"In a world so rife with vulgarity, with brutality and violence, love exists. I'm grateful to know that it exists."
~Maya Angelou

"We do not believe in ourselves until someone reveals that something deep inside us is valuable, worth listening to, worthy of our trust, sacred to our touch*."*
~EE Cummings

HCB501 Compassionate Care, Medical Humanities, and the Illness Experience
Instructors: Stephen G. Post, PhD & with Jeffrey Trilling MD (& Maria Basile MD)
Semester: Fall 2025
Schedule: Mondays, 6-8:30 pm
Location: FPPM Conference room 067
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COMPASSIONATE CARE, MEDICAL HUMANITIES & THE ILLNESS EXPERIENCE

"In the midst of hate, I found there was, within me, an invincible love.
In the midst of tears, I found there was within me, an invincible smile.
In the midst of chaos, I found there was within me an invincible calm.
I realized, through it all, that in the midst of winter, I found there was,
within me, an invincible summer. For it says that no matter how hard the
world pushed against me, within me, there's something stronger – something
better, pushing right back."
~Albert Camus

Background Statement
The World Health Organization has designated "compassionate care" as a goal of all medical education, and the AAMC has stressed this as a goal of US medical schools (*Kindness in the Curriculum* AAMC News, Sept. 18, 2018 https://www.aamc.org/news-insights/kindness-curriculum). The National Health Service in the UK published *Intelligent Kindness: Reforming the Culture of Healthcare* (2014) because both staff and patients felt a loss of human connection. Morale within the NHS had never been so low, they state. The NHS saw a solution in restoring its core founding principles - *kindness and compassion within a service that functions for the common good.* They argue that healthcare is more at risk now than ever from a deteriorating humanism, and assert that doctors must promote kindness and restore compassionate relationships between clinicians, across inter-professional teams, and with patients.

A 2011 U.S. survey looked at 800 recently hospitalized patients and 510 physicians; 85 percent of patients and 76 percent of physicians said that compassionate care is "very important" to positive outcomes (Lown, 2011). However, only 53 percent of patients and 58 percent of physicians reported that compassionate care was generally provided in the

U.S. healthcare system (Lown, 2011). In a benchmark study (Zugar, 2004) of 2,608 physicians surveyed nationally in the U.S., 87% of the 58% of physicians who reported erosion in their enthusiasm for medicine attributed this loss to the inhibition of empathic care. As an antidote, increased clinicians' satisfaction with their relationships with patients reduced professional stress, burnout, substance abuse, and even suicide attempts (Shanafelt, 2009).

Kindness, cognitive empathy, affective empathy, & compassionate care

We will try to be careful about definitions. *Kindness* is the relatively uncomplicated virtue of being considerate that involves words of acknowledgement and often small actions as well. It is akin to what Dr. Jeffrey Trilling means by "gentle curiosity" in his book *The Circle of Change: Beyond Technology's Reach,* which we will be reading. There is also *cognitive empathy,* which involves careful understanding of the other through a process of attentive listening and reflecting back to check for accuracy, and to thereby validate the other's experience. This is more complex than simple acts of kindness, and it can be practiced. But it need not come from the heart, and these days, anyone can get this sort of empathy from AI (just ask Chat GPT). Such cognitive empathy is not *affective empathy* because it leaves the other without a sense of emotional presence or resonance. *Affective empathy* includes *cognitive empathy* but adds an authentic motional presence that patients pick up on. Otherwise they may feel that they are only engaged in a role-playing exercise.

So what is *compassionate care*? Try this*: compassionate care* is (1) both *cognitive and affective empathy* (2) in the response to the other's *suffering* and (3) always accompanied by the will or at least the intention to alleviate said suffering, to the extent possible.

Of course, this definition begs the question of what suffering is, who is suffering, and how you detect it in others (and self). How does illness differ from disease? How does pain differ from suffering? Are all people suffering at some level, possibly all the time? Are some people more compassionate than others by nature and/or nurture? How do role modeling and narrative fit into this formation? Where does the classical idea of the "wounded healer" enter in, if at all? Can we draw on our own suffering to better understand suffering in others? Do we heal others better when we have experienced the illness that the they are experiencing? Can certain practices, including mindfulness, help with becoming a compassionate healer? If so, how? How do empathy and compassion influence patient outcomes, such as adherence to treatment in cases of chronic illness, or even biochemically? Does compassionate practice contribute to clinician meaning, well-being, and even resilience, in part because it avoids "moral injury"? What is the fate of compassionate care in today's healthcare system?

Discussion of suffering begs the question of *What is happiness**?*** Maybe we should do away with the idea that life can be lived exclusively in so-called happiness. And what is happiness, anyway (e.g., hedonic, flow, eudemonistic)? Why is happiness research so superficial? Is "inner peace" a better focus than "happiness." Are the Buddhists right that the only way to control suffering is to control desires for "success" and possessions by deepening our sense of what success is, and by using illness as an opportunity to do so?

We will cover a lot of big questions as a team, and hopefully we can all grow in the process.

READINGS

Required Inexpensive Paperback Books

(Purchase on Amazon or elsewhere)
Paul Kalanithi, *When Breath Becomes Air*, "Foreword" by Abraham Verghese. New York: Random House (2016).

Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023.

(There will be one more book that will be provided in later November. Surprise.)

All assigned articles will be provided in a weekly email from the instructors as attachments.

BIG QUESTIONS **Big Questions for each class**

Students bring to each class session one thoughtful Big Question, written out in one well-crafted sentence. Please have your Big Question with you and ready to read during class discussions when asked.

2025 COURSE OUTLINE (Mondays)

August 25, 2025
Topic 1: On Suffering
SGPost, M Basile & J Trilling

Topics: What is suffering? Is everyone suffering all the time or just sporadically, if at all? How can we "notice" suffering? How do we respond to it? How can we "treat" suffering? How is suffering related to compassionate care? Does pain always cause suffering? What is the "ether dome" at MGH? How does disease differ from illness?

Before Class Video: https://www.youtube.com/watch?v=cDDWvj_q-o8

Dr. Basile will begin with a reading of her poem *I've Looked at Clouds that Way*.
Can there be compassion without clouds? Can there be a lotus blossoming without the muddy waters?

What is happiness? How does it pertain to suffering and compassion?

Discussion: Compassion is an affective form of empathy that includes at least the intention to alleviate suffering in so far as this is possible under the circumstances? Eric J. Cassell MD (d 2021) was the foremost physician writer on illness and suffering in the last half century. His book *The Nature of Suffering and the Goals of Medicine* is considered a classic. Cassell suggests that "disease is something an organ has; illness is something a person has." He maintains that the goal of modern medicine must be to treat the individual's suffering and overall well-being, and not just the disease. Cassell's views on suffering are close to canonical in medicine today, as he advanced a subjective view of suffering, in which the beliefs and perceptions of the person experiencing the disease are paramount.

Suffering and illness revolves around big questions: What has happened? Why has it happened? Why me? Why now? Does "god" hate me? Is this justice or indemnification according to my Akashic Record? What do I fear most? What are my hopes? How can I be resilient? What about my core relationships? Is everyone suffering all the time, or to some extent, as the Buddha and various others (including western philosophers) have argued? Is anxiety a form of suffering? Is everyone anxious? What is the opposite of suffering?

Try to come up with your definition of suffering and how you might ask about it with patients.

Readings:
Norman Cousins, "Anatomy of an Illness (As Perceived by the Patient)." *The New England Journal of Medicine,* Vol. 295(26), 1976, pp. 1458-1463. Why do lots of people think of Cousins as the father positive psychology, even before Marty Seligman?

Eric J. Cassell, "Diagnosing Suffering," *Annals of Internal Medicine*, Vol. 131, 1999, pp. 531-534.

Eric J. Cassell, "Illness and Disease," *The Hastings Center Report*, Vol. 6(2), 1976, pp. 27-37. How do illness and disease differ?

Scarlet, J., Altmeyer, N., Knier, S. and Harpin, R.E. (2017), The Effects of Compassion Cultivation Training (CCT) on Health-Care Workers. *Clin Psychol*, 21: 116-124. https://aps.onlinelibrary.wiley.com/doi/full/10.1111/cp.12130

Question: A mother who is deeply and seemingly intractably grieving over the loss of a child? How do you diagnose suffering? Does this justify her having access to assisted suicide, as in the Netherlands? Or is this going too far?

Do you understand what the Spanish poet and essayist Miguel de Unamuno wrote about in his great book, *The Tragic Sense of Life*. Or what Soren Kierkegaard (1813-1855), the Danish theologian and philosopher described in his *The Concept of Anxiety*, coining the term that would echo down to us in psychiatry and existentialism. Or for what Buddhism describes with the phrase modernized by Thich Nhat Hanh in his great book *No Mud, No*

Lotus. Let's view a short 3 minute film by Thich Nhat Hanh
https://www.youtube.com/watch?v=stiG6IzDITc

September 1 (Labor Day) NO CLASS

Read independently *When Breath Becomes Air,* a best-seller in 2016. The words jump right off the page. It seems to touch everyone who reads it. Pay attention to big themes like happiness, suffering, hope, forgiveness, and resilience. Also, what does this book tell you about Kalanithi's evolving views of *success* in life and what can you learn from these? Who in this narrative exemplified compassionate care? What does the book say to you about meeting life's struggles? Do you like the title? But ask any questions you feel called to. Bring them to class.

Readings:
Read Paul Kalanithi's, *When Breath Becomes Air*. New York: Random House (2016).

September 8
Topic 2: Kalanithi's journey
Post, Trilling, Basile

Discussion of Kalanithi's journey

What is hope and where does Kalanithi find it? Hope is variously defined, but seems to pertain to a confidence in future events and circumstances. What are the characteristics of hope? Is it different than optimism? Where does it come from? How do patients gain, sustain, or lose hope? Is hope different under differing conditions of illness? Is hope rooted in community, spirituality, evolved cognitive structures, environment, past experience, habit, etc.? How can you as provider respect the dynamic of hope in patients, and why is this important?

Hope is not just optimism? Hope for a patient is about the uncertain expectations around which they constitute their lives in time of serious diagnosis or illness. Hope is deemed a virtue in hard times, while optimism is perhaps a dispositional quality, although these are discussable distinctions. The opposite of hope is despair – an unhappy resignation, an admission of defeat, a giving up of expectations. The skilled clinician must handle hope empathically, and be able to help shift patient and family hopes from one goal to another? Discuss hope in depth in the case of Paul Kalanithi.

**Is there such a thing as false hope in patients?*
**Where does patient hope come from? Individual experience, special relationships, communities, spiritualities, religion, the physician?*
**Is it justifiable to disclose diagnosis, but not a clear prognosis, in order to sustain hope?*
**What is the difference between optimism and hope?*

Pre-class Video (6 minutes):
https://www.youtube.com/watch?v=5FWn4JB2YLU

September 15
Topic 3: What Suppresses Compassion?
Post with Dr. Phyllis Migdal

Is a child by nature empathic? (Was Jean-Jacques Rousseau right about the kind child?)
Do the wrong buttons get pushed? If so, can this early negative influence be reversed?
How to raise a kind child?

How might negative role modeling play a role?
In-group/out-group selection? Arrogance?
A cultural loss of the right spiritual "grand narratives"?
Negative hierarchies? (Stanley Milgram and T-4, the Stanford Prison Experiments)
Time/ Being too busy? Stop Look Listen Model
Implicit bias and how to get rid of it?
The constant growth of technologies?

Please watch this TED talk by Dr Abraham Verghese
https://youtu.be/sxnlvwprf_c?si=l8MqAUx-eLUJWiHe

Dr. Phyllis Migdal: "How Implicit Bias Interferes with Compassionate Care" (45-minute presentation)

Readings:
S.G. Post, L.E. Ng, J.E. Fischel, L. Bily, et al., "Routine, Empathic and Compassionate Patient Care: Definitions, Developmental Levels, Educational Goals, and Beneficiaries," *20th Anniversary Issue of the Journal of Evaluation in Clinical Practice: International Journal of Public Health Policy and Health Services Research,* Vol. 20(6), 2014, pp. 872-880.

John L. Coulehan, Frederic W. Platt, Barry Egener, Richard Frankel, Chen-Tan Lin, Beth Lown, William H. Salazar, "'Let Me See If I Have This Right…': Words That Help Build Empathy," *Annals of Internal Medicine,* Vol. 135(3), 2001, pp. 221-227.

Austin Hake, SG Post, "Kindness: Definitions and a Pilot Study for the Development of a Kindness Scale in Healthcare," *PLOS ONE* Vol. 18, No. 7, e0288766

(Due Sept 22nd: Reflection Essay # 1 Due (20%) 5-page essay on When Breath Becomes Air with an emphasis on illness in relation to suffering, hope, and resilience. Email attachments are fine but do not send PDF files.)

September 22
Topic 4: Illness and the Wounded Healer
Facilitators: Post/Trilling

Sometimes healthcare professionals only realize the importance of healing relationships when they themselves become ill and are suddenly wearing the shoes of a patient. The psychoanalyst Carl Jung referred to the "wounded healer" who, through his or her own illness experience, can heal others through increased empathy. Very few ideas are new ideas. Prior to Jung, the ancient Roman philosopher Seneca wrote, "The wounded doctor heals best." Falling ill and seeing the other side of the coin can be tremendously instructive and transforming. Perhaps it is the "wounded healer" who can most be trusted to carve out time in daily practice in which connection and personal care receive their rightful place of honor. Yet, the conceptual advantage of a "wounded healer" is somewhat controversial, especially in psychiatry. (The shaman in historical and global perspectives is always someone who has suffered from illness and recovered, and therefore plays the role of the 'wounded healer.")

How comfortable would you be introducing your own illness experience (wounds) into your conversations with patients, if at all? Pitfalls and advantages of doing so?

An excellent account of compassionate transformation comes from a book entitled *A Taste of My Own Medicine*, written by Ed Rosenbaum about Jack MacKee, MD. The author, a successful surgeon whose bedside manner is unkind, arrogant, and discourteous. He is too busy to show personal concern toward his patients or family. One night he coughed blood and was soon diagnosed with throat cancer. During protracted treatment, he befriends June Ellis, a fellow cancer patient who eventually dies. Jack's cancer is cured, but the experience transforms his practice as he begins to teach medical interns the importance of compassion and personal concern for patients in making them better doctors. We will discuss segments of *The Doctor*, a movie based on MacKee's book.

Before this Movie Before Class:
Watch "The Doctor" starring William Hurt (try any on-line venue)

Readings:
Ky Lynch, "Consideration for the Wounded Healer" (unpublished essay, 2015) How careful should you be if you take on the persona of a "wounded healer"?

September 29
Topic 5: Three Ways Mindfulness Can Make You Less Biased and Open the Path to Empathic and Compassionate Care
Panel: Sarah Greco MA, Rev. Dr. Johanna M. Wagner, Dr. Jeffrey Trilling, Dr. Maria Basile (SGPost moderating)

There is just too much distrust and polarization in our culture today for kindness, empathy, and compassionate care to flourish. This class session is devoted to various mindfulness and meditational techniques that are shown to mitigate this adversarial tone,

which has been shown to tamp down both implicit and explicit biases. How does this work? ***By decreasing our negativity bias.*** **It is necessary to offer solutions to the problem of "implicit bias."**

Readings
Jill Suttie, "The Ways Mindfulness Can Make You Less Biased," *Mind & Body* (May 15, 2017.

Diana J. Burgess, MC Beach, S Saha, "Mindfulness Practice: A promising approach to reducing the effects of clinician implicit bias on patients. *Patient Education and Counseling* Vol. 100, 2017, pp. 372-376.

Yoona Kang, JF Dovidio, JR Gray, "The Nondiscriminating Heart: Lovingkindness Meditation Training Deceases Implicit Intergroup Bias," *Journal of Experimental Psychology* Vol. 143 (No. 3), 2014, pp. 1306-1313.

In addition, we will discuss "carefrontation" (SG Post & M Scott Peck) and the language of nonviolence.

October 6
Topic 6: How do you ask someone about their suffering?

What is kindness? We all know what it means when we could have been a little kinder, instead of dismissive (Hake 2023). Everyone can be kind always. (Fitzgerald FT. Curiosity. *Ann Intern Med*. 1999;130(1):70-72.

What is compassionate care? Again, one: Compassionate care is affective and cognitive empathy in response to suffering, and including at least the desire and willingness to alleviate suffering. Dr. Eric Cassell suggests that suffering involves "a specific state of distress that occurs when the intactness or integrity of the person is threatened or disrupted." He suggests that doctors ask patients directly, "Are you suffering?" "I know that you have pain, but are there things that are even worse than pain?" "Are you frightened by all this?"

Readings
Fitzgerald FT. Curiosity. *Ann Intern Med*. 1999;130(1):70-72. doi:10.7326/0003-4819-130-1-199901050-00015 or https://www.acpjournals.org/doi/pdf/10.7326/0003-4819-130-1-199901050-00015

Eric J. Cassell, "Diagnosing Suffering," *Annals of Internal Medicine*, Vol. 131, 1999, pp. 531-534. (re-read)

Brian W. Roberts, et al., "Development and Validation of a Tool to Measure Patients Assessment of Clinical Compassion," *JAMA Open Network 2019*
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6537812/

Fall Break Oct. 13 and 14

TRILLING ON 'GENTLE CURIOITY" AT THE IMPASS

October 20
Topic 7: The Case of Ms. Forevermore – An introduction to Impasse, First-Order & Second-Order Change
Jeffrey Trilling (Session 1 of Circle of Change series)

Please view this TED Talk by Abraham Verghese MD

https://youtu.be/sxnlvwprf_c?si=l8MqAUx-eLUJWiHe

Educational Objectives

This session begins to address the relevance of the clinician-patient relationship within a meaning-centered model of illness, one in which *the experience and meanings of illness are at the center of clinical practice*. It introduces the importance of *context* (the circumstances in which a problem occurs), including the mistakes we make when context is ignored. Through stories , this section is an introduction to clinical impasse, inviting the reader to appraise the need for a contextual approach to primary care problem-solving. Additionally, it lays the groundwork for conceptualizing and applying principles of Systems Theory, such as "First" and "Second-Order Change", to clinical situations.

At the conclusion of this session, you will have the information necessary to:

1. Define and understand "impasse" within the medical setting, distinguishing it from "conflict."
2. Be able to articulate some of the consequences that conflict and impasse may have on patients, clinicians, and society.
3. Define" context" and how understanding the context of disease may be helpful in prevention, diagnosis & management.
4. Define, understand, and explain the application of First and Second-Order Change
5. Critique my management of Ms. Forevermore's case from a straight-linear, biomedical standpoint – had I done my job?
6. Critique my management of Ms. Forevermore's case from a biopsychosocial standpoint – had I done my job?
7. Define and explain the need for and application of "Gentle Curiosity" in good doctoring.
8. Explain the nature of a meaning-centered model of illness.
9. Explain the nature of the biomedical model of medicine.

Readings

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read the Preface & Chapter 1 for class)

2. George L. Engel, "The Clinical Application of the Biopsychosocial Model," *American J of Psychiatry*, Vol. 137 (5), 1980, pp. 535-544.
3. https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:308fbc06-fea0-4c96-bedf-1f9e9cce5b42

October 27
Topic 8: The Significance of the Patient's Story
Jeffrey Trilling (Session 2 of Circle of Change series)

Educational Objectives:

Session Two highlights the significance of uncovering the patient's story (and the luggage they carry) in helping us understand how impasse and conflict occur. It is within the patient's narrative that one may find explanations to otherwise inexplicable behaviors such as non-adherence to treatment plans, aggressive attitudes, and resistance to change. Through narrative, this session makes a case for appreciating the human element in the practice of medicine, stressing that the clinician-patient relationship is not unidirectional. Clinicians may also have "stories" carried beneath the surface, laden with perceptual memories of negative impact that manifest behaviors that foster or maintain impasse and conflict. As such, self-awareness is not simply ornamental or a soft, curricular cake-topping, but a key aspect of good doctoring to be emphasized and taught.

At the conclusion of this session, you will have the information necessary to:
1. Appreciate the involvement of both patient's & clinician's individual stories (and the "luggage they carry") in the formation of clinical impasse & conflict.
2. Understand the difference between natural science and applied science.
3. Self-reflect on what feelings arise within you when someone does not follow your advice.
4. Self-reflect on how far you should push when your advice is not followed.
5. Be acquainted with the clinician-patient relationship and its variations.
6. Appreciate, understand, and be able to articulate how differences between clinician style and patient expectations can be a source of clinical impasse.
7. Self-reflect on what your own natural tendencies are towards clinician style, and the response you might expect patients to have pro or con about you.
8. Self-reflect on the appropriateness of changing your "style" of practice to meet a patient's expectations.
9. Self-reflect on the expectations you hold as a patient when it comes to your own physicians, and ponder any instances where expectations were not met.
10. Appreciate, understand, and be able to articulate how clinician self-knowledge can contribute to good doctoring.

Readings:
1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read Chapter 2 for class)

November 3
Topic 9: Formulation of the Doctor-Patient Impasse
Jeffrey Trilling (Session 3 of Circle of Change series)

Educational Objectives

Session Two introduced personality differences in both clinician style and patient expectations that can often result in impasse. Session Three illustrates additional predisposing factors contributing to the genesis of impasse, while identifying and defining specific components of the patient's story such as explanatory models of illness and consequences of change that help us understand impasse formulation and other seemingly inexplicable negative behaviors.

At the conclusion of this session, you will have the information necessary to:

1. Understand and articulate how lack of self-awareness may lead to judgmental thinking.
2. Think about what "luggage" you carry with you that may trigger reactive behavior.
3. Appreciate and articulate the usefulness of obtaining knowledge about the patient, family, and physician perceptions of a patient's illness experience and attendant meanings.
4. Be able to explain how inability to categorize or diagnose symptoms contributes to the genesis of a clinician-patient impasse in the face of acute illness vs. chronic illness.
5. Define and discuss the components of the Explanatory Model of Illness
6. Understand and explain how differing illness attributions amongst members of a system can precipitate impasse.
7. Explain how a patient's hidden fears, previous experience with an illness, or previous encounters with the medical system can foster and maintain an impasse.
8. Define and discuss the Consequences of Change
9. Understand and explain how the Consequences of Change can foster and maintain patient impasse to change.
10. Define what is meant by dependent and independent variables.
11. Explain the clinical and research significance of the Perceptual Frame as a function of Explanatory Models and Consequences of Change
12. Articulate some of the medical consequences and social ramifications of clinician-patient impasse.

Readings:

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read Chapters 3 &4 for class)
2. Jeffrey Trilling, R. Jaber R., W. Mendelson, A. Pandya, "Attribution Models, Consequences of Change and Chronic Sleep Symptomatology: A Pilot Study," *Family Systems Medicine,* Vol. 12, 1994, pp. 61-64.

November 10

Topic 10: Problem-solving Clinical Impasse utilizing the Circle of Change
Jeffrey Trilling (Session 4 of Circle of Change series)

Educational Objectives

In Session Three, we introduced *explanatory models of illness* and the *consequences of change*, the two major elements of the patient's story or *illness experience* that underlie the patient's *perceptual frame*. We also noted that when the patient's and clinician's perceptual frames differ, an impasse may occur. Delineating and understanding the formulation of the clinician-patient impasse is the first step in problem-solving its resolution. Understanding a problem's formulation, while not solving it, often has its own positive ripple effect in that it may effect change, first, in the clinician. Once the patient's story has come to light and the fears or concerns emanating from past experiences are understood, clinician frustration is often replaced by feelings of empathy or even compassion. The opportunity for problem resolution is then increased by the resultant maintenance of the clinician-patient relationship.

In this session we explore what follows problem-delineation, introducing the components of the structured, six-step, problem-solving technique, **The Circle of Change.** We will examine this problem-solving model's utility in assessing, organizing, and implementing second-order change solutions in situations of impasse and conflict.

At the conclusion of this session, you will have the information necessary to appreciate and have a basic understanding of how to:

1. Assess patients' assumptions regarding symptoms and signs.
2. Assess developing patterns leading to impasse.
3. Uncover and change implicit rules of interaction.
4. Re-evaluate solutions attempted and their contributions to maintaining impasse.
5. Hypothesize when negative consequences of change are an obstacle to problem resolution.
6. Implement the six steps comprising the Circle and understand their reciprocal nature.
7. Generate hypotheses from information garnered from the Explanatory Model of Illness, Generated Patterns, and Consequences of Change
8. Implement the art of reframing and co-creating (together with the patient) a new and more inclusive Perceptual Frame

Readings:

1. Jeffrey S. Trilling, MD, *The Circle of Change: Beyond Technology's Reach*. Outskirts Press, 2023. (Read Chapters 5 &6 for class)

(Due today Nov 10: Reflection Essay # Two (20%) 5-page essay on the Doctor-Patient Relationship. This should be an essay reflecting upon your thoughts about such items as the clinician-patient relationship and its utility, impasse and

conflict within the relationship and its consequences, impasse formulation & resolution, the purpose of medicine, the importance of the patient's story, what's wrong with today's medical system, or any of the topics that may have interested you from the seminars we have had.)

November 17 Class Convened at Book & Mortar Mount Sinai
157 N Country Road
Trilling Post Interview
"May You Heal with Kindness"

"As we come into this world with our first breath, we are completely open. There is no judgment, no preformed sense of self or other. We are, in that moment, pure unlimited love. Before words, before rational thought, our visceral experience penetrates deeply. We sense the complete love of a parent holding us just after birth as it flows into our every fiber of being. And if there is fear, worry, or rejection, this too is felt in full measure."
~SG Post *Pure Unlimited Love: Science and the Seven Paths of Inner Peace*

Nov 24 Student Presentations
Student Presentations of Drafts of their Papers for Peer Feedback

Topics: As you wish, but focus on the nature of suffering in some identifiable constituency that you care about in some way, and how their suffering can be addressed through compassionate care.

Prepare 5-7 PowerPoint Slides
1. Big Question and Significance & Beneficiaries
2. Thesis and Approach
3. Outline with Clear Headings and Subheadings
4. Conclusions and New Questions Raised
5. Four References beyond Assigned Readings and Selection Process

These should be based on a developed draft. Present for about 15 minutes and take feedback from peers and faculty for about 10 minutes. Peer feedback is vital. This contributes **10% to your final grade, along with participation over the semester.**

December 1 More Student Presentations
Research Papers due December 8 (50% of final grade)

GRADING AND ATTENDANCE

Active participation in class & class presentation (10%)

Grading:

Reflection Essays (2 X 20 = 40%)
December 8: Final Research Paper Due (50%)
Class Participation & Presentation (10%)

Research Paper

Focus on the nature of suffering in some identifiable constituency that you care about in some special way, and how their suffering can be addressed through compassionate care.

Students write an **8-page (max)** final research paper (plus a page of references in alphabetical order per APA reference style) **due December 8. (50% of grade).** It is fine to focus on articles and books assigned in the course, but students should also use at least 7 carefully self-selected outside articles from journal sources (these can be on-line journals or hard-copy journals).
Use APA format in all papers.

Structure of Final Paper
Writing Your Final Paper
1. Introduction

A successful thesis-driven piece of scholarship will always begin **with a very clear big question replete with careful definition of terms. Then state your answer to the question in a clear thesis statement. This is best placed in the first paragraph of the paper.** You will need to work on this and revise as needed, but do not ever lose sight of your thesis statement. You do not want to veer off course, because the rest of the paper is an argument supporting your thesis. Every sentence in your paper ought to be connected to your thesis in some way. It might help introduce your audience to the nuances of the topic you are discussing so that they will understand how your thesis differs from claims made by others.

A good paper usually includes a second paragraph that discusses in brief why the question and thesis are important. Is the thesis important for solving a major problem? Is it innovative? Who might be impacted by your paper? What is your audience?

A third paragraph usually describes how you are planning to structure the paper, and some mention of key sources. It is a good idea to ask about every topic or point in your paper, "how will adding this information help my reader understand my thesis?"

The outline and headings (i.e., the organization of the paper) should be designed to move your thesis forward in a constructive way. Outline your thoughts before you begin to write.

2. Main Body

Be certain to use headings well. Headings are a roadmap for the reader. They are like signposts on the highway. They should not be complex or long, so choose a few effective words. Subheadings can sometimes also be quite helpful. **Headings** should be in bold, and *subheadings* should be in italics.

Develop your ideas and use transitions to link the major strands of your exposition. Remember, though your interlocutors may be able to follow certain moves you make because they are familiar with the literature the public will not. Make sure that an intelligent person who is not an expert in your topic could easily follow your argument. If you jump around without an indication of why, it will be extremely difficult for your reader to follow you.

When agreeing or disagreeing with an author don't merely state that you agree or disagree but make a case for why you do. Clearly identify the views of the author whom you will be discussing. Highlight important distinctions and concepts of which the author makes use. It is essential to use citations when doing this. This will indicate to your interlocutors precisely the point at which you disagree, while introducing the public to an important aspect of the conversation you are engaging in and of which they may not be aware.

If you plan to disagree with an author's position, then raise at least one objection that you would advance against the view as you understand it. While the public may be interested

in simply learning alternative views on the matter, your interlocutors will want to know why your position differs from those already accepted. If you plan to agree with the author's position, then be sure to explain why it is important that you agree. Others may have raised objections to the position with which you agree. Explain these objections and then explain how it is that the position you endorse overcomes them. Once again, proper citation is essential to this aspect of your paper.

When in doubt, break up long sentences and split up long paragraphs. Semi-colons are hard to use well, so avoid them unless you are sure of your grammar and avoid page-long paragraphs that beg to be broken up into two or three.

Be careful to select quoted phrases, sentences, or segments of several lines with scholarly precision. Only quote the material that makes your point best, and always reference it. There is no need to quote excessively, and you should help the reader understand what you want them to get from a block quote, rather than leave it dangling at the end of a paragraph. We will talk about quotes and style in class. Block quotes are okay if used wisely, but they should rarely, if ever, exceed five to ten lines.

So often, a student really gets clear on their thesis in the final and concluding paragraph of the paper. Therefore, it can be very useful to try placing that final paragraph up at the front of the paper as you go through drafts and incorporate it into the thesis section. Then write a second conclusion in a later draft.

Conclusions
Conclude with a summary of your paper. Also, be sure to point to another Big Question (or two) that your paper has not answered, but that seems now to be the next one you would want to see answer in your topic area (and why).

From Official Stony Brook University Policy:
Statements required to appear in all syllabi on the Stony Brook campus:

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If you have a physical, psychological, medical, or learning disability that may impact your course work, please contact the Student Accessibility Support Center, Stony Brook Union Suite 107, (631) 632-6748, or at sasc@stonybrook.edu. They will determine with you what accommodations are necessary and appropriate. All information and documentation is confidential.

Students who require assistance during emergency evacuation are encouraged to discuss their needs with their professors and the Student Accessibility Support Center. For procedures and information go to the following website: https://ehs.stonybrook.edu/programs/fire-safety/emergency-evacuation/evacuation-guide-disabilities and search Fire Safety and Evacuation and Disabilities.

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Each student must pursue his or her academic goals honestly and be personally accountable for all submitted work. Representing another person's work as your own is always wrong. Faculty is required to report any suspected instances of academic dishonesty to the Academic Judiciary. Faculty in the Health Sciences Center (School of Health Professions, Nursing, Social Welfare, Dental Medicine) and School of Medicine are required to follow their school-specific procedures. For more comprehensive information on academic integrity, including categories of academic dishonesty please refer to the academic judiciary website at http://www.stonybrook.edu/commcms/academic_integrity/index.html

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Stony Brook University expects students to respect the rights, privileges, and property of other people. Faculty are required to report to the Office of Student Conduct and Community Standards any disruptive behavior that interrupts their ability to teach, compromises the safety of the learning environment, or inhibits students' ability to learn. Faculty in the HSC Schools and the School of Medicine are required to follow their school-specific procedures. Further information about most academic matters can be found in the Undergraduate Bulletin, the Undergraduate Class Schedule, and the Faculty-Employee Handbook.