The art of medicine

The suffering of physicians

During the past 40 years, we have become all too familiar with the dehumanisation of modern medicine: new technologies have altered the relationship between doctor and patient; specialised physicians know more and more about less and less; doctors treat diseases rather than people; medical schools teach the science but ignore the art of medicine; medical technology has outpaced moral understanding; and hospitals have become cold, impersonal mazes. This critique of dehumanised medicine and its ethical quandaries helped give rise to the development of bioethics and the medical humanities. And reform-minded educators have pressed the case for respecting the patient as a person, and for taking care of the whole person through active listening, compassionate presence, and collaborative decision making.

But the patient is not the only "whole person" in the consulting room. Evidence in recent years suggests that physicians also suffer from the dehumanisation of modern medicine. There are many signs that being a physician today is not good for your health: rates of anxiety, depression, and suicide are higher among physicians than in the general population. Job stress among generalist physicians in the USA is directly linked to measures of poorer physical and mental health. In the USA, about 15% of physicians will be impaired at some point in their careers, which means that they will be unable to meet professional obligations, in some cases due to mental illness, drug dependency, or alcoholism. One index of these problems—burnout—has received a great deal of recent attention. Indeed, numerous studies in US health science centres have confirmed what everyone has known for years—namely, that rates of burnout among medical students, residents, and faculty are a cause for concern.

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Burnout is not just an American problem. The Annual Meeting of the European Forum of Medical Associations and WHO, which is comprised of more than 40 European countries, met in Berlin in 2003 and called for more attention to physician burnout. In Australasia, emergency physicians and hospital consultants have been found to have high rates of burnout. Burnout among Japanese physicians has been called a "catastrophic collapse of morale". Another study reports that cardiology residents in Argentina suffer from burnout. This list could go on. Burnout is usually identified by three major symptoms: emotional exhaustion, depersonalisation, and decreased sense of self-efficacy. But burnout, we believe, is also a euphemism for what many physicians experience as a crisis of meaning and identity. A deeper understanding of burnout, we suggest, begins by acknowledging its context: physicians in many developed countries live and work in a technocentric, dehumanised, and financially driven environment, often within a broken and unjust system of health care. Those who work in academic health centres face institutional strains caused by the marketplace restructuring of health care, a shrinking safety net, more indigent patients to care for, and increasing competition for research funding. Their counterparts in developing countries often work under conditions that are shaped by inadequate resources, a shortage of health workers, and weak health-care systems. In different settings worldwide, therefore, physicians may work under conditions that increasingly prevent them from living up to their highest ideals. This is the background for grasping the valuable definition of Christina Maslach and Michael Leiter: "Burnout is the index of dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will—and erosion of the human soul."

One useful lens through which to view physician burnout is Theodor Adorno's notion of "ethical violence". In *Problems of Moral Philosophy*, Adorno called attention to a cruel aspect of collectively enforced morality. In his view, any set of ethical maxims or rules must be appropriable by individuals "in a living way". When an ethical norm "turns out, within existing social conditions, to be impossible to appropriate", the result is ethical violence. Institutions that ignore existing social conditions and rigidly enforce moral rules are, according to this view, perpetrating violence on those expected to do the impossible. Of course, Adorno had political history in mind, but his analysis of ethical violence can help us understand the suffering of physicians. Medicine is filled with many people of good will, integrity, and commitment who strive to provide compassionate and

ethically sound care, teach and mentor students, maintain scientific standards of practice, keep current with the most recent literature in one's field, and undertake biomedical research. These are all good and necessary activities. Yet current conditions can limit the ability of physicians to live up to these requirements and ideals, which in some individuals creates a cognitive dissonance that leads to cynicism, disillusionment, self-doubt, dis-ease, and a retreat from ideals. When institutions do not acknowledge the gap between ideals and the various limiting conditions of work, they unwittingly allow ethical violence to undermine health and wellbeing.

In this context, how can we humanise the experience of doctoring? One answer points to the need for structural and cultural change in large institutions where doctors work—for example, in hospitals, health science centres, or health maintenance organisations. The disillusionment of many physicians in many countries derives from the imbalance between the energy and focus devoted to strategic planning and generating a financial surplus and the attention given to the primary goals of professionalism and patients' care. Another answer involves promoting activities that encourage self-care, reflection, and development. Academic and other health-care institutions and professional organisations need to provide opportunities that support and guide physicians in their search for meaning, wellbeing, and self-care. Physicians need compassionate and non-judgmental listeners. This is especially true, for example, among physicians who take care of seriously ill and dying patients. Our work in this area has shown that first-person narratives by such physicians can reveal some important themes that deserve increased attention: unmourned losses; unrealistic expectations; uncertainty in relating; unasked questions; and unexplained suffering and death.

Unmourned losses can mount up when taking care of critically ill and dying patients. It is no secret that physicians tend to suppress their feelings to maintain their composure and ability to take care of the next patient. But the consequences of neither talking to anyone nor allowing oneself to feel the impact of these experiences often results in an accumulation of pent up emotion and unmourned grief. Similarly, the unrealistic expectations that physicians encounter can also be challenging. In *Just Here Trying to Save a Few Lives* emergency medicine physician Pamela Grim writes about informing a family of the death of their loved one: "This is the time when people hate you as a doctor. You have failed, flunked, dropped the ball. You should be sued—you will be sued. You are a quack…And a part of you believes all this because no matter how sure thing the death was, some part of you believes you really can perform miracles."

Uncertainty in relating is another key issue. In 1979, Lawrence Grouse inaugurated the "A Piece of My Mind" column in *JAMA* and later wrote a piece titled "The Lie" for the column. He recounted the story of Annie who came into the emergency room having been kicked in the stomach by her horse. As Annie bled into her abdomen and went into shock, she asks Grouse "Will I live?" Grouse thought she was dying but assured her that she would live. When Grouse later told Annie that he had thought that she was, in fact, going to die, Annie felt betrayed and angry. Did Grouse do the right thing? This case is not simply about the ethics of disclosure—it is also about guilt, shame, regret, and the sheer uncertainty physicians face in such pressing circumstances.

The difficulty in having open conversations with critically ill patients is illustrated in the posthumous memoir of the physician Steven Hsi, *Closing the Chart: A Dying Physician Examines Family, Faith, and Medicine*. Despite the compassionate care he received, Hsi was most troubled by his physicians' failure to ask the crucial questions: "What has this disease done to your life? What has it done to your family? What has it done to your work? What has it done to your spirit?" As suggested by Hsi, physicians faced with questions of unexplained suffering and death are loathe to ask existential questions that have no biomedical answer. Some physicians, as David Smith points out in *Partnership with the Dying*, may hold an unspoken practical theodicy, a way of relieving the shame and guilt of failure by leaving matters ultimately to God or a higher power. But they tend to keep these thoughts to themselves.

There are no quick fixes for the suffering of physicians, just as there are no quick fixes for the suffering of patients. But we suggest that caring, compassion, and conversation are important in both contexts. Helping to recover meaning and to avoid burnout among vulnerable physicians involves respect for physicians' stories, which in turn requires that physicians tell their stories. But to whom should physicians tell their stories? In some instances, physicians themselves need professional care. Alternatively, or in addition to obtaining therapy for themselves, doctors must seek—and institutions must provide—avenues for dialogue that allow renewal, self-care, mutual support, and reflection. Professional associations and institutions must create better working conditions and provide programmes that support stress-reduction, healthy lifestyle choices, personal reflection, and self-care. In turn, self-care must be seen not as an option but as an obligation. The obligation to care for the patient entails the obligation to care for the self, for when the health of the physician is compromised, is not the quality of patients' care also compromised? We are just beginning to realise that humanising medicine depends in no small part on recovering the humanity of physicians.

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