Dr. David Kuhl Engagement - "Relationship-Based Change"

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KEY RESOURCE AS RECOMMENDED BY DAVID:

www.reinventingorganizations.org

APPENDIX 1

Dr. David Kuhl

David is the Founder and Director of the Centre for Practitioner Renewal. He is a Professor in the Department of Family Practice, Faculty of Medicine at the University of British Columbia. Dr. Kuhl graduated with a Masters in Health Sciences (Community Health and Epidemiology) from the University of Toronto in 1981, and received his medical degree from McMaster University in 1985. In 1996, he became a Soros Faculty Scholar, Project on Death in America. This award allowed him to conduct a qualitative study, Exploring Spiritual and Psychological Issues at the End of Life. The study served as the basis for his doctoral dissertation (Interdisciplinary PhD, UBC 1999) as well as for 2 books, entitled *What Dying People Want: Practical Wisdom for the End-of-Life* and *Facing Death Embracing Life, Understanding What Dying People Want*. The research also served as the basis for David's work to understand the essence of iatrogenic suffering, thereby founding and developing the Centre for Practitioner Renewal.

Through his work at the Centre for Practitioner Renewal, David is working to combine his interests in medicine and psychology to develop a program of service, education and research that sustains health care providers in the work place, seeks to understand the effect of being in the presence of suffering and strives to work with health care providers in addressing features of resilience, communication and healthy relationships in the workplace.

Excerpts from Book Chapter by Dr. Kuhl et. al.

FIRST DO NO SELF-HARM

Understanding and Promoting Physician Stress Resilience

Edited by
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TREATMENT AND PREVENTION WORK

Center for Practitioner Renewal

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(1)

The Center for Practitioner Renewal (CPR) is dedicated to understanding the psychological, emotional, and spiritual needs of health care providers as they care for patients and residents. In defining our work, we ask three questions:

1. How do we sustain health care providers in the workplace?
2. What is the effect of being in the presence of suffering?
3. What would be reparative and healing or restore resilience for health care providers?

(2)

On the other hand, at the CPR we expected the constructs of vicarious trauma,[22] compassion fatigue/secondary traumatic stress, and moral distress to be particularly salient for health care providers. These constructs look at the impact of caring for the suffering of others, which delineates an area of stress for health care providers that is quite independent of the situational or systemic factors in the workplace, although clearly complicated by them.

We have learned in the past years that health care providers experience a considerable degree of estrangement—from self, others, and Other. Of the parent/child relationship Carl Jung stated that the greatest burden a child must bear is the unlived life of the parent. In health care it might be said that the greatest burden patients must bear are the unrecognized/unresolved psychological and spiritual issues of the health care provider. In that context it is important for health care providers to ask some difficult questions of themselves: What brought me to health care? What are some of the unresolved issues in my life that come with me from my family of origin, from my past relationships, and from my current life situation? Do I have a need to be liked? What type of relationships give me meaning? What did/do I expect of myself and others in the health care workplace?

(3)

There are many features that are a challenge to well-being in health care: economic restraint and restructuring, rapidly developing technologies, increased access to information (and misinformation), increased patient complexity and an aging population, shortage of practitioners and multigenerational issues, decreased numbers of beds, and a more critical and litigious social climate. Professional barriers to well-being include heavy physical and emotional demands coupled with consistent exposure to suffering; a culture of stoicism, self-sufficiency and silence; stigma about mental health issues and help seeking; perfectionism and compulsiveness that are sanctioned and reinforced by work pressures and societal expectations; reluctance to disclose personal or a peer's distress; lack of sufficient and easily accessible resources. Personal barriers to self-care include internalized stigma, feeling over burdened and lacking peer support; denial, minimization, or trivialization; prior experience of being "shamed and blamed"; unwillingness to become a patient and/or challenges in being treated as a patient; fear of loss of license and livelihood; fear of possible diagnosis; concerns about family/friends/colleagues not accepting or negatively judging them.

(4)

Group therapeutic interventions include process-oriented group therapy, team interventions, resolution of unfinished business between and among employees and medical staff, and a variety of psycho-educational workshops related to promoting well being and effective interpersonal skills. Group counseling models suggest that creating a climate maximally conducive to effective interpersonal interactions, support and learning requires paying attention to group members' basic needs. To that end, the groups we conduct are informed by two related approaches to group process. Schutz proposed that group members have three basic needs: the need for inclusion; the need for control;

and the need for intimacy/trust. Pursuant to definitions given by Schutz and for ease of remembering, we renamed the needs as SIT:

Safety clarity about the structure, ground rules, the facilitator's responsibilities, and degree of personal control/safety

Inclusion a sense of belonging, feeling accepted by other group members and the facilitator, and experiencing the group climate as supportive

Trust a deepening of mutual trust and sense of we-ness/community among group members