on and vice versa. What emotions do you experience as you think about the turning point now?

- How much personal choice was involved in this branching point? How much control did you have or was it something that was completely out of your control? Who or what were the external influences?

- Branching points are "branching points" because they change our lives in one or many ways. In your view, what are the ways your life was changed because of this branching point? What effect, impact, consequences, did it have on your life? How would your life have been different if it had not occurred?

Source: Birren, J., Deutchman, D. (1991). Guiding autobiography groups for older adults: Exploring the fabric of life. Baltimore, London, John Hopkins University Press.

Appendix F 2 – Family

Who is your family?

Who is in your family of origin (grandparents, parents, siblings, aunts, uncles, other people you experienced as "family")? Who is in your family of adulthood (spouse/partner, children, grandchildren, friends you have chosen as family)?

Which family members played a significant role in shaping your life as a child and young adult – in positive ways, in negative ways? Who in your adult family has been important in how your life has unfolded to this point in time? What would another person have to know about your family to understand you and how you've come to be the person you are?

Sensitizing Questions:

- How was affection expressed in your family? Who loved you in your family? How did you experience that love? Who did you confide in, go to for comfort? Which family member(s) have you been closest to? Who did you know the least, not feel close to – even though you may have wanted it to be different? Were there heroes, favourites, black sheep in your family? How did you know?

- Who held the power in your family? Who made the decisions and how were they made? What were the rules in your family, the "shoulds" and "oughts"? What were the major areas of conflict? How was conflict resolved? What was the feeling tone in your family (e.g., happy, sad, crowded, spacious, noisy, quiet, warm, cold)?

- What were (are) the strengths and weaknesses in your family? What are some of your favourite, joyful memories? Some of your painful memories? Was there anyone in your family that you were afraid of or fearful for? External events that created anxiety? What experiences have torn your family apart or made you closer?

- How do relationships in your family of adulthood reflect or contrast with those in your family of origin? Which familiar patterns (e.g. attitudes, values, strategies, behaviours, worldviews) have you chosen to carry forward or pass on? Which have you wanted to be different? What are the memories of playfulness and spontaneity in your childhood? How are those features expressed in your life today?

Source: Birren, J., Deutchman, D. (1991). <u>Guiding autobiography groups for older adults: Exploring the fabric of life.</u> Baltimore, London, John Hopkins University Press.

Appendix F 3 – Career

Theme Assignment: Your Career as a Family Physician

Career is your major life's work. It occupies your energy, your activity and your time. Usually we think of it as work for pay. Yet, career/life work is also expressed in ways that do not necessarily involve a salary: For example in being a spouse, partner, friend, parent, or mentor; in spiritual commitment, play, learning, community service, or creativity. We may have a sequence of careers, a number of careers or both. Sometimes the shifts, variety and intermingling of our careers/life work may be complementary, at other times they may compete for our attention and energy.

As you think about your career as a family physician, remember that the following questions are offered only as prompts for reflection. You don't have to answer all of them, or be limited by them.

Sensitizing Questions

- How did you find/choose your career? As a child what did you want to be when you grew up? How old were you when you decided to become a doctor? What people, events or circumstances influenced your decision to pursue medicine as a career? How much choice did you have in setting this as a career goal? What did you imagine/hope it would be like to be a doctor?

- In what ways was your experience in medical school and residency training inspiring or dispiriting? In what ways was it rewarding? Was becoming a family physician always your goal or did this evolve over time? Were there significant people or events during this time that either strengthened your commitment or led you to question your choice of career?

- How has your experience of being a family physician unfolded? What have been the peaks and valleys? Have there been minor or major changes, setbacks, or perhaps shifts in focus? What has significantly influenced you in constructing the path of your career? For example, people, places, events, values, goals, needs?

- What are, and have been, the challenges of your career? Your experiences of success, joy, fulfillment, failure, disappointment, sacrifice? What do you enjoy the most? The least? In what ways has being a family physician met your expectations and hopes? In what ways do you feel let down? What sustains you in your work?

- How has being a family physician added meaning to your life - allowed you to express who you are and want to be in your life? How has it detracted from this? How has being a doctor enhanced or limited other important life work – other roles and activities that you cherish?

- If you got to do it over again, what, if anything, would you want to be different? Would you choose the same career?

- Given your life experiences what ordinary wisdom would you want to pass on to young men and women who are choosing to be family physicians?

Source: Birren, J., Deutchman, D. (1991). Guiding autobiography groups for older adults: Exploring the fabric of life. Baltimore, London, John Hopkins University Press.

Appendix F 4 – Stress and Distress

Theme Assignment: Your experiences with stress, distress and bearing witness to the suffering of others.

> "The weight modernity places on its heroes (being the beginning and end of all things – having to settle the task of the universe) – physicians feel this weight" (Arthur Frank, 1995).

In addition to other sources of stress and distress that can arise over the course of a lifetime, those of us who work in helping and healing professions are vulnerable to experiencing vicarious traumatic stress. This is often described as the stress that results from helping or wanting to help suffering or traumatized people – the natural stress response to an abnormal event or cumulative exposure to suffering. Paradoxically, having the ability to foster healing relationships and connect deeply and empathically with others are some of the qualities that can render us most vulnerable to experiencing secondary traumatic stress.

Becoming a physician invites direct exposure to human suffering and to the joys and sorrows of caring for others. In the course of your work as a family physician you have likely been expected to carry responsibilities, do things, witness events and contain anxieties that most people would not usually or consistently encounter in their professional lives.

What have been the major stresses and experiences of distress in your work life? How have you coped with the weight of being a family physician? What have been the major rewards? What have been/are the consequences of stress in your life? How have distressing events affected you physically, emotionally, mentally and spiritually? What sustains you in your work?

Please remember that the following questions and "Critical Incident Reflection" are offered only as guides. Don't feel you have to respond to all the questions or be limited by them as you reflect on experiencing and witnessing stressful and distressing events in your professional life.

Sensitizing questions:
- What did you learn about stress from parents, teachers, peers? How did you learn to cope with stress? What did you learn about stress and coping with stress in your residency training? During this time, did you have a role model or a mentor who inspired and supported you?

- In what ways have the lessons you learned about how to cope with stress (through teachings and difficult personal experiences) been helpful or unhelpful to your personal and professional resiliency? How have your ways of coping with stress changed over time?

- In your career as a family physician, what have been the continuing or cumulative stresses? The intermittent or short-lived stresses?

- How have you coped with the uncertainty and complexity that is inherent in family practice medicine? How have fears about making mistakes and/or experiences of questioning your judgment impacted you? How have you known you were feeling stressed – what were the clues? How have you responded to these clues?

- How has caring for dying patients affected you? How have you experienced the loss of patients with whom you established deeply caring relationships? Do you feel guilty about any patient's death? Helpless? Angry? Resentful?

- Under what circumstances do you find yourself least able to cope with stress? Most able? In what circumstances have you felt helpless in the face of unfixable suffering? Which troubling patients' stories have remained with you? Which patient's stories have inspired you? How have you coped with encounters with difficult, frustrating, challenging or frightening patients?

- In distressing circumstances when have you felt most understood and supported? When have you felt least supported or alone? Where do you turn to for support? To what extent do you feel validated and supported in the work you do? What have been the positive and negative consequences of stress in your life? How would you want things to be similar or different in the future?

Appendix F 5 – Meaning in Life

Discerning and creating meaning in our lives:

> "We are often intimidated by fear, of course, but it may be a much more fearful thing not to have been who we were meant to be than to face the fears that stand in our way. What we owe the world, then, is respect for each person's summons to be unique. We owe ethical behavior so that we may live in a society which supports each person's possibilities. And we owe the world the contribution of our best selves. It is in our uniqueness, our special talent or capacity or calling, that we add to the richness of the world."

- James Hollis (2003). On this journey we call our life.

> "... the more we tell and read the texts of our lives, the more that direction will reveal itself on its own; our unique inner wisdom will be freer to be our guide. Mystical as this sounds, there can be no cookie-cutter patterns, no packaged analytical schemas, with which to story our lives. Ultimately, we are a novel. We alone can judge. Only thus can the story we live be *our* story, our *whole* story, and *nothing but* our story. Restorying is thus something we ourselves can direct. We may draw on outer resources as they apply, but we need not surrender our authorship to others, whether an individual like a therapist, parent, or spouse; a collective such as our clan or creed; or a program that would push its preferred formula, template-like, for making sense of our lives. No one but ourselves can tell us who we are, or who we can become. The onus is on us. Within the rich, sprawling text of our own infinitely interpretably experience we hold whatever answers we need and wisdom we seek. These precious things lie within us, not without; they cannot be prescribed by others, only discovered by ourselves."

- Gary Kenyon and William Randall (1997). Restorying our lives.

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Theme Assignment:
The Meaning of your life, and your aspirations and life goals

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Feelings, thoughts and questions that we have about meaning, values, purpose, and spirituality can be difficult to put into words. The simple delineation of right and wrong in childhood years often becomes vastly more complex in our adult lives. As adults, the choices we face require us to leave familiar standpoints and move into unknown territory. Hollis (2003) contends that we are often called to accept discomforting levels of anxiety, ambiguity and ambivalence as we seek to discover the path that is right for us – to live our own journey (rather than someone else's) and avoid walking in shoes that are too small. Many people find support and guidance in a traditional spiritual practice. Others follow a humanistic philosophy. Many people develop their own belief system - a synthesis of diverse elements.

How do your life goals fit into your own beliefs and values? How have you set your life goals? What are they? As you reflect on the history of your moral or spiritual development, what patterns and changes do you notice? How have experiences of significant losses and gifts in your life shaped the person you are today and the way you create meaning and purpose in your life? Do you have a philosophy of life? What is it? What does your life mean? What does human life in general mean?

Please remember that what is written above and the following questions are offered only as guides to your personal reflections. You don't have to answer all or any of them.

Sensitizing Questions:

- Were there spiritual traditions and practices in your home as a child? In what ways have you carried them forward or chosen to change them in your adult life?

- What spiritual symbols hold significance for you? What is your relationship to the natural world, plants and animals? Have you had a spiritual/transcendent experience in your life? What were you doing and where did it happen? How did you respond?
- What are the principles that guide your life? What are your standards? How do these reflect or differ from strongly held familial, social and cultural values that you were taught as a child? What does it mean for you if you don't live up to your principles, your standards?

- What has been your purpose in life? Have you had more than one purpose? How has this purpose (or these purposes) changed? Have you ever found life meaningless? Did it fill you with despair? Did you come to some understanding?

- Do you have a sense that you are on the right journey regardless of the approval of others? What parts of yourself do you want to get to know better and/or express more fully in the future? What do you want to leave behind, change or bring into your life to enhance your personal sense of being well in the world. What do you need to do to avoid walking in shoes that are too small and to celebrate the unique gifts you bring to this world?

- What kinds of different goals do you have - material, social, personal, universal, moral, spiritual - and how important are they to you? What are three things you want to do before you die?

Sources:
Birren, J., & Deutchman, D. (1991). Guiding autobiography groups for older adults: Exploring the fabric of life. Baltimore, London, John Hopkins University Press.

Hollis, J. (2003). On this journey we call our life: Living the questions. Toronto: Inner City Books.

Kenyon, G., & Randall, D. (1997). Restorying our lives: Personal growth through autobiographical reflection. Westport, CT: Praeger Publishers.

Appendix G – Initial Research Interviews

The purpose of the initial research interviews is to understand what it was like for each of you to participate in this Life Review program. I don't plan to be asking you a set of pre-prepared "interview questions". I'd like us to be able to engage in a conversation that will hopefully allow us to create together an understanding of what stood and stands out for you as personally significant about engaging in group-based life review with other family physicians.

As a guide to our conversations, I thought may be helpful for us to start out by looking at how your experiences unfolded over time: To begin by reflecting back to your initial decision to join the group and then consider each subsequent week in terms of what you experienced as significant both during the group meetings and the time you spent reflecting, writing about the various themes and journaling your experiences.

We will also have time to talk more generally about your overall experience of the program: What you got out of it; what got in the way of your learning and /or enjoyment of the process; what, if anything, you will take from this experience into your professional and/or personal life; ideas about how this program could be more effective and responsive to the needs of family physicians based on your own experience.

You may find it helpful to bring your writing on the themes and your journal to the research interview in case there are particular events or stories you want to re-call during our conversation and/or reflections that you feel it would be important to share with me in creating an understanding of your experiences in group-based life review.

Appendix H – Transcription Key

Item	Symbol	Example
Short pause in conversation	...	that it... um
Long pause in conversation	....	felt like it......
Incomplete words	/ fill-in?	respons/ ibility?
Emphasized words	**bold**	I **hope** that...I think, **enough**
Raised voice	CAPS	ARE YOU KIDDING!
Quiet words	(softly)	(backward life)
Interjection	(initial:)	(HP: Yeah)
Overtalk	{talk}	{both speaking at once}
Emotional expression	[emotion]	[shared laughter]
Environmental	[noise]	[clock chiming]
Inaudible	(inaudible)	(inaudible name)

Examples of typical script

HP: It was more his skill as you say in the counselling that was really important. {R: Yeah.} Yeah. Mhmm........
R: So that, so that um... that, that no I don't actually think that having being a physician or **specifically** a family physician would necessarily be that important. ...(H: OK.) Um... hmmmm ... ... let's see, what I have written down [flips through her journal] things that [inaudible loud noise] [flipping paper?] I actually took this with me. (H: **OHH**, on your **holiday**?!!!!! [shared laughter.]) That's right, but then I realized that, that um, I needed sort of **private** space to do this and to do it on the airplane wasn't really appropriate and so I (H: Right.) it got taken to the beach with me [shared laughter] [R: Flipping through journal.] ....

HP: So feeling a little bit outsi/de - feeling just on the edge.
V: On the edge. You know, ...you know,... not excluded by any group dynamic but just, ...you know looking around and trying to see, ...you know,...... how this **fits** (H: Um hmm.) and who I was in this **group** (H: um hmm.). Um, I was **concerned**. I said about being very, ...about being a BORING [somewhat ironic tone.] contributor [self-deprecating laughter] um, that was one of the things that I wrote down, (H: Ahhh.) it was one of my **worries** (H: Um hmm.) that was, like, during the session.
HP: Yes, {during the session}