

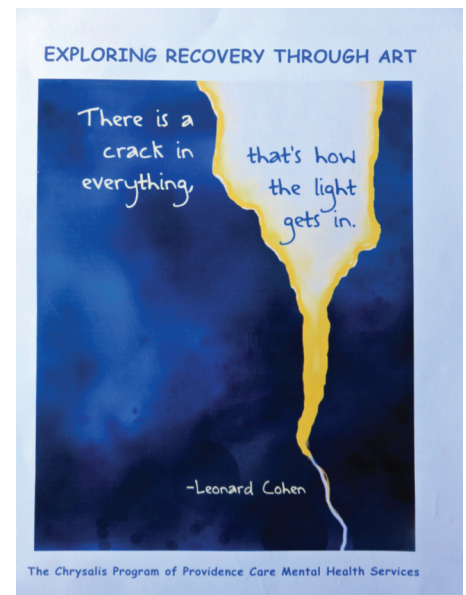
“There is a crack in everything/ That’s how the light gets in”:

A socially engaged art project created
by participants of the Chrysalis Program

BY MARGO RIVERA AND PIERRE LEICHNER

Art is necessary to the health and well-being of everyone, and core to the development of diverse communities and their integration into a vital society.¹ There is increasing concern in the past couple of decades that too much of contemporary art has distanced itself from the public by sequestering itself into museums and galleries. The Canada Council for the Arts, the main public arts funding organization in Canada, is now fostering active community participation in art-making, and engaging a wider range of citizens than those who identify as professional artists in the artistic life of society, notably through “attendance, curation, active participation, co-creation, learning, cultural mediation and creative self expression”.²

Concerns about the limitations of mainstream arts culture has led to socially engaged art, a medium that focuses on collaboration within communities and institutions in the creation of participatory art. Professional artists working in this genre co-create their work with a specific social group or audience through dialogue, provocation, collaboration, and immersive experiences, with the goal of making “art that matters”.³ The artists have an expanded repertoire of skills, including a familiarity with creative and learning processes, an awareness of social issues, and a capacity to integrate these skills into the production of a wide range of artwork, including visual arts, theatre, music, and the written and spoken word.⁴ A growing number of artists seek to incorporate socially engaged art practices into the expression of their creativity, questioning the idea that a fulfilling life and career should be based upon economics and collectability as their sole rubrics.⁵



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Editor's Note

Our cover essay by Margo Rivera and Pierre Leichner describes an innovative art project they pioneered here in Kingston as part of the Personality Disorders Service in the Department of Psychiatry. Some of the art, which was publically exhibited in a storefront gallery in downtown Kingston in November 2015, is also reproduced within our pages.

Our second essay is a personal reflection on postgraduate medical education and both the possibilities and challenges that are upon those of us who teach and mentor resident doctors. Competency-based Medical Education (CBME) will be a reality across Canada in the next few years, and at Queen's in less than one. But do we understand it?

Our back page goes to an original poem by psychologist Irwin Altrows—a musing on something we do daily and often pride ourselves on: diagnosing.

We hope you enjoy the prose and, as always, welcome your comments.

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The increasing interest in socially engaged art and the more frequent use of art in mental health care settings might have shared cultural origins. At the same time that there has been a movement to develop, acknowledge, and support community art-making, widespread reform in mental health systems has shifted the focus of many psychiatric services to include the service user as an active participant in the treatments offered to them. Within this context, frequently called the “recovery movement,” many mental health services have integrated a range of art-making programs into their more traditional therapeutic interventions.

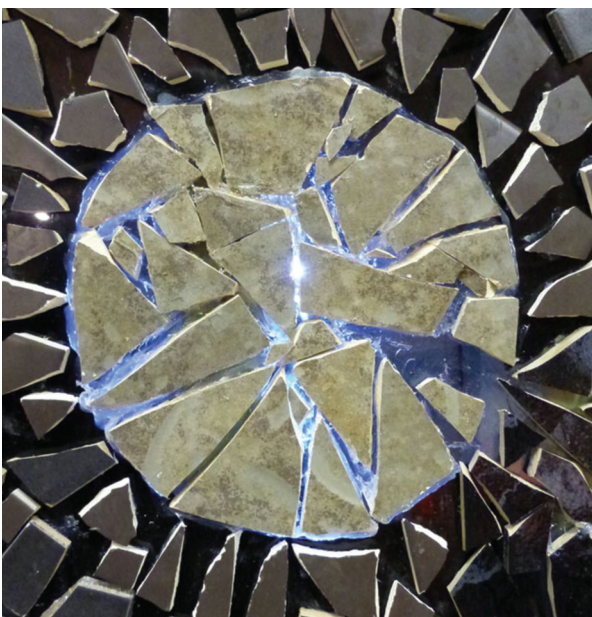
The benefits of art practice in health care have been thoroughly reviewed by Sapuna and Pamer.⁶ These include a more accepting and respectful treatment environment, the improvement of the self-esteem and communication skills of the participants, and, in some cases, an engagement with the community outside the mental health system such that stigma is challenged and social isolation is decreased. In general, research has demonstrated that engaging in the arts has led to a greater capacity for self-reflection, self-esteem, and the capacity to develop and maintain healthy interpersonal relationships.⁷ In the last decade, the arts have been integrated into many mental health settings around the world because of increasing awareness of their significant benefits.⁸ When socially engaged art is integrated into mental health programming, the participants and the artist decide consensually on both the structure and the content of the project. The more active and equal the participation, the more likely the benefit to the participants.⁹

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The Chrysalis Program—part of the Personality Disorders Service, Providence Care-Mental Health Services—recently offered its participants the opportunity to participate in a community art project. This enterprise arose from the communication between the program's current clinical leader and co-author of this article (MR) and a Vancouver artist who was once the co-director of the Personality Disorders Service. The second author (PL) has had a range of experiences in socially engaged art projects since retiring from his psychiatric practice and becoming a full-time interdisciplinary artist.¹⁰ Two of his projects, *Window to discover* and *maladjusted*, are particularly relevant to the evolution of the art project created within the context of the Chrysalis Program. *Window to discover* explores social isolation in the community experienced by people in an outpatient psychiatric program,¹¹ and *maladjusted* is a participatory theater play that investigates the mechanization of mental health services.¹²

The Chrysalis Art Project is set in an outpatient program of a psychiatric hospital, and the artists struggle with a wide range of debilitating psychological challenges. That members of the program agree to be active and responsible participants in their recovery has been one of the founding principles of the Chrysalis Program since it was established in May 1995 by the co-authors. The Chrysalis Program was created by the Personality Disorders Service staff of Kingston Psychiatric Hospital in response to the expressed need from the medical, mental health, and social service communities for a specialized service that would offer intensive and effective treatment to individuals suffering from borderline and other personality disorders who were using crisis lines, general and specialized hospital beds, emergency room services, and family doctors' support, with great frequency and rarely much benefit. It also evolved out the Personality Disorders Service staff's frustration as they tried to help our clients make deep and lasting changes with only two treatment options to offer them—weekly outpatient sessions or psychiatric hospitalization.¹³

The program is staffed by a small multi-disciplinary team, and participants register for a fifteen-week semester, which currently includes an intensive regimen of group psychotherapy two days a week initially and then sometimes moving into a one-day program to consolidate gains and growth before





graduation. Many group participants engage in several semesters before they are ready to graduate. Psychodynamic Psychotherapy and Dialectical Behaviour Therapy are evidence-based therapies that are incorporated into this unique program that has been successful in creating a milieu that makes it possible for suffering people to create stable and satisfying lives.^{14,15,16,17} Expressive art therapies have always been one of the ways self-expression has been encouraged since the program's inception.

In the Fall of 2014, the co-authors began to correspond about the possibility of introducing a different type of art project into the Chrysalis Program to enhance the current focus on art therapy. This art-making project is not art therapy; it is quite different from participation in making art as a direct aspect of one's ongoing therapeutic process. Rather, the focus is on the participants as artists and the opportunity to be mentored by a more experienced artist. The participants are in charge of developing the theme of the project and deciding on how the art will be made and exhibited. Members of the Chrysalis Program were approached by the co-author (MR) regarding any interest they might have in volunteering to engage in this socially engaged art project in the Fall of 2015, and twelve people agreed to participate. A review of the evolution of the project and its qualitative evaluation follows.

Prior to the onset of the project, funds for materials were obtained by the co-author (MR) from the Queen's University Department of Psychiatry Research fund. The first phase of the project was primarily cognitive. It consisted of an introduction to the work done by the artist/mentor (PL) and a discussion about a range of socially engaged art. At the following meeting, a lively conversation about potential themes took place. The theme—Light and Darkness—was generated by a quotation from a Leonard Cohen song: "There is a crack in everything/That's how the light gets in". Further discussion took place regarding a venue for exhibiting the artwork to the community, and the participants discussed whether they were willing to be identified in the exhibit and whether or not they wished to sell their work. The issues of the potential benefits of the project to the artists and its possible emotional and social costs were also raised

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and considered seriously by the participants. All the participants agreed to exhibit their work and to offer feedback about their involvement in the project, and the appropriate consent forms were signed.

Keeping in mind the limitations of space and the time of one month, the artist/mentor then suggested working with a single modality—broken tiles to make mosaic images on Plexiglas—to manifest the theme of letting the light through. The participants were enthusiastic about learning to work in a modality that was new to them, and each artist agreed to produce one individual piece on pre-cut Plexiglas. Two group projects were also proposed, one larger communal mosaic and a light and shadow installation inspired by the works of Tim Noble and Sue Webster.¹⁸ The artists were also encouraged to bring in previously created works of art that were relevant to the theme, and they contributed sculptures, drawings, paintings, and photographs. Some of these works were framed, and all were exhibited. The work space (a large multipurpose room in the clinical setting) was transformed into a studio and made available on a drop-in basis for the duration of the project. The artist/mentor was present most weekdays and curated the final installation in a large vacant storefront on Kingston's main street.

A successful opening was held on November 20, 2015, and a wide range of interested and appreciative members of the public attended the opening and viewed the artwork during the two following weekends that the work was exhibited. A local television news reporter interviewed several of the artists about their work, as well as the clinical leader of the Chrysalis Program about the utility of both the art-making and the exhibiting and communicating about the process to the public. A total of 28 art pieces including nine individual mosaics, a large group mosaic, a shadow installation created by the group, and 18 individual drawings, photographs, sculptures, and multimedia pieces were exhibited, and several works were sold.¹⁹

The artists who participated in this project were asked to respond to several questions regarding their particular experiences of the art-making and exhibiting, both at the beginning of the project and after it was completed. The major themes of their initial responses were a combination of excitement about

making a new kind of art while working collaboratively with others who were engaged in an active recovery process, and an initial fear of the challenges of making art with others and concerns about exhibiting. The following concerns were expressed by ten out of twelve of the participants in their initial interviews:

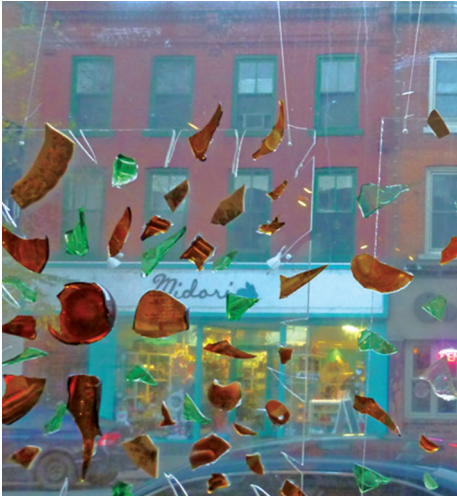
- Would their art be judged negatively by their peers?
- Would they be stigmatized as people with mental health problems rather than seen and respected as artists?
- Would their artwork be stigmatized by the unknown members of the public who visited the exhibit for being part of a program designed for individuals struggling with mental health problems?

The responses offered in interviews and written comments after the exhibit was dismantled expressed a high degree of satisfaction. One participant dropped out of the project after the first group meeting, and the comments from the eleven remaining participants reflected their personal experiences of the art project:

- A general sense of pride and satisfaction with having had the courage to engage in a project that was new to their experience
- Gratitude for the warm and supportive connections made with the other artists who participated in the project
- An increased level of confidence about their capacity to make art that a wide range of people appreciated
- Personal satisfaction with participating in exhibiting the art in a context in which almost everyone who viewed the work was more interested and focused on the artwork itself than the mental health program in which the artwork was created

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One participant noted, “Everyone who came to the exhibit knew that the works were made as part of a mental health treatment program—it said so in the introductory poster inside the door—so it wasn’t like it was a secret. But what they were struck by and wanted to talk about was the art. This was extremely encouraging.” Another participant felt proud that he had been able to show his works to the television reporter and speak about their meaning and the process of creating them in a way that was confident and self-respecting. Several participants taped the news program that included both the interviews and all of the artwork so that they could show it to friends and family who were not able to attend the exhibit.

The following reflection is part of a written reflection that one participant submitted after the completion of the project:

I found myself completely immersed in the art! Day after day I went home, cleared whatever I could from my schedule and did art! I reflected on things in a way that was new to me. I drew and I planned and I went for long walks only to hurry home again as some idea began to take form. I lay awake at night thinking—not taken over by out-of-control thoughts, but really thinking about the theme of Recovery through Art, of MY recovery, of how far I have come and it suddenly seemed like a very long way! And I let myself imagine what it would be like to allow my vulnerability to be exposed for others to see. I cringed with the thought of others touching that which is so personal to me, and I wrestled with the shame I feel, aware of the very real stigma attached to those deeply personal struggles. Slowly I came to realize that I am no longer terrified by any of it.

As the days went by, I found myself becoming more comfortable in my own skin, more secure in bringing all of myself to the table, as it were. And in being able to really experience all of myself fully in this multi-dimensional way, somehow shifting and unlocking yet one more important piece in the complicated puzzle that is my mind.

This “kind of different art project” into which I was invited seems to have helped bring me to a new place...a place of understanding that only by accepting and experiencing all of who I am can I ever really see and experience everyone clearly for who they are. Maybe this is a rather simple concept, but it is like explaining Arctic nights to someone from the Caribbean; it can never truly be understood until experienced.

Pierre Leichner, MD, was formerly co-director of the Personality Disorders Service at Queen's University, and is now a full-time interdisciplinary artist based in Vancouver, BC. His website is www.leichner.ca

Margo Rivera, PhD, CPsych, is Associate Professor and the Director of Psychotherapy in the Department of Psychiatry, Queen's University, and Clinical Leader of the Personality Disorders Service at Providence Care-Mental Health Services. She has published two books, *More Alike Than Different: Treating Severely Dissociative Trauma Survivors* (University of Toronto Press, 1996) and *Fragment by Fragment: Feminist Perspectives on Memory and Child Sexual Abuse* (Gynergy Books, 1999).

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Lost in Lingo: Medical Education made Inexplicable

ERIC PROST

I am not a fan of the U.S. tax system. I was once snarled in its net. I actually don't mind paying taxes, even high ones, as long as the reasoning is just, the process transparent, and the collected treasure used for the common good. However, if the reasoning is opaque, the process labyrinthine, and the treasure squandered, I feel, perhaps, a little like Shostakovich, the Soviet composer who spent his life hounded by power, his creativity in check and his artistic output in jeopardy.

Whether postgraduate medical training is an artistic pursuit or a collection of technical skills is debatable. It is likely a fusion of the two—and more. But one thing is clear: the assessment of postgraduate trainees and the structure of their training and monitoring of their progress should have nothing in common with either the Politburo or the Internal Revenue Service. The education of medical residents—from organization of clinical rotations to evaluation—must be both orderly and understandable, even to the educated layperson. I cannot ask that it not be arduous or sometimes painful, both to the student and the supervisor, for learning can be hard, correction stinging, and evaluation frequent. But it cannot appear intelligible only to the expert, must not frustrate the users, and, most of all, must not stifle, leaving all involved on edge, confused, and focused on meaningless objectives rather than thoughtful and creative goals.

As we attempt to reorganize postgraduate medical education in the 21st century, including here at Queen's University, let's remember the US tax code: it is more than 74,000 pages and getting longer. Well-meaning bureaucrats add to it at an average rate of more than one change daily. Each individual change likely makes some sense, but the whole is obscene. It is 10 times longer than the complete works of Tolstoy (illustrated, no less), but which volume has had a more laudable effect on human understanding? Unlike the tax code, medical education and the documents that underpin it must have limpid reasoning and straightforward processes, and the treasure collected—the evaluations, the data, the results of examinations—must be used for the common good. The huge effort involved in assessment must not be squandered. The residents, the supervising physicians, and the patients will become frustrated and dispirited if our new code does not result in physicians who can think, communicate, and perform better.

Let's use another example, leaving communism and taxation for the moment. And the more examples the better, since I am trying to show that medical education is not, and cannot, be divorced from life, the daily experience of non-doctors and non-academics. *What* physicians learn includes memorizing chemical combinations, navigating the inside of brain arteries, and understanding the minutiae of someone's mental state, but *how* physicians learn should be comprehensible to all.

I'm hunched in an examination building surrounded by little desks at which other graduate students with similarly bad posture scribble essays onto foolscap sheets, occasionally glancing up or extending their writing arms and shaking them violently at the wrists. We're answering questions like, "Explain the Franks' consolidation of power with relation to the Holy Roman Emperor". In this context, the Franks are not the neighbours who own the next cottage. They are a political dynasty in 9th-century France.

As you read this, it is likely you know next-to-nothing about early mediaeval Europe. That's the *what*. (And you're not expected to unless you're on track to become an academic historian.) But it is likely that you can understand *how* I was being evaluated: I was expected to know enough about the early Middle Ages that I could glance at the examination questions and then begin to write in clear prose, with well-developed paragraphs, a sensible argument about religious and secular power in the year 800. This may be a terrible way to test graduate students in history. It might scare them (true); it might bore them (surprisingly, false); it might shame them (not really). The evaluation process itself, however, is understandable to the non-historian: it doesn't include a lot of acronyms known only to the initiated, it doesn't include multiple confusing steps, and, as long as you don't have to mark the resultant scrawl, it doesn't leave you dispirited.

When medical supervisors assess residents, the evaluation tools (and thus the evaluations themselves) tend to focus on two areas—traditional medical knowledge and interpersonal skills.¹ This tendency is criticized, as other areas like "professionalism," "advocacy," and "scholarship" may be ignored but are certainly important roles of all 21st-century physicians. How do we assess these many areas of competence needed to perform as a modern doctor while keeping our heads and without descending from ordinary English into technical jargon?²

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We could do worse than focus on these first two domains, medical knowledge and interpersonal skills. After all, having a doctor who is brimming with up-to-date medical knowledge and who can then communicate it clearly while exuding kindness is what most patients want when they have an increasing PSA, a decreasing mood, or a stable fracture. It's a little like the Ten Commandments. When asked which was the greatest commandment in the Law, Jesus replied, "Love God." Then he added that the second was similar, "Love your neighbour," and that everything else hung on these two. All the other commandments and the rest of the whole Law were subsumed in these two short sentences. So if your doctor's knowledge is up-to-date, she can be called a scholar; if your doctor talks to you clearly and respectfully, he is a professional. It doesn't mean that measuring professionalism more specifically isn't valuable, any more than enforcing "Thou shalt not kill" isn't valuable. It's more specific than "Love your neighbour," but it's really much the same thing.

As we stray farther from these two training basics of "Know your medicine" and "Talk to the patient kindly and so he gets your meaning," we encounter opposition because we encounter complexity. As soon as the ancient Israelite parsed "Love your neighbour" into "Thou shalt not kill," questions of the meaning of justice, punishment, forgiveness, reparations, and culpability arose. When doctors who supervise resident trainees are asked to evaluate them on professionalism and leadership, for example, more definitions are necessary, more evaluation tools needed, and the code begins to grow.

Opposition to the expanding code arises partly because doctors can be conservative. This doesn't mean that they are against gun control or for balanced budgets, but simply that they like to maintain the status quo; they are conservative in the sense that they may like to preserve patterns and institutions from the past and only allow change that is incremental or gradual, seldom initiating an about-face and always attempting to save the baby, and even most of the bathwater if it isn't clearly contaminated with E. Coli. Perhaps this comes from decades of observing the body heal itself or from multiple occasions when it disintegrates and dies despite our best efforts. It is a respect for the natural order and what may or may not be possible. Since one version of the Hippocratic Oath begins, "First, do no harm," then doctors are inclined not to act for the sake of acting and not to change for its own sake. Equilibrium is important in medicine: salt and water must be in balance; blood that is too thick clots in the vessels, but if too thin escapes the vessels entirely; moods that are consistently low are called depression, but if too high, mania. The body strives for homeostasis. So often do its trained healers.

In addition to a tendency toward preserving the past and the status quo, doctors are practical. If they spend much time doing the clinical work of actually

seeing patients, physicians are used to making consequential decisions based on limited data, and then moving on to the next complaint. The idea of “getting things done” is central to clinical medicine. Reflection happens, but decisions also have to be made. In medicine, therefore, we end up with a background of venerating the status quo and how things are currently done, along with a foreground pattern of quick decision-making, taking action, and ticking off tasks. Year-to-year we like changelessness, but moment-to-moment we make dozens of decisions that effect great change (at least for the patient). Any rumour that change at the wider system level is in the offing—whether it be a new medical record system, extra hand-washing protocols, or new ways to evaluate trainees—is met with resistance, at least partly because it might upset the smooth, familiar, and fast-paced flow of clinical decision-making that has little slack built in as it is.

If, therefore, we are to change postgraduate medical education, we must have a sound product that justifies altering decades of training patterns, and we must then present the product in ways that make doctors buy it.

Is Competency-based Medical Education (CBME) that product?

The obvious joke (which I’ve heard many times) is that a structure for training doctors that isn’t based on competence wouldn’t be desirable. So what have we been doing all these years as senior clinicians, I’m asked, as we observe trainees, point out their mistakes, correct their deadly errors, and inspire them even when exhausted, if not engendering competence? Of course we have been basing education on competence all along.

CBME is a buzzword or acronym, but it does have meaning. By breaking the complex training of a physician down into specific bite-size parts that can be specifically evaluated, CBME attempts to render medical education manageable. It also keeps trainees from getting away with stuff. If a resident must be evaluated on specific tasks and attitudes such as being able to establish rapport with young psychotic patients, insert a chest tube on his own, or write orders for dialysis treatment, and get this signed off before he can try other tasks, the resident will necessarily gain competence in all the most important parts of his calling.

When I was a medical student, CBME was unheard of, or might have been a trucker’s radio handle. Nevertheless, we were subjected to at least one process that would make today’s medical education specialists proud. My obstetrics rotation was on a busy labour and delivery ward where neither the resident nor the medical student slept at all. One of the student’s jobs in this whirling and bloody endeavour was to do cervical checks. This consisted of inserting my gloved fingers into vaginas periodically and sweeping around the edges of the (hopefully) dilating cervix, and calling out a number in centimeters, thus telling all the expectant people involved how soon the baby might arrive and whether the night would be long for all of us.

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The CBME part of the task was this. Medical students had to perform 10 cervical checks on our own, recording the number of centimeters dilation, and then waiting while the staff obstetrician checked as well. The labouring and long-suffering patients endured this all in the name of education (too bad we couldn't have told them it was "CBME" back then). If the student's number was the same as the obstetrician's, the latter would ceremoniously sign a cervical tally card. When ten were done accurately and signed off, you could perform cervical checks on your own. It was a bit like a stamped coffee card. I still have my card. Proud of it, in fact. (I became a psychiatrist.)

The craft of doctoring is an involved one. It includes many roles that overlap nearly exactly with being a priest, a mother, a scientist, and a diplomat. In addition, some specialties include skills as disparate as that of carpenter and physicist. Most doctors are also expected to be both successful business owners and public speakers. When these disparate roles are broken down into bites—chewable, digestible, and specific—we dub them in the CBME model "entrustable professional activities" and "milestones". And there are understandably hundreds of them in any medical specialty. Performing cervical checks on pregnant women is an important "activity" for any aspiring obstetrician to master, to have entrusted to her, but it is only one of many in the early stages of training, and a concrete and easily measurable one at that. Performing enough forceps deliveries to become competent, counseling enough patients about painful intercourse, assisting with enough vaginal hysterectomies—the "activities" go on and on.

Defining these bite-size activities makes sense to the task-oriented and busy clinician. Tallying the number of MRIs of the brain a trainee has interpreted accurately is the easy part. It's intuitive. It's what clinicians do everyday anyway. Any doctor who drinks coffee knows how to stamp a card tallying "encounters," whether with depressed patients, febrile children, or baristas. What's harder is to dissect the humane skills and to parse qualities of character into measurable milestones. Anyone who has tried to do this realizes that he is attempting to document the measure of a citizen, or the function and likability of a personality, or resilience in the face of the vicissitudes of life, or the worth of a human being even. Is the trainee humble? Is she insightful? Does he learn from adversity?

How did the Romans measure *pietas*, that central virtue of performing all one's duties completely and being humble, knowing your place, and giving others what was their due? Did they stamp encounter cards? How did the Victorians measure "manliness," that prized virtue of empire that Rudyard Kipling tried to summarize in verse, and which may still apply to the overworked medical resident: "If you can keep your head when all about you/Are losing theirs and blaming it on you", or, when the staff physician drones on about some point of physiology when there are patients to be seen—"If you can wait and not be tired by waiting", or, when expected to break bad news to the entitled patient while caring for the homeless—"If you can talk with crowds and keep your virtue/Or walk with Kings—nor lose the common touch". Did the subalterns in British India submit encounter cards that read, "This junior officer walked with 5 kings this month while demonstrating the common touch on 4 of these occasions. Consistently meets expectations."?

Rather than rising to religious terms like the ancients or poetry like the Victorians, when medical educators attempt to quantify the humane virtues necessary to treat the sick, they descend to the lingo and opaque vocabulary of business and the academy. Instead of making virtues plainer, we make them murkier. We divide the virtues into tasks like, "Explain how the Intrinsic Roles need to be integrated into the practice of their discipline to deliver optimal patient care," or, "On the basis of patient-centred priorities, seek assistance to prioritize multiple competing tasks that need to be addressed." Even Kipling couldn't make this one rhyme: "Participate in systems-based informatics development and improvement."³

Clear? Is this what you hope your doctor is good at?

Taxing the electorate is for the common good. Tax codes, however, are often interpreted and applied by a bureaucracy of experts to the frustration of the laity. Educating physicians is for the common good. If we are to be truly patient-centred, however, as the current lingo (and common sense) requires, the organization and implementation of medical education must be comprehensible to all.

Eric Prost, MD, FRCPC, is a staff psychiatrist at Queen's University, and the editor of *Synergy*.

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- ² George Orwell, in his novel, *1984*, as well as his extended essay, "Politics and the English Language," warned of pretentious diction and words that have no meaning, are imprecise, or are clichéd. Language, he warned, can "give an appearance of solidity to pure wind".
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The Diagnostician

IRWIN ALTROWS

To diagnose, to know apart,
Part science, partly stellar art.
To name the thing that you suspect
Creates the anguish you dissect,
“Dissecting nature at her joints”
As God himself your mind anoints
With oil so you make no mistake
Deciding whom He shall forsake.

Now tell me what could nobler be
Than stripping the humanity
From those downtrodden, beaten, bent,
Whose souls are damned, whose clothes are rent,
Whose terror shrieks with voices shrill,
Whose only comfort is a pill,
Who need to be well classified
So we can walk from them with pride
And say “You’re welcome, and please see
That you are not at all like me.”

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