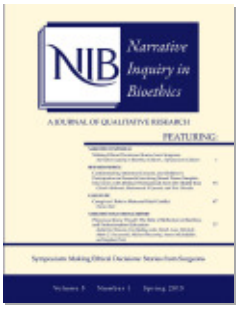
# Physician, Know Thyself: The Role of Reflection in Bioethics and Professionalism Education



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# Physician, Know Thyself: The Role of Reflection in Bioethics and Professionalism Education

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**Abstract.** Reflection in medical education is becoming more widespread. Drawing on our Jesuit Catholic heritage, the Loyola University Chicago Stritch School of Medicine incorporates reflection in its formal curriculum and co–curricular programs. The aim of this type of reflection is to help students in their formation as they learn to step back and analyze their experiences in medical education and their impact on the student. Although reflection is incorporated through all four years of our undergraduate medical curriculum, this essay will focus on three areas where bioethics faculty and medical educators have purposefully integrated reflection in the medical school, specifically within our bioethics education and professional development efforts: 1) in our three–year longitudinal clinical skills course Patient Centered Medicine (PCM), 2) in our co–curricular Bioethics and Professionalism Honors Program, and 3) in our newly created Physician's Vocation Program (PVP).

> I was most surprised by Dr. C's ability to move from one patient to the next with such ease, with each case being so different. There was one instance when we had just spoken to the radiologist on staff and he informed Dr. C that a particular patient had some sort of mass on a part of his brain. Immediately, Dr. C went to the patient's room and spoke to his wife about what they had found. He spoke very calmly and reassuringly, even though they were not quite sure what to make of the finding. It was obvious that although the patient's wife was distressed she appreciated the time that Dr. C took to speak with her and keep her up to date and really connect with her.
>
> I hope to one day be able to speak with patients and their loved ones in a similar way. I think I'll remember that scene for years to come and use it as motivation through medical school because it really does represent what I want to do. —M2 reflection

Reflection and reflective writing have been described as "a deliberate process to develop understanding and to inform future actions" (Chretien, Chheda, Torre, & Papp, 2012). Similar to the

professionalism movement, the reflection movement has become entrenched in health professional education. A search of the term reflective writing produced 353 results in PubMed. Although many of these articles focus on reflective writing in undergraduate medical education (Samir, 2014), some examine residents' reactions to reflective exercises (Shaugnessy & Duggan, 2013). Others discuss the role of reflection in the education of nursing students (Bowman & Addyman, 2014) or pharmacy students (Nuffer et al., 2013). Still others focus on faculty development and reflective writing (Boudreau, Liben, & Fuks, 2012). These articles typically fall into one of two categories: 1) an analysis of the utility of reflective writing for student formation, or 2) a description of curricular innovations that feature reflective writing as a skill. This paper fits in the latter category. Although reflective writing and reflective practice have become entrenched in many medical schools, we describe how we utilize reflection in bioethics and professionalism education rooted in our Jesuit Catholic heritage, to form self–awareness in our students to help them better engage with the challenges of their profession. We view reflection or reflective practice as a broader umbrella term that includes reflective writing as one subset activity (i.e. reflection can be internal or verbally shared in a dyad or group).

Wear, et al., in a 2012 *Academic Medicine* article, discuss and endorse the value of reflection but call for "greater clarity, among faculty and with students, about what reflection is—and what it is not" (Wear, Zarconi, Garden, & Jones, 2012, p. 608). To use reflection to foster professional identity development, the authors recommend that medical educators guide students to commit to the following actions:

- "Carve out time."
- "Commit to new viewpoints."
- "Include intuitive and emotionally guided reasoning as well as logic."
- "Emphasize changes in understanding and action." (Wear et al., 2012)

We endorse these recommendations and make the case for reflective practice in a unique educational setting. We are all medical educators at Loyola University Chicago Stritch School of Medicine ("Stritch"). Stritch is one of four Jesuit medical schools in the United States. These medical schools are sponsored by the Society of Jesus, a Catholic order of priests and brothers. Their founder, St. Ignatius of Loyola, emphasized the formation not only of priests and brothers, but those educated at Jesuit schools across the world since its founding in 1540.

Reflective practice is a prominent part of Jesuit Catholic education. As Chris Lowney, former Jesuit and author of *Heroic Leadership*, stated: "[O]ne achieves self–awareness not by reading how someone else achieved it but through focused reflection on one's *own* experience" (2003, p. 114). This self–awareness is the cardinal pillar for the Jesuits, as Lowney describes it. Knowing one's "strengths, weaknesses, [and] values" is where it all begins (2003, p. 113). This principle animates much of what we do with regard to reflective practice at Stritch. Moreover, our hope is that reflective practice deepens our students' commitments to becoming men and women for others. Beyond merely exhorting students to behave ethically, this process of reflection encourages our students to delve more deeply into their own aspirations, fears, anxieties and hopes as they progress through medical school. Although reflection is threaded through all four years of our formal undergraduate medical curriculum, this essay will focus on three areas where we as bioethics faculty and medical educators have purposefully integrated reflection in our medical school, specifically within our bioethics education and professional development efforts: 1) in our three–year longitudinal clinical skills course Patient Centered Medicine (PCM), 2) in our Bioethics and Professionalism Honors Program, and 3) in our newly created Physician's Vocation Program (PVP).

## Reflection in the Formal Curriculum

During the introductory lecture to PCM–1, the course director Aaron Michelfelder, MD, shares the following guidelines with our students:

> The four–year process of taking a disparate selection of college graduates and forming a cohesive professional identity frequently

> involves the abandonment of many preconceived notions about oneself, others and the medical profession in general. The purpose of the reflection process is not to generate a series of "touchy–feely" essays about your thoughts and emotions in given clinical situations. The goal of reflection in any context, is to encourage an approach of critical self–analysis as the experience and knowledge of medical school accumulates.[1]

One of the learning objectives in PCM–1 is to "[d]emonstrate reflection in personal and professional development." Eight first–year medical students are randomly assigned to a small group within PCM–1, and each small group is led by two faculty members, who also serve as the academic advisors for all four years for their PCM–1 small group students. Each PCM–1 small group has at least one faculty physician and one additional faculty member who can be another physician, or come from diverse backgrounds such as bioethics, chaplaincy, psychology, etc. PCM–1 small groups meet in person for 2–3 hours weekly during the academic year. This system creates close and trusting relationships between the faculty and their advisors. Additionally, the first year students in PCM–1 are paired with a physician preceptor, a third–year student mentor, and a chaplain mentor. Physician preceptors are all practicing physicians with direct patient contact who have volunteered for the preceptor program and are each randomly assigned a first year student. The physician preceptor program serves as a way for first year students to practice their burgeoning medical history and physical exam skills with real patients under the supervision and direction of their preceptor, and requires at least three contacts in the first year. As part of their own professional development, all Loyola third year medical students are assigned to mentor a first year student, and are randomly assigned within the same gender. The first year students are expected to see patients with the third year students as they progress through their 3rd year clerkships. Same–gender pairing occurs for the practical reasons of changing in pre–surgical locker rooms, etc.

As described above, PCM–1 is comprised of small groups of 8 students and two faculty members for small groups. Each small group is assigned to a pre– and post–chaplain mentor session, which the eight students attend together. In between these sessions, the students will individually spend 8 hours with a chaplain seeing patients in the hospital. Twice in year one, students are expected to log encounters with their physician preceptor and student mentor and submit a joint reflection paper about their experiences with all three programs. The joint reflection assignments are designed to help students not only consider the experiences they have, but also the impact of these experiences on their own development in a broader way, as students must step back and consider these programs in a holistic way. Students are also required to participate in a service learning project during their first year and then prepare a paper that is both descriptive and reflective in its content. These reflection papers are turned in to the students' PCM–1 faculty/advisors who will review the reflections in a general way in their PCM–1 small groups while facilitating group processing. In addition, the PCM–1 faculty/advisors will also personally read and provide written feedback to the students on every reflection. Due to the close relationship between students and advisors, the reflections as well as the feedback can be deeply personal.

Moving beyond mere description in the written reflections can be a challenge. We pose a number of trigger questions that aim to elicit deeper, more meaningful responses. For instance, we ask the students the following questions (Remen, 2014)[2]:

> 1. Whom did you encounter in this activity? What did you learn from this person or about this person?

*1 Michelfelder, A. "Guidelines for Reflection," in Patient Centered Medicine 1 Oral Presentation.*

*2 Questions 2,3,4 are from Rachel Remen's (2014) work. The others were created by our colleague Mark Kuczewski.*

2. What surprised you?
3. What touched you?
4. What inspired you?
5. What part of this encounter came easily to you? What not so easily?
6. What connection did you discover between your head and your heart during this encounter? Did what took place encourage your developing sense of personal belief, however you name the reality of belief and faith in your life?
7. What skills did you display in this encounter or similar activities?
8. What did you like about how you performed, behaved, or reacted in this situation?
9. Are the professional behaviors and clinical skills you displayed congruent with the type of physician you hope to become?
10. What professional skills do you think need further development?
11. Are you pleased with your professional development at this point? What additional experiences do you think would be helpful in developing the professional skills you wish to have?
12. Do you feel you are becoming the physician you wish to be? The one you set out to become when you first wanted to be a doctor?

These questions offer some opportunity for the students to interrogate and puzzle over their own experiences (Wear et al., 2012). It may even facilitate transformed action as well as further engagement with the broader community (Wear et al., 2012).

During the third year of medical school, all of the students are assigned back in their original PCM–1 small groups, with their same faculty/advisor leaders for PCM–3. PCM–3 small groups meet approximately every 6 weeks during the third year of medical school for a 1–hour reflection session. After the small group session, each PCM–3 session continues with 3–4 more hours of curricular content, usually with the class together in a large lecture hall. Offering our students a familiar small group setting with their original PCM–1 facilitators/advisors allows them to share their thoughts, to learn to listen to their colleagues graciously, and to feel the comfort of being listened to. We reinforce the importance of this course by recruiting physician leaders and having outstanding academic teachers help facilitate the small groups. The PCM–3 small group sessions work to create a space where students can reflect upon their development as physicians–in–training. Students are not graded for the content of these sessions, but attendance is required. In addition, all third year students write an ethics case paper reflecting on a specific case, examining its ethical issues, and discussing its impact on the student and others (Kuczewski et al., 2014).

Faculty are specifically trained to engage all learners in their small groups, which is facilitated by the trust and familiarity which has been built by the long–term relationships of the same eight students, with their same two faculty facilitators since the first day of medical school. We discuss with our students their personal experience with reflection and validate its importance as part of their personal and professional development. We equip each of our students with a small note book that can fit neatly in their lab coat and then provide them with four questions to reflect upon in their journal: 1) What surprised you? 2) What touched you? 3) What inspired you? 4) Do you feel you are becoming the physician you wish to be? When we meet face to face, the reflection process is oral as opposed to written (although if a student misses a small group meeting, they are required to write a written reflection of their recent clerkship experience).

Many of the same trigger questions utilized in PCM–1 are used in PCM–3; facilitators of small groups may directly ask students these questions or have them reflect generally about their clerkship experiences. Are they still excited about being a medical student? Is third year what they expected? What do they think and feel about each clinical rotation? How do they feel about their patients? What do they think of the residents/fellows/attendings/nurses they work with? The facilitators try not to dominate the discussions and instead allow the students to shape the discussion and build on one another's reflections. This overt reflection process seems to benefit our students in crafting greater meaning for themselves during their critical year of clinical training. By the end of the third year, students are expected to focus on an area of specialty training. This decision in itself may create anxiety; the reflection process hopefully defuses some of this anxiety and reminds students that they are part of a community and not alone in this process.

In the fourth–year, the Healer's Art course (originally designed by Dr. Rachel Remen) actually focuses on reflection as a key coping skill in preventing physician burn–out and promoting life–long career satisfaction (Remen, 2014).

As with any educational innovation, we have room for improvement. For instance, in earlier iterations of PCM–1, students were required to submit 14 reflection essays during their first year of medical school. Reflection fatigue ensued and students started to view reflection writing as merely another academic burden as opposed to a helpful exercise in introspection. Thus, we have reduced the number of essays required to a more manageable number. We have also asked first year students to rate the following statement regarding their experience in PCM–1: "I found the service project and reflection to be helpful for my personal and professional growth." For the years 2012–2014, the majority of students agreed with this statement. Nonetheless, a minority (roughly 20%) disagreed.

Compared to PCM–1, students in PCM–3 were even more receptive to reflection exercises, with substantial majorities of students agreeing with the following statements:

- The small group reflection session is likely to help me to address the stress of the clinical rotations. (79.8%)
- The small group reflection session is likely to be useful in helping me to integrate my professional ideals into my clinical experiences. (81.5%)
- The small group reflection session increases my appreciation of what it means to be a doctor. (83.2 %)

## Reflection in the Bioethics and Professionalism Honors Program

The Bioethics and Professionalism Honors Program (BPHP) is a co–curricular program that functions outside the medical school curriculum. BPHP began in 2003 and was built on two main premises. First, reflection would be used as the key tool to promote the student's professional self–development. Second, developing excellence in professionalism through reflection upon formative activities is a communal rather than competitive activity. We hoped that on this theoretical foundation we could build a program that would empower medical students to guide intentionally their personal and professional development in accord with their ideals and aspirations. And, we hoped that the program would ameliorate some of the "moral erosion" that was believed to occur during a student's medical education (Feudtner, Christakis, & Christakis, 1994).

We allow entry into the honors program simply by self–identification as a way to dispel any notion that this is an elite activity for a select few. Students enter in January of their first year and complete the program at the end of their third year. On average, 36% of all first year students (n=150) enter the program and 64% of those complete it. Upon admission to the program, students are assigned a bioethics faculty advisor (mainly PhDs) who meets with them and comments on their work via a secure online portfolio system 2–3 times per year. The curriculum of the BPHP contains both structured and self–directed elements. Students set annual goals articulating what they hope to achieve related to their bioethics and professionalism activities and development, skills and knowledge. These goals are self–identified and a key part of the self–directed learning approach of the program. At the end of each year, students reflect on these goals, activities and experiences, and their impact on the student, in the portfolio. Four seminars (one introductory and three topical) are required and provide an opportunity for group discussion and interaction. Finally, students complete a capstone proposal and project. They meet with their advisor to discuss the development of their capstone proposal and project. They are also encouraged to develop relationships with other mentors who have relevant experience for their project, i.e. a pediatrician or community based expert.

The capstone project, which can be empirical/clinical, pedagogical, service–oriented, or conceptual in nature, is the culmination of their efforts in the program and requires them to present their project orally to their peers and faculty and create an academic poster at the end of their third year. The amount of time invested varies by project and is largely self–determined by the students, though all are required to participate in at least 24 hours of activities annually

related to their goals for the BPHP. Select students receive a distinction for their capstone projects based on its content, approach to the problem/issue, implementation, organization, and innovation. Once completed, students submit a brief description of their capstone project, which is included in their dean's letter for residency applications. They are also recognized at graduation and completion of the program is noted on their transcript.

The structure of the program was purposely kept simple and focused on self–directed learning. As a Jesuit medical school committed to social justice, Stritch has long attracted students who were very active in terms of social justice, service work and engagement in student organizations that focused on the needs of underserved and marginalized persons. For instance, more than one–half of our medical students have traditionally participated in the school's international medical mission program. In designing the BPHP, we did not necessarily want the students to increase their activity level significantly, but wanted them cognitively and affectively to do more with their current activities. We wanted them to plan their activities, set explicit goals and use reflection to incorporate their learning into their being. We hoped that reflection could bring together their reactions and thinking.

> My first time volunteering at NLVS (New Life Volunteering Society) was practically a stereotype of the M1 in a clinical situation: awkward silences as I tried to gather my thoughts, questions blurted mostly at random, and an exercise of my best attempts not to seem as inexperienced as I was. I'm fairly sure the patients saw through me; what surprised and humbled me was how gracious they were. Despite my inexperience, I was treated with patience, even respect – and I left wanting to do better, and to be worthier of serving those who had come to me for help.
>
> Now, at the end of my first year, I am truthfully not much more capable of diagnosis or treatment. But at least in terms of taking a clinical history, presenting a case in an organized and logical manner, and even simply dealing with a patient on a professional basis, I think I've learned a lot. —M1 reflection

It is easy to see the proactive as well as the restorative aspect to reflection in this model. On the one hand, we hoped that reflection would enable students to maintain a course toward their ideals, i.e., toward becoming the physician they set out to be. But closely related to this ideal is the fact that students can inadvertently be stripped of their ideals by the toxicity of the clinical training environment. We intended the use of reflection to enable students to transition from being passive victims of such an environment to proactively guiding their development as physicians. Similarly, faculty advisors provide feedback on students' reflections thereby relating to their struggles and reinforcing their efforts to maintain a constructive outlook (Kuczewski et al., 2006).

Reflection has been a critical component of the BPHP from its inception, and builds on the Jesuit mission at Loyola. Annually, students set goals for their professional development and submit written reflections assessing their progress toward them. The goals focus on their self–directed activities within bioethics, professionalism, service, social justice and health policy.

> This past year I also continued my participation in the PULSE program. This year I not only acted as a mentor, but also helped organize the events for the students of the Proviso Math and Science Academy to provide with them to exposure to the field of medicine. . . . It was extremely rewarding to see how much the students both enjoyed the events and learned from them. However, what surprised me most was how much you can learn from teaching others. I usually do not think of myself as an educator, but I really enjoyed having the opportunity to teach eager minds something new about medicine. Having the ability to communicate information and explain concepts in this fashion will definitely be an important tool to use on rotations next year as well as during residency. Constantly in medicine I will be required to teach someone else what I already know, and having this skill set is vital to successfully becoming a knowledgeable and respected physician. –M2 reflection

The reflections contain both an assessment of what the student thinks and feels about their goals and experiences and the impact on personal and professional development. One of the hopes is that students develop the habit of stepping back from a situation and being able to reflect on it critically,

i.e. evaluate what is happening for him/her and others, and the impact of those experiences, both positively and negatively.

> This year has been a challenge in maintaining the service goals I have always had in the back of my mind. In prior years, I had always been able to incorporate consistent service projects into my academic life but this year was the first time in many years in which I was not involved in an extracurricular activity that allowed me to serve in my community on a weekly basis. I think because of this, there was a time during this third year in which I lost my own focus in medicine. When I first decided on pursuing a medical career, I thought it was perfect for me because I can still have science and have the most resources to care for those that are underserved. However, I realized during third year my own limitations and struggled to accept them. . . . I struggled to manage all my desires this year, and I'm slowly regaining my perspective as now I need to reflect again on why I chose medicine over teaching and graduate school. As I decide between Family Medicine and Medicine–Pediatrics, I feel I face a decision between primary care and specialization, between service and my love of pathophysiology and science, and between working against injustices, ensuring medical equitability, and working internationally in resource scarce areas and having time for a family and outside projects. . . . I felt this year was a struggle to decide whether the grand dreams I have had since I was a child to change the world in my own way were realistic in face of the limitations I began to fully realize. Now that the year is over, and I have time to sit and reflect, I realize I'm still hopeful and in many ways I do not want to put aside those childish dreams. I still have hope that medical training is as much learning about various medical conditions as it is learning how to manage clinical demands, my personal life, my health, and my desires to be active in my community. –M3 reflection

Over the years, the BPHP has evolved in response to student feedback. For instance, the initial development of the program required increased structure, largely requested by students, which resulted in the introduction of formal seminars, advisor meetings, and the capstone proposal requirements. Future improvements will include more detailed reflection prompts for each year in the program (M1, M2, M3) and investigating additional structured components and requirements. Additional ways of capturing the impact of co–curricular programs on medical students are needed, such as a national survey as well as specific institutional data.

## Reflection in the Physician's Vocation Program (PVP)

Unique to Stritch, the Physician's Vocation Program (PVP) began in 2012 to create a forum in which medical students could explore the intersection of their faith and their professional development as physicians through a program of coursework, prayer, and reflection. While Stritch's medical school campus ministry department offers retreat programs and service immersion experiences with reflective components, the PVP sought to offer a sustained experience of academic study tied to prayer and reflection that runs through the medical curriculum in its entirety. The program uses the spiritual tradition of the Jesuits and their founder, Saint Ignatius of Loyola, as its seedbed and guideposts.

Ignatian Spirituality is rooted in Ignatius's own writings on prayer entitled *The Spiritual Exercises*. This short book is a manual of prayer and guided reflection developed from Ignatius's own life experiences. His foundational spiritual insight was that God was present to him through the routine elements of his daily life. This observation led him to understand God to be found "in all things." What is needed for a healthy spiritual life, then, is a habit of reflection that attends to God's presence or absence in the events of a day. The root of Ignatian reflection is first a process of personal introspection that moves to a decision about how one ought to love and to serve God in all things (Gaans, 1991).[3] Therefore, reflection in this program focuses on

*3 This section is the final meditation in the Exercises the "Contemplation to Attain Love." For a more extensive commentary and the important link that this contemplations, a form of reflection, has on the importance of service see David L. Fleming, S.J. (2007).*

experience—in this case, the experiences of medical students—and how these experiences form and inform the way in which they will practice medicine. For the students who self–select into the program, reflection occurs both in the context of prayer and coursework. Students are encouraged to develop a habit of daily, reflective prayer in the form Ignatius recommends called the *examen*. This review of one's day is intended as a time to reflect on one's actions and experiences in order that she might be more aware of the moments in which God's presence was recognized, or not, in the activities of a person's life. Its hallmark is a reflective stance of personal gratitude for all that has come into one's life in the course of a day—an attitude which can change one's outlook and interaction with others.

As healthcare becomes more driven by metrics, efficiency, throughput and outcomes, the affective, human dimension of illness for both the caregiver and patient finds less room for considering the personal dimension of the clinician–patient relationship. The diminishment of the "personal" aspect of medicine, in turn, contributes to burnout and cynicism in the healthcare professions (something that all three of these programs strive to counteract). The habit of reflecting upon the events, conversations, and experiences of a day against a transcendent horizon and informed by gratitude, we suggest and hope, offer physicians an opportunity to maintain a humanistic and compassionate mindset in their practice.

This habit of prayer is augmented by coursework that seeks to unearth the spiritual roots of medicine's practice: the experience of illness, the possibility of healing and hope, what it means to be embodied and destined to die, and how one reconciles the claim of a loving God with a world that suffers. The coursework, then, provides the framework for some of the more personal reflection that takes place in class. Each week students read 30–50 pages and write an approximately 300 word synthesis paper that highlights a key take away point from the reading and a personal or professional application of that issue. The purpose of the synthesis paper is not a mere summary of the material that they read, but rather an understanding that moves towards an integration of who they are and what they are doing as medical students and people of faith. The integrative dimension of these reflective writings aims to allow students to see themselves as actors in their medical education process and those who shape the culture of medicine (Freire, 2005). Thus, the writing assignments offer an avenue for expressing this active dimension of their education that led them to medical school, but often fades throughout its duration. The cognitive dissonance that can develop between students and their patients, makes it difficult to maintain a spirit of compassion and empathy as they inevitably encounter patients in the midst of suffering.

During the second year of the course, students read theologian John Swinton's *Raging with Compassion: Pastoral Responses to the Problem of Evil* (2007). The book begins with a tragic story of the sudden death of a friend's daughter. Swinton describes his utter loss for words and inability to do "anything." This is not an uncommon feeling for families who experience the death of a loved one. While death in and of itself is not an evil, the feelings of isolation, depression, and failure can be. Upon reading this story, a student took up Swinton's suggestion to not focus on why this awful event occurred, and instead argued:

> [W]e should be focusing on the problem of what evil does in reality for those who are suffering . . . [and] thereby empower the voice of the sufferer (and thus the voice of Christ) to be heard. . . . By empowering the voice of the victim, a community can provide an opportunity for the victim to share and draw others into fellowship . . . It is only in reframing the question away from the 'why' (why does evil exist?) and towards the 'who' or 'what' (who is suffering? what can we do to help? what comes next in this story?) that we can have an appropriate, effective response to suffering and evil in our world. —M2 reflection

This student points to a particular problem in medicine when patients ask, "Why me?" This can offer particular challenges in caring for patients at the end of life. Physicians are trained to be problem–solvers. Death, therefore, presents a unique and ultimately unsolvable problem. Rather than

being rendered impotent in the face of the "why," her response asks how one ought to be present, perhaps in some small way, to "what comes next in the [patient's] story."

In the final writing assignment of the semester, students are given a very broad assignment: Describe in essay form a reading from the semester that altered the way you think about your vocation as a physician. In our final class session in which these papers were shared, one student spoke of the importance of having a space to share and reflect on the struggles of becoming a physician. Another shared a paragraph from her essay in which she reflected upon the role of doctors in fulfilling the expectations of their patients:

> This course has been instrumental in affirming my belief that love still has a place in the patient–physician relationship, even with the barriers that modern medicine so readily presents. Modern medicine forces both patient and physician to live simultaneously in a "world of love and a world of technological efficiency" (Shuman & Volck, 2006, p. 132). With my clinical years fast approaching, I hope to be able to both recognize the undeniable value of newly developed diagnostic and therapeutic technology, but to never forget the even more critical value of the comforting human touch that accompanies even a brief physical exam; an act that can express solidarity, trust, and acknowledge a patient's fears. —M2 reflection

Our student here expresses how she envisions the patient–physician relationship in a way that resonates with her own experience as a member of the Christian faith. But we would humbly suggest that these words would be welcomed by many patients, religious or not, because they speak to something deep in each of us, the desire to be not only competently treated but also cared for and comforted in a time of anxiety and need. The Physician's Vocation Program seeks to form physicians who will bring to the practice of medicine not only technical proficiencies and business efficiencies, but also human wisdom and compassion to the practice of medicine and the patients for whom they care. Our program does so through the use of a habit of reflection rooted in a spiritual tradition some five hundred years old—but ever new to those who employ it.

This program offers students of faith an opportunity to integrate their commitments of faith with their professional formation as physicians through a series of invitations to reflectively integrate these two dimensions of their lives. This program is designed for a subset of a typical medical school student population. In a class of 150, we anticipate no more than 20 students being seriously interested in such a program thus limiting the number of students who have the potential to be positively affected by the group's dynamic and dedicated time for reflection. The cost of the program's reach, in our thinking, has been offset by the opportunity to deeply engage a specific religious and spiritual tradition as a means for thinking about professional formation. While the students' reflection is not formally evaluated, students are given written feedback that suggests ideas for further thought and possibilities of future practical application. As we complete the second year of the program, we continually look for ways to maximize the little time that these students have by selecting targeted readings and seeking out experiences that can lead to deeper engagement in the praxis of medicine.

## Conclusion

As reflected in this essay, the bioethics faculty and medical educators at Loyola University Chicago Stritch School of Medicine have purposefully integrated the habit of reflection in three key areas: in our formal curriculum, in our Bioethics and Professionalism Honors Program, and in our unique Physician's Vocation Program. One of our aims is to integrate reflection in a way that makes it second nature for our students in their formation as future physicians. Reflection can be done formally through writing or informally when a student in training takes just a few minutes each day to take stock of their own inner life and how they are reacting to the world around them individually or in conversation with others.

Our hope is that the Ignatian practice of reflection has a number of tangible benefits for our students—it

creates greater self–awareness, enhances emotional intelligence, deepens one's commitment to social justice and possibly even prevents burn out. The ability to reflect is crucial for future physicians as they enter a fast paced and changing world in healthcare. The practice of reflection hopefully helps students develop their ethical and professional acumen and sensitivity. When faced with challenging ethical and professional decisions, our goal is that students have a strong foundation in reflection, which will enable them to evaluate and learn from their practice and experiences. The hope is that our medical students develop this skill, recognize the insights it provides about oneself and others, and that it helps them become the physicians they strive to be. Finally, we believe that the practice of reflection in a Jesuit medical school setting such as Stritch will further humanize an educational experience that can be at times emotionally and intellectually overwhelming and even toxic but ultimately rewarding and even transformative.

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