The Experience of Vulnerability:

A Key to the Education of Health Professionals[[1]](#endnote-1)

**Richard Katz and Stephen Murphy-Shigematsu**

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*Richard Katz and Stephen Murphy-Shigematsu propose that the often-disturbing experience of vulnerability, in which persons question and thereby become able to transcend their assumptions, is a key to initiating and sustaining education as transformation. Focusing on the education of physicians and other health professionals, they argue that effective training for becoming healers should value the trainee’s experiences of vulnerability, which are too often excluded by the dominant emphasis on competence*

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**The Experience of Vulnerability, and its Relationships to**

**“Education as Transformation,” Healing and Synergy**

While I (Richard Katz) was teaching at Harvard, I was invited to give a talk about the education of healers to students in the combined Harvard-M.I.T. MD/PhD program. The invitation came from a student in that program who was interested in my research on spiritually oriented healing in Indigenous cultures, and who led me to believe that fellow students in his program would be eager to hear me. Looking forward to such an opportunity to speak with interested young people in an elite medical training program, I eagerly accepted.

The day of the talk arrived; the place the Harvard Faculty Club. As I entered the club, I saw the audience for my talk. And my heart sank. I truly felt like running away. The students were there as expected. But what made me totally nervous was that, unexpectedly, their faculty was there too! I was looking at those faculty, all older than myself, imagining that, as professors with the elite Harvard Medical School and the M.I.T. biomedical graduate program, the last thing they wanted to hear was a lecture on spiritually based healing, a subject I was convinced they would see as “soft,” “unscientific,” and of little relevance to their biomedical curriculum. And these professors were skillfully sharp at and committed to academic criticism. I felt at a loss, my world made no sense at that moment – “why and how did I end of up in this place?” I worried, “and why should I proceed with the talk, and open myself to humiliation and shame.” I felt vulnerable, exposed and unprotected.

I was now in a world that I did not want to be in, waiting to be judged as inadequate, if not a fool. But I felt I had no choice but to accept the dark view of distress that this experience of vulnerability offered. My comfortable world of competence, even expertise, based on the assumption of the importance of spiritual healing, was shattered for the moment. I now had to also live, even comfortably, in this other world that discounted the value, reality even existence of such healing. I had to accept my vulnerability so I could reach out more effectively to other worlds.

My talk proceeded well. The students were mostly interested; their professors mostly not. But when I spoke about the importance of vulnerability in all forms of healing and medicine, and especially in the training of doctors, a dramatic shift occurred. The professors took note, and the students listened most intently.

After the talk, a number of students came up to thank me, especially for dealing with vulnerability. They emphasized that experiences of vulnerability were important, if not critical for them, but were typically dismissed, if not ignored in their education. “Vulnerable, that’s what we often feel in our training,” said one student, “but we can’t talk about that. Our professors are so high-powered, one accomplishment piled on top of another. All of our training is toward making us competent, super-competent. There’s no room for vulnerability.” “We keep being told how elite our program is,” another student added, “but we are like everyone else. We make mistakes. We don’t know the answers all the time. But since we can’t share our feelings of being vulnerable, we are made to feel like we’re not measuring up.” A third student emphasized, “It’s hard always having to be the expert. I just want to be myself, a person who sometimes doesn’t know where he’s going . . . or why.”

My experiences of vulnerability temporarily froze me into a state of fear and confusion. But by working to accept the terrifying unknowns of vulnerability, I was eventually able to face and move beyond my fears. While giving my lecture, I was coming into a world very different than my own, the world of positivistic medicine antithetical to notions of spiritual healing. If I were truly interested in the respectful exchange of knowledge between Western and Indigenous healing systems, then I had to move beyond the comfort zone of my own worldview, and enter that “foreign” world of Western biomedical science, respecting those biomedical professors’ point of view, while presenting my own differing view with clarity and integrity. Only then could dialogue be possible, could there be collaboration between the two apparently disparate healing systems, and could synergy be released and healing options enhanced.

The Harvard-MIT students had their own learnings. They were able to own their feelings of vulnerability as real, normal and even natural, even if they didn’t share them with their faculty. Just because they made mistakes or didn’t know the answers or were confused about which direction to take, didn’t indicate their failure, but in fact affirmed their growing ability to listen to, care for and help their clients – in short by loosening their grip of having to be competent at all costs, they could affirm their humanity. Accepting their vulnerability as both real and valuable offered them a doorway toward more effective practice as physicians, and scientists.[[2]](#endnote-2)

By vulnerability, we mean a radical questioning of one’s world-view, such that what was assumed, often implicitly, as “valid,” “correct,” “obvious,” and “common practice” is no longer. This experience of vulnerability entails giving up the often comfortable and comforting protection of one’s world-view; understanding the world from within another person or community/culture then becomes possible. While the reality, indeed importance of spiritually based healing was “obvious” to Katz before his Harvard-M.I.T. lecture, he had to give up that comfortable assumption to begin to really understand what was equally “obvious” to those medical school professors, namely that spiritual healing was neither important nor real. Only then could he begin to understand more fully their worldview – and his own as well.

Experiences of vulnerability are a key ingredient in encouraging “education as transformation,” a model for enhancing the training of health providers that is based on the expansion of their consciousness beyond the limits of conventional understanding (see Chapter Six). Vulnerability sets the stage for a person to go beyond their comfort zone, to enter often frightening and utterly new territories of the mind and heart. As one leaves the comfortable and comforting confines of one’s familiar and dependable world, one becomes more truly able to experience another in their world, while previously that other world might only have been hypothesized as an abstract concept. Experiencing that state of unexpected and new realities, transformation becomes possible, releasing synergy and its ability to enhance efforts toward both educating healers and healing itself.

Considering deeply existential questions, Welwood (1983) writes about the vulnerability that accompanies “moments of world collapse.” These moments occur:

. . . when the meanings on which we’ve been building our lives unexpectedly collapse. When an old structure falls away and we don’t have a new one to replace it, we usually feel a certain inner rawness. That kind of tenderness and nakedness is one of the most essential qualities of our humanness, one which we are usually masking. (p. 148 – 149).

Henry (1972) discusses vulnerability, what he calls the “susceptibility to destruction and defeat,” as a characteristic of our nature. He suggests that for society to function, it must educate its members to understand and accept their own vulnerability. For First Nations Elders, vulnerability expresses and respects the very nature of existence, namely we cannot control what happens, and we are not invincible. When Elder Tony Sands of Mistawasis First Nation was asked if he could perform a ceremony at some future specified date, he would typically reply “I will be there . . . if I can,” thereby expressing he could not know with any certainty what the next moment might bring.

Vulnerability resides in all aspects of the process: giving up one’s familiar, often familial world view; existing, even for a moment – and that is all one can typically endure – between or without worldviews; understanding the world from within the view of a different person or community/culture; with this understanding, realizing the often unsettling multiplicity of valid world views; and finally, accepting that experience of vulnerability, gaining the possibility of both going beyond one’s own worldview and joining with another, seemingly conflicting worldview, to create a whole of possibility larger than the sum of its parts. Experiencing one’s own vulnerability allows for a deeper access into another person’s or culture’s world. By giving up or suspending one’s own world view, another, apparently conflicting worldview, which is sometimes perceived as dangerous, can be understood, even accepted. Being inside another person’s world or another culture, exposed to the risks and touched by the joys of that other world, one can hear a richer, more accurate story about that other world because it will be more of a story from within.

Carl Rogers (1982) deals with these issues of “access” to another’s world in his discussion of the therapeutic importance of counselor empathy. Focusing on some of the more extreme demands of empathy, e.g. the need for the counselor to overcome her fear of a client’s world because it is perceived as too dangerous to enter, Rogers alludes to the key role of experiencing and accepting vulnerability as a prelude to this empathy.

Empathy, accurately defined as the ability to accompany a person wherever his feelings lead him – no matter how strong, deep, destructive or abnormal they may seem – is, in my estimation, helpful, and not harmful (Rogers, 1982, p. 286)

Though it may eventually be accepted, the experience of vulnerability is rarely intended in most ordinary situations, much less cultivated, because it is a source of fear, even at times terror. Katz certainly did not go to his Harvard/M.I.T. lecture in order to experience his own vulnerability; that experience was thrust unexpectedly upon him. His only real choice was whether or not to accept or deny that experience.

But the situation one is in, e.g. a human crisis or natural disaster can demand vulnerability, wresting what is a human condition to the level of awareness. Also, in many cultures there are explicit rituals of transition and transformation, what van Gennep (1960) described as “rites of passage.” These rites of passage purposively guide participants into experiences of vulnerability, into what van Gennep called the “liminal stage”, where one is neither being here nor there. These rites of passage also guide one out of vulnerability and into new understandings. Likewise, many spiritual meditative practices cultivate experiences of vulnerability as a necessary prelude to going beyond oneself to reach true understanding, an “at oneness,” connecting with a larger, more universal Self.” “Letting go” of one’s ego concerns, especially being willing to overcome the human need for prediction and control, becomes critical to accepting the experience of vulnerability.

Accepting the experience of being vulnerable can open the door to special knowledge, in part through opening the door to profound self-knowledge. Through experiences of vulnerability, one can begin to understand more fully the limits of self and the potentialities of the larger whole. Instead of being *dismissed* as subjective, this self-knowledge, when it comes honestly from the depths of a person’s understanding, can become an important source of *valid* data, and can help erase distinctions between subjective and objective knowledge that are based on their relative validity. Kxao =Oah, a powerful blind Ju/hoan healer, insightfully erases boundaries between subjective and objective. “When the healing begins,” Kxao =Oah says, “you can really see, you see the insides of people and all that troubles them. At other times, when we are not healing, you can look but you do not see “(Katz, 1982). Though totally blind, Kxao =Oah, like so many healers in all parts of world, distinguishes between forms of seeing: one is a seeing which has healing potential, and depends on seeing truthfully from inside one’s experience, guided by a transpersonal understanding; the other seeing, remaining on the so-called objective level of the material world, may not release healing potential.

The experience of vulnerability is a way of knowing, learning, and being. It involves profound shifts in consciousness and perspective. That experience is also a dynamic process; there are typically fluctuations in these shifts of consciousness as a person, in an ongoing attempt to keep in balance, goes into and out of experiences of vulnerability. For example, Indigenous Fijian healers seek to follow the “straight path” (Chapter One; Katz, 1999). But that is neither a simple nor easy task. The path of the healer in ordinary life is never straight; there are many deviations from the moral values of the straight path. In fact, the further along you are on that straight path, the greater the temptations are to deviate from the path – in part because being advanced in the path lulls one into thinking one is special, even fully developed, and it is that complacency, even arrogance, which makes one vulnerable.

Since the key to experiences of vulnerability is shifts in consciousness, the settings in which vulnerability occurs are secondary. Also the experience of vulnerability need not occur within a dramatic setting; the experience occurs more commonly within subtle contexts. Furthermore, vulnerability often occurs cumulatively, over time. A one time dramatic revelatory experience of vulnerability is neither typical nor necessarily the most effective way of gleaning understanding from being vulnerable.

By considering the nature of the experience of vulnerability, we can understand more clearly the nature of “education as transformation.” Education as transformation has been described as involving a “transformation of consciousness, a new experience of reality in which the boundaries of self become more permeable to an intensified contact with a transpersonal or spiritual realm” (Chapter Six). But as we see with vulnerability, education as transformation focuses on shifts in consciousness that commonly occur within subtle contexts, and are often cumulative in nature. The possible connotation from the phrase “intensified contact with a transpersonal or spiritual realm” that education as transformation is a dramatic, once and for all revelation is misleading. The emphasis in education as transformation is on the “transformation of consciousness” and the “new experience of reality,” in which going beyond oneself is the key, whether or not that transformation is explicitly described as a spiritual experience.

In order to have education as transformation, there must be the experience of going beyond oneself, so that one can see/feel/experience the reality, even the texture and rhythms of other worldviews and worlds, especially those that appear in conflict with one’s own (comfortable/comforting) world. This often involves letting in “new” data, seeing things one ordinarily cannot or wishes not to see/experience. At a practical level, education as transformation allows one to hear, and understand more deeply, the stories of others. The experience of vulnerability is a key ingredient in encouraging and supporting that education as transformation.

If one accepts the experience of vulnerability and the education as transformation it can help initiate, then one can begin to accept those alternate worlds, on their own terms. One gets to experience a larger picture of the world, encompassing what might have previously been thought of as incompatible worldviews. There can now be a working to bring about a whole greater than the sum of parts in which one’s own and another’s worldviews can fruitfully co-exist, can collaborate, forming a larger, more inclusive way of being, knowing, learning. Synergy releases and is released by these transformational processes.

The process of healing, including research on healing and the education of healers, is ideally suited for establishing this connection between vulnerability and education as transformation. Healing is a process which brings together apparently disparate elements to make a whole greater than sum of parts, and as a result enhances healing resources, and makes them more available. Therefore health providers, including physicians, whose job is to promote healing, could benefit from experiences of vulnerability in their training.

**Vulnerability in medical education, and by extension, health care providers in general**

The education of doctors typically focuses on curing disease and doctors are taught to value their ability to keep patients alive as long as possible. The driving engine behind these aims is for the medical student to develop their knowledge base and skill level, in short their professional competence, and to lead with that sense of competence in their eventual practice. However, Dr. Sheila Harding, Associate Dean of the University of Saskatchewan Medical School, delivered a different message in her lecture on the “Hidden Curriculum in Medical School” (Harding, 2010). She discussed the importance of medical students knowing how to fail, so they could handle failures, and admitting and accepting their mistakes so they could correct them; in short, accepting their own fallibility, as opposed to always striving to be competent. We could say that Dean Harding was calling for an appreciation of experiences of vulnerability in the education of doctors, and by implication, an introduction of education as transformation into the medical school curriculum. Given the historical absence of education as transformation in the education of doctors (see e.g. the discussion of the education of psychiatrists in Chapter Six), Harding’s talk suggests the important and potentially radical shift that is now taking place in medical education.

Some of this shift is taking place within the context of “cultural competence” training, which has become a part of the curriculum of virtually every health profession. Such programs are generally designed to help health providers cope more effectively with the growing diversity of their patients, seeking to sensitize practitioners to the special needs of different populations, with the goal of providing accessible and appropriate care to all. But within this movement to teach cultural competence, there is an insistent voice warning that, in its zeal to instill awareness of cultural difference, the cultural competency movement can lose sight of important features of culture, promoting a false sense of competence that mistakenly treats culture as an explanatory variable, subject to prediction and control (Murphy-Shigematsu, 2010).

“Cultural humility” is an alternative approach to promoting attitudes and skills that enable health care providers to work effectively with patients from diverse cultural backgrounds. Tervalon and Murray-Garcia (1998) define cultural humility as a process of continual self-reflection that requires doctors and others to be humble as lifelong learners. The doctor enhances patient care by effectively adopting an attitude of learning about cultural differences, rather than needing to the expert. This approach cultivates self-awareness by encouraging physicians to acknowledge the belief systems and cultural values they bring to patient encounters. The humbleness engendered enhances patient care as the understanding of patient belief systems becomes integral to their health care.

Juarez and colleagues (2006) have designed a curriculum in which cultural humility is woven into each training activity by either exposure to a different belief system or exploration of one’s own beliefs. The curriculum’s pedagogy is to select activities that allow trainees to see the world through the eyes of a patient, which in turn provides the opportunity to increase the trainee’s awareness and empathy. Teaching health care providers to be culturally humble requires greater emphasis on fostering self-awareness, interpersonal sensitivity, and an attitude of openness and learning from patients.

The emphasis on self-awareness and vulnerability goes beyond the area of cultural competence training to what Charon (2006) calls “narrative medicine”. Having observed that the connections between reflection and empathy affect both caregiver and patient and are mutually nourishing, DasGupta and Charon (2004) use reflective writing to teach medical students empathic interactions with patients. When doctors or medical trainees reflect on their own lives in medicine and when they inspect the memories and associations triggered by their care of the sick, they become more available and useful to their patients. Their explicit awareness of their own feelings and experiences deepens their capacity to respond empathically to patients while their generosity toward patients can promote them to be more generous toward themselves. These narrative writing exercises require students to reflect upon clinical experiences from either the perspective of themselves as clinicians or from the perspective of the other who is the patient.

Although medical practice is dedicated to examining, diagnosing, and treating bodies, the relationship of physicians to their own bodies is typically unaddressed. A few physician-writers have bravely explored this area, such as Rafael Campo in his book, The Desire to Heal: A Doctor’s Education in Empathy, Identity, and Poetry (1997). However, there is still little opportunity afforded to physicians to deal with personal illness experiences. One way to address this need is through a personal illness narrative writing exercise that creates an opportunity for students to elicit, interpret, and translate their personal illness experiences. I (Murphy-Shigematsu) developed a particular classroom exercise of self reflection on a personal illness narrative to help medical students get in touch with their own feelings of vulnerability as a patient (Murphy-Shigematsu, 2009). We ask students to reflect on a personal illness experience and reflect on what their experiences show them about worldviews of illness and healing and how these worldviews could affect their clinical encounters as a doctor. They then pair with a partner and share these stories, after which we reflect on these exchanges as a whole group. Through this exercise students connect with their vulnerability, in the spirit of Carl Jung’s admonishment that a doctor is effective only when he himself is affected. “Only the wounded physician heals. But when the doctor wears his personality like a coat of armor, he has no effect.” (Jung 1965, p. 134).

This process of self-reflection in health providers is also furthered in the films of Maren Grainger-Monsen which explore physicians confronting their own vulnerability. Grainger-Monsen was a young emergency room physician who began an amazing transformation when she encountered her first dying patient for whom she had to accept “defeat.” It was an eye-opening experience for the young doctor because she realized that nothing in her education and training had prepared her for that difficult task. She had only been taught how to treat disease, and save and prolong life, not how to accept when life becomes a fate worse than death. For her, death meant failure in her ability to heal patients. This awakening started her on a quest to understand how doctors need to accept vulnerability and use it to provide care when there is nothing in their black bag that will cure the disease. Dr. Grainger-Monsen became a filmmaker and focused her first film, *The Vanishing Line* (Grainger-Monsen, 1998), on her personal quest to know how to meet the needs of the dying and their families. The film looks at the choices involved in treating what has no cure with the right balance of technology, compassion and care. Her subsequent films, *Worlds Apart* (Grainger-Monsen and Haslett, 2003) and *Hold Your Breath* (Grainger-Monsen and Haslett, 2005) continue to develop this theme, showing physicians confronting their vulnerability in cross-cultural encounters with patients. We have used these films in training medical students and other health professionals (Grainger-Monsen and Murphy-Shigematsu, 2010; Murphy-Shigematsu and Grainger-Monsen, 2009).

Increasingly, courses are being developed which seek to legitimize the value of vulnerability in health care practice. For example, Tommy Lee Woon has developed a course that emphasizes physician self-care, emotional literacy, and cultural versatility; it is called, “Building Our Humanity: Culture, Emotions, and Medicine” and has offered at Stanford and Dartmouth medical schools. In a small class, students are encouraged to disclose their innermost feelings, to gain insight into how to be vulnerable, and to learn how to create emotional safety for themselves. Students are put into pairs or small groups to develop and practice more effective listening and attending skills; a better understanding of emotional healing; an ability to respond to emotions; an ability to maintain one’s humanity; a commitment to eliminating health-care disparities and prejudices; and a professional dedication to equity and diversity in medicine.

Perhaps the most widely used curriculum based in vulnerability is The Healer’s Art course designed by Dr. Rachel Naomi Remen,[[3]](#endnote-3) It has been taught annually by Dr. Remen at UCSF Medical School since 1993, and replicated at more than 60 medical schools across North America and beyond. The course often runs as a fifteen hour, one credit elective for first and second year students through the Department of Family Medicine, with a low student, faculty ratio. The faculty involved are physicians who strive to bring honesty, sensitivity, respect, and natural compassion to their work, participating as equals in the small group discussions and exercises, offering perspectives as individuals on the same professional path as the students, just further down that path. Through interactive dialogue, students often come to know one another at a new depth in exploring their personal insights and stories. The course is based on a “discovery model” in which there are no experts, no right answers, and it is acceptable to “not know.” The wisdom of the group’s collective life experiences is recognized, with curiosity and exploration encouraged as a part of the dialogue. There is also encouragement for the respect of others, self-exploration and self-trust, and personal connection with the fundamental principles of healing. Remen’s (2006; 2001) beautiful writings are permeated with the message of the importance of vulnerability in medical education and physician development and self care.

**Challenges to bringing the experience of vulnerability into the education of health care providers**

As the above examples suggest, there is a vital and varied effort to bring experiences of vulnerability into the education of health professionals. But these efforts are still in their infancy. When health care providers are allowed to experience their own vulnerabilities, they are better prepared to serve their clients, and better able to foster the development and equitable distribution of healing resources. As an essential ingredient in education as transformation, vulnerability helps trigger the synergistic release of expanding healing resources. Yet, we have also emphasized that the experience of vulnerability is not easy to initiate or maintain; challenges abound.

There are several structural and institutional challenges. For example, when the dominant medical and health provider educational system considers vulnerability, and the education as transformation it can stimulate, as sources of knowledge, they are labeled as “subjective,” and hence “soft,” “unscientific,” and “biased,” – in short, not valuable or valued because they are not “objective.” This negative judgment still represents mainstream medical education, reflecting as it does general socio-cultural values. That is why the emerging trends supporting the introduction of vulnerability into the education of doctors and therapists still remain mostly on the fringe.

But there is also an emerging critique of the distinction between “objective” and “subjective” knowledge, in which that distinction is erased, and a new set of criteria for assessing the value and validity of knowledge is put forth (see e.g. Ermine, 1995; Tart, 2009). Polanyi (1958) was one of the earlier critics of this subjective/objective distinction when he argued that all knowledge, being “existentially dependent,” is a fusion of subjectivity and objectivity. His argument is particularly persuasive in the realm of medical education, which has such a strong component of “existentially dependent” learning. Polanyi (1958) establishes an alternative ideal of knowledge: “[There is] personal participation of the knower in all acts of understanding but this does not make our understanding subjective . . . Such knowing is indeed objective in the sense of establishing contact with a hidden reality . . . “(p. vii – viii)

Many knowledge systems throughout the world, in placing ultimate value on personal experience, also remove the pejorative connotation of subjective knowledge. For example, Ermine (1995), in discussing Cree First Nations epistemology, emphasizes that personal experience, and more generally the world of “inner space,” is the source of the most valuable and valid knowledge. That point of view would more than substantiate the essential role of vulnerability, with its emphasis on personal experience, as a source of learning for doctors.

Another structural challenge to according experiences of vulnerability a place in medical education is the criticism that such experiences will take away from time needed for what is considered “primary” training, i.e. the transmission of technical knowledge. But we believe that the introduction of opportunities for personal reflection – which would include experiences of vulnerability – not only does not significantly take time from other more technical training inputs, but also, in strengthening the students’ ability to deal with the stresses and anxieties of medical education, better prepares them for learning these technical units.

There are also several psychological challenges to initiating and maintaining experiences of vulnerability in medical and more generally therapists’ education. For example, there are limits to our emotional and cognitive flexibility and openness, our risk-taking capacities and motivations, and in the end, or willingness and ability to transcend our ego needs. These limitations, which seem to some combination of traits, habits and conventions, pull us back from the edge of the unknown, of what we sense will be painful, or at least confusing, in short, what we perceive as the realm of vulnerability. There is the continual desire to maintain the status quo, to keep comfortable and keep things predictable, in short to stay in control; as a result, we seek to avoid or cut short or cut off experiences of vulnerability.

And these motivations to stay in control are not assuaged after an experience of vulnerability. The very nature of that vulnerability means that it will continually be relived and will continually reemerge. Vulnerability is not a one-time experience, but a cumulative experience composed of multiple occasions where vulnerability comes to the fore or is absent. When vulnerability is accepted as an integral part of medical education, the students’ conventional need for control is severely tested by any wish for the special learnings that can arise from being vulnerable. Maslow describes this motivational conflict or tension as our “need to know and the fear of knowing” (Maslow, 1963).

Related to this desire for control, this pulling back from emotional and cognitive openness is the motivation to avoid “mistakes,” to avoid feelings and experiences of “failure,” to be and stay “in command.” This desire to be mistake-free is especially powerful in professional training settings that emphasize competence, almost at all costs, such as the medical school. In such settings, mistakes are seen as failures. And the patient’s voice is typically ignored or silenced, since it may offer views, experiences and data that are an alternative to or even contradict the health care provider’s positions or conclusions. As we heard one patient put it: “I don’t talk to my doctor because he is afraid to listen.” The teachings of vulnerability, where mistakes are opportunities for learning and competence is given a place *among* other educational aims, are ignored.

A recent groundbreaking article by a surgeon, David Ring, in the prestigious *New England Journal of Medicine,* supports the importance of recognizing and owning one’s mistakes as part of competent, effective medical practice, even as a model of best practices (Ring et. al., 2010). Contrary to the convention in medical practice of hiding or not acknowledging, at least publicly, one’s mistakes, Ring writes about the error or mistake he made in a surgical procedure on a patient’s hand. By explicitly and public owning his mistake, or as he says breaking the “silence that surrounds doctors’ errors,” Ring examines his fears, such as fearing his peers’ ridicule or negative judgment about his competence, and fearing the loss of his patients’ trust and patronage. But he insists that owning his mistake shows the full range of his humanity, and thereby presents a more realistic picture of his skills and limitations. In the end, he argues, owning his mistake will also lead to a more effective therapeutic practice, characterized by a more realistic assessment of his ability to help, and a more open exchange between himself and his patients.

Ring concludes that owning and accepting mistakes is the only way to learn from them, and thereby lessen their future occurrence. “We’re transitioning from the blame-and-shame culture,” he says, “[Our mistakes] are not something you sweep under the rug” (quoted in Aleccia, 2010). But he reminds us that owning one’s mistake is very difficult: “I hope none of you ever have to go through what my patient and I went through” (Ring et. al., 2010, p. 1957). “Just imagine the worst thing that ever happened to you and that’s how it feels” he adds (quoted in Aleccia, 2010). Ring argues that an honest facing of one’s own fallibility – we could say accepting one’s vulnerability—is a pathway to better practice – and most of the letters from colleagues responding to his article enthusiastically support Ring’s conviction, expressing gratitude for his courage and honesty. It is in the work and struggles of physicians like Ring that we can clearly see the potential that vulnerability has to enhance the quality of health care. In accepting his vulnerability, and learning from his mistakes, Ring can inspire other caregivers to do the same – as letters to his original article suggest. The potential for improving the quality of care giving could then begin to expand exponentially, as synergy could be released into healing resources.

1. 1. Portions of this chapter are based on material first presented in Katz (1987, 1999) which discussed the importance of vulnerability in the effective practice of qualitative research, and in particular field work and community-based research. [↑](#endnote-ref-1)
2. In working with our Clinical Psychology doctoral students and medical school students, we have found similar occurrences of and reactions to vulnerability. [↑](#endnote-ref-2)
3. http://www.ishiprograms.org/programs/medical-educators-students/course-description/ [↑](#endnote-ref-3)