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Quality of Care and Quality of Caring

Developing a compassion training for physicians: a summary report

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More information and the latest news about the project can be found at www.professionalperformance-amsterdam.com. For questions and suggestions: professionalperformance@amsterdamumc.nl

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1. Reader's guide

This report provides an overview of our research project entitled *Quality of Care and Quality of Caring: developing a compassion training for physicians*. We will describe the research process, our findings and the outline of our final compassion training for residents.

In section 2, the introduction, we describe the urge for developing this compassion training. We will also briefly address the APH innovation grant, our project goals and the project team.

In section 3 we give a short literature overview regarding the following themes: views on compassion, intervention types to train compassion, ways to assess compassion and the common barriers and facilitators to deliver compassionate care.

In the fourth section we will describe our methods. We will describe how we set up and conducted our interviews and the co-creation session. The way we analyzed our data will also be discussed here.

Section 5 presents our interview findings. The first part summarizes the results from the patient interviews, structured by the research questions: a) What are patients' needs regarding compassionate care? and b) What do doctors need to learn according to patients to deliver care that is more compassionate? The second part summarizes the results from the resident interviews, using the research questions: a) What are hindering and facilitating factors according to residents to deliver compassionate care? b) What did residents learn about compassion in their curriculum and how did they experience the educational methods used? and c) Which learning needs do residents have regarding compassionate care and what are their preferences regarding educational methods or interventions?

In section 6 we present the intervention we have developed and in the last section we will describe how we plan on evaluating and pilot-testing the training. The training is planned in October-December and will be evaluated consecutively. Under the present circumstances, with the current measures regarding the corona crisis, this training can take place physically.

2. Introduction

2.1. Problem statement

Healthcare in the Netherlands has been among the best in the world, largely thanks to physicians' high performance and their genuine desire to help patients (1). Compassion is described as a key element of health care quality by physicians, patients, families, and policymakers (2, 3), and it is thus crucial for successful medical care. Compassionate care has been related to positive patient, provider and health care system outcomes (3) and; a lack of compassion has been related to lower quality of care and increased risks to harm patients (6). For physicians, compassionate care has been associated with deriving greater pleasure from their work (7), lower burnout and improved well-being (8). However, providing compassionate care is not self-evident; for instance due to the demanding and rapidly changing work environment of physicians (2,3,6,9,10). Trzeciak et al. (2017) even talk about a 'compassion crisis' because of the lack of humanization in healthcare systems (2).

2.2. APH innovation grant – Quality of Care

In 2019 Amsterdam Public Health opened a call for innovative research proposals within the Quality of Care program. The goal was to enhance thematic deepening on the research theme, profiling of the Quality of Care research program and to exchange ideas and expertise among researchers and research groups aligned with Quality of Care within Amsterdam UMC. In order to be eligible research proposals should fit at least one of the following themes: optimizing professional, institutional and healthcare system performance, striving for equity, achieving person-centered care or patient safety. New collaborations between AMC and VUmc were being prioritized over existing ones.

2.3. Project goals

Following the problem statement described in section 1a, the aim was to develop a low time intense compassion intervention to train physicians to be better equipped to sustain compassionate care within Amsterdam UMC. Recognizing physicians' and residents' demanding work environment and the barriers they face in the ability to deliver compassionate care, has led to the development of various compassion interventions of which some have already shown to be effective to enhance compassionate care behaviors. We, however, wanted to create an intervention which was specifically based on the input of patients and physicians (in training). Moreover, most of the interventions found in the literature are quite comprehensive as their time investment ranges between 18hr and 54hr. Taking into account time pressures physicians face, we decided to focus on co-creating a low time intense intervention.

2.4. Project team

The project team consisted of researchers and practitioners from both VUmc and AMC; more specifically the former department of Medical Humanities of VUmc[1] and the department of Medical Psychology, General Practice (the former section of Medical Ethics*) and the Center of Evidence Based Education (CEBE) of AMC.

[1] The department of Medical Humanities of VUmc and the section of Medical Ethics of AMC are fused within the new department of 'Ethics, Law and Humanities.

3. Literature review

3.1. Defining compassion

There are many definitions for the construct of compassion and it is often considered similar to empathy, which is understood as "*an effective state of mirroring or understanding another's emotions (8).* It is, however, important to make a distinction between both. For the sake of clarity and workability, in our project we have defined compassion as *"the emotional response to another's pain or suffering involving an authentic desire to help".*(8)

From our literature review, we found four theoretical perspectives on compassion, illustrating the construct's richness. First of all, there is the psychological perspective. From this perspective compassion is regarded as an emotion related to other emotions like empathy, pity and sympathy (11). Secondly, there are the 'love-based' conceptions of compassion. Within this frame compassion is associated with love and tenderness, altruism, dignity and respect, valuing the other and human flourishing (12). Ultimately this idea of compassion has strong ties with the concept of self-compassion, which briefly entails self-kindness - *being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical* (13). The third perspective encompasses the evolutionary perspective in which compassion serves a function, namely to survive and reproduce as human being. One line of reasoning for example argues that it is a desirable emotion in mate selection processes (11). The last perspective we have distinguished derives from virtue ethics. From here compassion can be seen as a "virtue", the midway between over-empathizing with another and being ignorant. Although there is not just one "right middle" –this is highly dependent on the context- , people can be trained to develop the characteristic of being a virtuous, or compassionate person (14).

3.2. Interventions to train compassion and its effectiveness

Our project builds on a literature review on compassion interventions performed by Auke Boertjes. We really appreciate all the work he has done in collaboration with the research group PP&CC and will elaborate on some of his results. Aukje performed a short literature search on compassion interventions for professionals in healthcare settings in the PubMed, Scoupus and PsycINFO databases using the keywords 'intervention', 'compassion', 'healthcare professional' and variations thereof (Appendix 1). Out of 2515 unique hits 25 studies were included. Important inclusion criteria were: effects measured via comparable groups and/ or over the course of time, published in an academic journal, study population consisting of licensed healthcare professionals, detailed description of intervention available and quantitative outcome measures should be reported.

The studies describe several types of interventions (and measured effects) to increase compassionate care behaviours in healthcare professionals. The different interventions vary in their focus on how compassion can

be addressed/ enhanced/ cultivated, including the following topics or methods: Communication Skills, Meditation, Story Sharing, Knowledge Transfer including courses and seminars, Role Modelling, Narrative Practices like writing, Standardized Patient Simulation, a full Participatory Action Research or a Combination of the previous topics or methods.

For the intervention types focusing on Communication Skills, almost all studies showed a significant positive effect on some compassion outcome measure (15;16;17;18). Meditation interventions typically entailed mindfulness exercises and increased compassionate behaviour effectively (19;20;21;22). We found two Story Sharing intervention studies (27;28), of which the low time intense intervention showed significant effects on empathy scores (28). The Knowledge Transfer interventions for compassion varied in way they were set up. Glembocki & Dunn's intervention consisted of a 24-hour educational seminar divided over three days and Riess et al.'s developed a four week empathy training module focusing on the neurobiology and physiology of emotions. Both showed positive effects in caring behaviours like 'doing for', but did not find a significant increase in empathic attitudes as such (29;30).

For the Role Modelling, Narrative Practices, Standardized Patient Simulation and the Participatory Action Research intervention types we found one study each (31;32;33;34). Except for the Standardized Patient Simulation, all these intervention types found significant positive effects on some sort of compassion-related scale. In the next paragraph we will shortly elaborate on the different kinds of instruments that are used to measure the concept of compassion. The Combination of Methods intervention types often included many different elements or exercises like knowledge transfer, sharing experiences, mindfulness meditation, narrative exercises, educational videos, group discussion, etc. The effects of these kind of interventions, however, vary (23;24;25;26).

In sum, compassion interventions vary in the teaching methods that are used, the topics that are being addressed and in their effectiveness. However, interventions focusing on communication skills and meditation seemed to be both pretty common and promising. The differences in effects found in the intervention types that make a combination teaching methods tells us that this seems useful; making sure that the right elements should be selected.

3.3. Instruments to measure compassion

The studies included in our overview of compassion interventions used 19 different instruments to measure compassion (attitudes). Many of them only appeared once. The ones we encountered more often, the more common instruments, were the Jefferson Scale of Empathy (JSE), The Consultation and Relationship Measure (CARE), The Interpersonal Reactivity Index (IRI) and The Empathic Skill Scale (ESS). A closer look at these

instruments however learns us that mostly measure empathy related behaviors or attitudes. Although empathy is part of compassion, empathy does not capture the whole concept.

In their critical review, Sinclair et al (2017) mention several other instruments for measuring compassion in healthcare systems. These instruments include more compassion-related items and have been used in several studies on compassion before. They found one self-report instrument; the Compassion Competence Scale (CCS), specifically developed to measure compassion competence amongst Korean nurses. Three patient reported instruments measuring the importance of healthcare provider compassion were mentioned: The Compassion Scale, The Compassionate Care Assessment Tool (CCAT) and The Schwartz Center Compassionate Care Scale. They found one instrument measuring organizational support for compassionate care; The Compassion Practices Scale. What is important to notice, however, is that all three instruments have severe (psychometric) limitations. Most only measure certain aspects of compassion, lack conceptual congruence or information on measurement reliability and validity, and present insufficient evidence of the adaptability to diverse practice settings. According to Sinclair et al. (2017) there is thus still a lack of psychometrically validated instruments that comprehensively measure the construct of compassion in healthcare settings (35).

3.4. Facilitators and barriers for providing compassionate care

In their scoping review Sinclair et al. (2016) make a distinction between educational barriers and practice setting barriers. Examples of educational setting barriers are suboptimal training environments, inappropriate training methods, insufficient time to reflect and a gap between theory and practice when learning to deliver compassionate care in the classroom (2). Common practice setting barriers are for example a lack of time, support, staffing and resources, a negative workplace culture, difficult patients or families or complex clinical situations (2;5).

Less information is available on the facilitators for compassionate care behaviours. Some studies focused on factors facilitating the delivery of compassionate care by nurses. One Iranian study for example found that personal factors like the nurses' personalities, attitudes and values play a role. But the authors also found socio-cultural factors and initiator factors with subcategories like patient suffering and patient emotional and psychological necessity (40). Another study among physicians found that (spiritual) self-care was an important facilitating factor for the ability to provide compassionate care (41). However, definitely more research on the facilitating factors for physicians to deliver compassionate care is needed.

4. Methods

4.1. Interviews with patients and residents

A fundamental part of our research project consisted of conducting interviews with both patients and physicians. In total we talked to 10 residents and 9 patients from both AMC and VUmc. We purposefully selected residents from various postgraduate years and gender from different specialties within Amsterdam UMC. Patient participants were recruited via medical specialists and the Client Advisory Council. All participants were either e-mailed with an interview invitation or phone called. The topic guides for our interviews were based on the literature review. All interviews were audiotaped and subsequently transcribed verbatim In the interviews with residents, we asked about their experiences with providing compassionate care, what hinders or facilitates them in providing compassionate care, what they learned during their medical education and what their needs and wishes with regards to a compassion training would be. We asked patients about their experiences with compassion during their time at the hospital, what their needs regarding compassionate care are and what they think physicians have yet to learn. Participation in the study was voluntary and anonymous.

4.2. Co-creation session

Together with patients, physicians in training, and experts on compassion(interventions) we organized a co-creation session on the 29th of October 2019. The goal of the session was to discover the different elements that should be present in a compassion training for residents. It became clear that the intervention must include the following aspects: assessing one's assumptions, beliefs and emotions considering patients and patientcare, empathizing with the patient and finding out what the "right" amount of compassion in a situation might be. Moreover, the co-creation session seemed to function as an intervention on its own; serving as a platform where patients and physicians in training could exchange their ideas about and experiences with compassion.

4.3. Data analysis

In order to analyze the interviews we used template analysis. Template analysis a style of thematic analysis in which the main question guides the analytic process which leads to new (and the final) templates (42). Four researchers first individually coded three interviews from residents. Then we discussed and compared the codes resulting in our initial template which was discussed in the lager project team. In the subsequent coding process we wrote down which codes in the template were missing or should be adapted. We adapted the template, went back to coding and repeated this process one more time. We all agreed that after two rounds our templates fit the data sufficiently. We run through the same process for the patient interviews.

5. Results

5.1. Patient interviews

There were two main questions guiding our interviews with patients: (a) What are patients' needs regarding compassionate care? And (b) What do doctors need to learn according to patients to deliver care that is more compassionate? The results from our interviews can be divided into three subcategories: *doctors' attitudes, doctors' (humanistic) skills and the setting*. For each subcategory we now present our main findings regarding both research questions.

A. Doctors' attitudes

Doctors' attitudes was a prominent theme when, implicitly or explicitly, patients were asked about their needs concerning compassion. Almost all patients appreciated it when the doctor's attitude reflected one of sincere interest and sympathy; giving the patient the feeling that he or she was really heard and seen. One patient describes this in the following quote

"I don't mind someone quickly typing something on their computer, but it shouldn't be the only way someone is having a conversation with you. That you also – well, what I say, feel heard and seen. I think that the most important thing is that you feel heard and seen." (Patient JK)

In addition, patients often seemed to prefer doctors who stayed calm, were perceived knowledgeable and acted competently. Patients, moreover, wanted to be treated with respect and found it important that they were being taken seriously.

When it comes to what doctors could still learn with regards to their attitudes, it was often mentioned that many doctors should learn how to better empathize with their patients. Patients explained this for instance by using the example of doctors talking clinical language which patients didn't always understand. Another example of this is that some patients still perceived a mindless doctor with regards to the impact of certain utterances. Furthermore, patients mentioned that some doctors still have a little room for improvement with regards to their professional attitude: they could for example try to learn and come to know who the patient is, but also what the limits of their own medical knowledge and skills are.

B. Doctors' (humanistic) skills

Within this subcategory two important needs were found. The first is clear communication. Many patients wanted to be told what is being done and why, and what will happen next. Patients expected doctors to make an estimation about what (level of details in) information was preferred by each individual patient, since not

every patient shared the wish to be updated about every small detail in their treatment process. Apart from clear communication, thus, adapting the treatment plan and the level of information to the patient's needs was a highly appreciated need. The latter is illustrated in the following quote:

"I think that's the most important thing in such a field; that a patient doesn't feel as if a doctor is thinking: 'Oh, I've studied for so many years, this is in my book. Oh, if disease A comes and situation B, I have to respond C.' You know - just almost like some kind of table. While if you really see: 'O, wait, I see that that person is struggling with it, well then I will wait a little longer to give you more information.' Instead of showing a lot of information, while the person is really like: 'I don't follow half of it'." (Patient JK)

The patient-need described in the quote above – having the feeling that the information or the treatment plan is adjusted to the patient's needs – is closely related to the elements we found with regards to what doctors need to learn within this subcategory according to patients. Doctors should, patients told us, learn not only what to tell and what not to tell, but also *how* to provide information to their patients and adjust it to their cognitive capacity. An example can be found in the quote underneath:

"That one is able to present complex material in a way that is understandable to the patient. I think that is very important ." (Patient WD)

A final skill that doctors could still develop more is their ability or the courage to ask patients about their personal life, needs and preferences, and subsequently to support them to feel in control of their disease (as far as possible), their treatment and their situation. In other words, the true skill of shared decision making in many cases still leaves room for improvement and is considered very important by patients, as the following quote illustrates:

"Yes, I think that that is even more important: to go and stand next to each other. And indeed go like: well, what do you want as a patient?" (Patient HK)

C. Setting

The final category of needs with regards to compassionate care can be described as the setting. As the category 'setting' didn't really show up in the answers to question (b) What do doctors need to learn according to patients to deliver care that is more compassionate?, for this category only some patient needs with regards to compassionate care were found. What is most important settings-wise, is that privacy should be guaranteed, especially for hard or personal subjects. Furthermore, a room should be furnished in a way that facilitates a conversation; an example can be that a family conversation takes place at a round table. Finally, patient mentioned a well-organized and smooth organization process as something that smoothens improves their experiences regarding compassionate care.

Last but not least, as an overarching result we found that it makes patients feel truly good and safe in their patient-physician contact when they feel a connection between them and the physician, as is described in the last quote of this section:

"It can also be nice if you have a good connection with a doctor, then it helps to ask more questions and come back next year or come back sooner. Or to sound the alarm when something is wrong." (Patient JK)

5.2. Resident interviews

We describe the results from our resident interviews according to four sub questions. The first two sub questions are about the barriers and facilitators for residents to deliver compassionate care. Our findings for those two sub questions can be divided into: *person-related, system-related, and patient-related* barriers and facilitators.

A. What are barriers according to residents to deliver compassionate care?

All the residents we spoke see compassion as a crucial part of their work. However, all of them encounter various barriers in delivering compassionate care.

Person-related barriers

Often mentioned person-related barriers are the residents own wellbeing or mental state of mind. Another personal aspect hindering the delivery of compassionate care is the fear of being overwhelmed by (too much) emotional involvement. Several residents mentioned how they don't want to get too emotionally involved with their patients, since they feel this might result in them getting emotionally exhausted.

System-related barriers

Residents often mentioned time pressure as barrier to deliver compassionate care, which is described in the quote below:

"That you make a little extra time by explaining a little longer, sitting there a little longer. Sometimes people just want to tell their story or something. Hear all that and don't be looking at your phone all the time or wanting to leave. And lack of time, that makes it difficult." (Resident KB)

Other system-related barriers to deliver compassionate care were administrative burden and a department culture focusing on efficiency and the medical-technical side of health care predominantly. Also, the fact that patients rotate between physicians and the way a work-week is scheduled, resulting in residents feeling tired at the end of the week, often make it harder for residents to be compassionate towards their patients.

Patient-related barriers

Residents said that inappropriate patient behavior challenged their ability to deliver compassionate care, for example when patients are arguing or 'bragging' about everything:

"If someone really blames you for things beforehand, then my compassion goes a little… - And then you go, then we just do it by the book." (Resident IvdO)

Other patient-related barriers for compassionate care are patients who have unexplainable symptoms or patient noncompliance.

B. What are facilitating factors according to residents to deliver compassionate care?

Person-related facilitators

Residents mentioned that their personality also plays a role in their (in)ability to deliver compassionate care. Some residents, like the one below, told us that is easy for them to deliver compassionate care, just because it is what they naturally do:

"Well, it goes kind of easy for me. It is in my character. It's not that I consciously think of every patient like, OK, now we're going to talk about it… - You know, it's kind of coming up naturally." (Resident AK)

Another person-related facilitator is that some residents consciously acknowledged and felt that the humanistic part of delivering care is part of their job; it is why they chose to do what they do. When attitudes like these are present within residents; they may serve as a facilitator to delivering compassionate care.

System-related facilitators

A system-related facilitator for the delivery of compassionate care is the department culture. The following quote illustrates this perfectly:

"That you can discuss everything. Actually your colleagues, a nice group of colleagues that makes of course that... – And yes, even if you had a few of those patients sometimes where you get a bit annoyed, that you then have a sounding board/. Then you can piss a little, joke to colleagues. Then you get a bit more cynical, but that way you can continue the rest of the afternoon a bit more lightheartedly. Of course that helps a lot." (Resident TW)

Other system-related facilitators mentioned are sufficient time and frequent contact with the same patient.

Patient-related facilitators

Important patient-related facilitators are a connection between the patient and the physician and, very often mentioned, the seriousness of the situation:

"If there is a really bad situation, you put more effort into the patients, you make more time and I think that that it makes you more conscious about making those feelings discussable." (Resident AK)

Furthermore, residents mentioned that it helps in being compassionate when patients are able to understand the ins and outs of medicine. Somehow this decreases discrepancies between physicians and their patients.

C. What did residents learn about compassion in their curriculum and how did they experience the educational methods used?

Residents noted that compassion was often not explicitly addressed in the curriculum. Intervision and seminars on practicing communication skills are present in the current curricula and most of the time these were appreciated by the residents.

What seemed to be the most prominent way in which residents learned about compassionate care was looking at role models: their supervisors. Although many supervisors did not serve a proper role model function, role modelling is a good way to learn how to behave in a compassionate way (or how not to):

"With every supervisor you go like, when you see how they communicate with patients, that you think: 'I really like this and I want to do it in the same way'. And with certain things you think: 'I never ever want to do it like that. For God's sake, please have someone say it to me when I talk to a patient like that." (Resident TW)

D. Which learning needs do residents have regarding compassionate care and what are their preferences regarding educational methods or interventions?

The bottom line is that the training should not be "an extra something they need to do". There is a strong aversion for learning "tricks" on how one can pretend to be compassionate and in general residents also do not like to be patronized. What they would really like to learn are useful practical tips in how they can deliver compassionate care *despite of* their demanding work environments. One resident describes this need as follows:

"But yeah, that, how do you that and how can you achieve it as quickly as possible so that it actually becomes a habit or automatism? That it is not some something that you need to put extra energy into at that moment." (Resident ND)

Other learning needs residents mentioned were to reflect and discuss real time situations with their fellow residents, to learn more about what it really means to be compassionate, to adjust their behavior and

information to the patient's needs and to learn more about insights and (common or their own) beliefs and misconceptions about the construct.

6. Future steps

In October and November 2020 we will pilot test and evaluate the intervention as part of the Residents Generic Competencies Curriculum ("Discipline Overstijgend Onderwijs") within Amsterdam UMC. The outcomes of the project will result in two scientific articles: (1) the development and evaluation of the intervention, and (2) the meaning and experience of compassion of patients and residents. The collaboration of our project has proven to be very energetic, fruitful, creative and productive. In order to pursue this collaboration we are discovering funding opportunities that will help us to be able to implement the intervention on a larger scale.

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Appendix I. – Search strategies per database

PubMed
(((((((("Compassionate care"[tiab]) OR Compassion[tiab]) OR Empathy[tiab]))) AND ((((((((((((((health personnel[MeSH]) OR "Health Care worker*") OR "Healthcare worker*") OR "Health Care Professional*") OR "Healthcare Professional*") OR "Healthcare provider*") OR Professional*) OR Doctor*) OR Nurse*) OR Physician*) OR Clinician*) OR "Medical student*") OR "Nurse student*") OR "Nursing student*") OR "Medical trainee*") OR Resident*)))) AND ((((((((((((Improv*) OR Enhanc*) OR Promot*) OR Intervention*) OR Preserv*) OR Embed*) OR Train*) OR Teach*) OR Impact) OR Education*) OR Program*) OR Method*) OR Workshop*) OR Module*)))
Filter: Clinical Study

Scopus
(compassion OR compassionate OR empathy) AND (care OR healthcare OR doctor* OR nurse* OR "medical student*" OR "nursing student*") AND (intervention OR train* OR enhanc* OR promot* OR educat*)
In title and/or abstract.
Article type: Research articles

PsycINFO
ab((((((((((((((health personnel) OR "Health Care worker*") OR "Healthcare worker*") OR "Health Care Professional*") OR "Healthcare Professional*") OR "Healthcare provider*") OR Professional*) OR Doctor*) OR Nurse*) OR Physician*) OR Clinician*) OR "Medical student*") OR "Nurse student*") OR "Nursing student*") OR "Medical trainee*") OR Resident*) AND ab((((("Compassionate care") OR Compassion) OR Empathy) OR "Compassionate healthcare") AND ab((((((((((((Improv*) OR Enhanc*) OR Promot*) OR Intervention*) OR Preserv*) OR Embed*) OR Train*) OR Teach*) OR Impact) OR Education*) OR Program*) OR Method*) OR Workshop*) OR Module*)
In abstract.
Filters: (empathy OR intervention OR compassion) NOT (burnout AND vicarious traumatization)

Appendix II. – The Intervention

Program

DAY 1 – 4 hours	
Introduction - Introduction of teachers and participants - Explaining the program of the training - Warm up	30 min.
Background of compassion. Subjects: - What is compassion? - Being compassionate is already a part of you - Effects of compassionate care	20 min.
Individuals' convictions and beliefs regarding compassion - Taking position - Breaking free from	60 min.
Break	20 min.
Determining "the right middle" in being compassionate	50 min.
Role of one's own emotions in the ability to be compassionate - Breathing exercise - Attention exercise	45 min.
Wrap-up	15 min.
TOTAL	**240 min.**

PRACTICAL EXERCISE
Observing and being observed delivering compassionate patientcare.

DAY 2 – 4 hours	
Opening day 2 - Experiences with compassionate care after the first day - inventarisation of (learning) needs and preferences	10 min.
Discussing the practical exercise - Exchanging experiences in pairs - Plenary discussion	55 min.
Break	5 min.
Perspective/ needs patients - Interview with patient about compassionate care	90 min.
Break	15 min.
How to put compassionate care into practice? - Dilemma game - Departments' culture	50 min.
Wrap-up	15 min.
TOTAL	**240 min.**

FOLLOW UP MEETING – 2 hours
- Reflecting on delivering compassionate care in practice - Repeating exercises (according to needs/ preferences): determining "the right middle", or attention exercise.