



SHORT NOTE

Quality Care and the Soul of the Physician

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Abstract

Quality care for the patient is the source of vocational satisfaction and also a measure of physician well-being. Both are impacted positively by the spiritual life of physicians which contributes significantly to resiliency in the midst of current stresses in medical care. Additionally, a majority of patients identify spiritually integrated care as desirable in their physician's treatment. The author examines qualities of vulnerability, humility and compassion integral to the person of the physician who offers quality care to patients and which is prophylactic to higher risk of suicide among medical practitioners compared to other professionals.

The original intent of the Hippocratic oath and the desire for a genuinely humane healing partnership has been under siege for some time now. Since Henry Ford introduced the mass assembly line, business has sought increasing efficiency in production with the consequence of increasing depersonalization of the healing relationship. The advent of computers and health care management as a business has reconfigured physicians to more and more cumbersome record-keeping 'providers' who in some cases are under pressure to see a new patient every 8-12 minutes.

A surgeon bemoaned, "I am measured on productivity and they want to keep track of my time also in order to find ways to squeeze more out of me". Meanwhile, patients have morphed into passive 'consumers' who are allowed one problem per visit and conversation must be kept to a minimum. This helps us understand why 67% of physicians, interrupt their patients [median = 11 seconds] after asking them what problem brings them for a consultation [1,2].

A 2018 survey of 15,000 doctors in the United States, reported that 42% of physicians feel burned out, with the highest rates being in the specialties of critical care (48%), neurology (48%) and family medicine (47%) [3]. This is twice the rate existing among professionals in

other fields [4]. And there does not appear to be significant change over the past 40 years. A longitudinal study published in 2017 calculated that annual productivity loss of medical services in the United States that is attributable to burnout may be equivalent to eliminating the graduating classes of seven medical schools [5].

But overwork is not all that is going on. Dr. Richard Gunderman suggests that physician fatigue and burnout are not a function of enduring the situational factors and stresses of medicine, but are more closely related to the physician's own neglected soul. Gradually going unnoticed and untended over time, the gradual loss of meaning and betrayal of the personal nature of the healing vocation in the corporatizing of medical care is giving rise to the spiritual pain inherent to a loss of vocational satisfaction that comes from being able to care for patients.

"[B]urnout at its deepest level is not the result of some train wreck of examinations, long call shifts, or poor clinical evaluations. It is the sum total of hundreds and thousands of tiny betrayals of purpose, each one so minute that it hardly attracts notice. [Physicians] find themselves expressing amazement and disgust at how far they've veered from their primary purpose" [6].

Gunderman's observation identifies spiritual pain accumulating from a thousand endured papercuts of conscience that brings to mind the words of playwright Anton Chekhov. "Any idiot can face a crisis-it's this day-to-day living that wears you out [7]". Why? Because the action and intention of being fully human and personal in the healing partnership is a pre-requisite for sustaining quality of care and vocational satisfaction over time.

The healing partnership is not a one-way technical exchange, as the language of “providers and consumers” and emphasis on “best practices” would lead us to believe, nor can it be continually shaped into corporate service as a “healthcare mill” to meet financial demands without losing its personal dimension.

A distinguished graduate of Harvard Medical School and member of its faculty, Dr. Francis W. Peabody served in war and disaster conditions around the world, contributed significantly to research in polio and typhoid, survived bouts of serious illnesses and was a beloved mentor for many a young doctor. In his lecture to the 1926 graduating class of Harvard Medical School shortly before his death, he made an oft-quoted observation that remains as true today as it was then, which takes us to the heart of the spiritual problem of physician vocation and patient care which is increasingly under assault. The ethics, vocational fulfillment and secret of patient care can be summed up in one word. He writes,

“The personal bond [with the patient] forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for... *the secret of the care of the patient is in caring for the patient* [8]”. [my emphasis]

“The secret of the care of the patient is in caring for the patient”. Lest we underestimate the profound observation captured by Dr. Peabody’s double entendre, let us call caring for the patient what it actually is: “Love”. The healing partnership grows out of and depends on love, but not any old kind of love. The ancient words of St. John the Apostle orient us to the fulcrum upon which success or failure in love depends: “In this is love, not that we love God but that God first loved us... [9] Medicine is in its largest context, an act of synergy in partnership with the Only Healer and Lover of Humankind, rather than one of individualistic self-sufficiency or technical expertise.

The Importance of Spiritual Care

By focusing purely on the symptoms of the physical body or psychiatric symptoms apart from the full person of the patient, which includes the larger spiritual dimension, the more comprehensive etiology behind of the identifying symptoms is easily missed. Jean Claude-Larchet points to the vital need to view the patient first and foremost as person.

The body does not only express the person; to a certain extent it is the person. The person does not merely *have* a body, he or she *is* a body, even though the person as such infinitely transcends bodily limits. This is why everything that involves the body involves the person as a whole. By refusing to consider the spiritual dimension of human persons when we seek to alleviate their physical ailments, we do them immeasurable harm [10].

“To ignore the spiritual aspect of illness is to ignore a significant dimension of the experience [11]”. Surveys have consistently revealed patients’ desire for their physicians to show interest in their spiritual life [12], especially those suffering from cancer and in palliative care facing end of life issues [13]. Data published in the Archives of Internal Medicine reported that 85% of critically ill patients report trust in their physician increases when the physician addresses their spiritual concerns and 95% of patients for whom spirituality is important want their physicians integrate this into their medical care. Remarkably, even 50% of those who stated spirituality was not important, still said they wanted their physician to be sensitive to their spiritual needs and integrate this into their care [14].

How can this be done if spiritual health is not a central organizing factor in the life of the physician, practically and theoretically shaping how he or she sees the world and views the patient in the larger context of spiritual meaning? [15] Henri Nouwen in his classic book, “The Wounded Healer” made the observation: “You cannot expect someone to lead you out of the desert unless the person has been there [16]”. No one should travel alone.

This is even more critical for physicians who are often isolated and attempt to treat themselves rather than trust another physician to care for them, let alone seek out a spiritual physician for their own souls. Yet finding spiritual healing for the physician’s own soul is not only essential for resilience and well-being, but an essential ingredient in the healing partnership.

The Stigma that Isolates

There is no question that physicians are under constant pressure to avoid harm coming to patients. Thirty-year-old data from the Institute of Medicine’s 1999 reports medical error is responsible for 98,000 deaths annually [17]. A more recent conservative estimate is 200-300,000 deaths annually, or about 700 people a day, making medical error the third leading cause of death in the U.S. Mayo Clinic physician Steve Swenson adds to that number, “And most of those have a second victim: the nurses, doctors, social workers, managers, pharmacists involved in their care [18]”.

But what about care for themselves? Neglect of one’s spiritual life and shared community is integral to emotional exhaustion and burn-out. Douglas Graham, MD with the Physician Support Program in British Columbia identified what he calls the “five soul killers” of physicians: isolation, fear, anger, exhaustion and shame. The Canadian Medical Association Journal recently reported that depression affects 39% of physicians at some point in their career, twice the rate of the general population [19]. Part of the reason for this is a medical culture which has tended to avoid the stigma of vulnerability.

Forty years ago, in a special article in a 1977 issue of JAMA on physician suicide, the authors pointed to what they called the “psychological barrier” toward recognizing personal illness that is related to a certain personal ethos that mitigates against physicians seeking help.

Doctors tend to regard personal illness as weakness, a narcissistic injury which triggers defensive psychic regression and impairs reality-appreciation, allowing the doctor to deny a suicidal danger that would be quickly detected in a patient. This denial is often supported by the doctor’s fantasy that he or she is a miraculous healer, immune to disease [20].

Fear that one’s professional colleagues may view mental suffering in the physician as a sign of weakness creates a climate of secrecy and shame for one who is by vocation, called to offer healing to others. This is particularly difficult for female physicians in what has traditionally been a male dominated profession. In a survey of 2,100 female physicians, one third reported receiving a formal mental health diagnosis since medical school, but only 6% disclosed their diagnoses to state licensing boards [20]. Most of those who self-identified also tried to manage their problem on their own, including writing their own prescriptions, rather than seeking professional support and consultation.

Physician Suicide

Suicide is usually associated with severe depression, anxiety and cognitive narrowing to myopic hopelessness regarding options. Researchers in the Interpersonal theory of suicide have pointed to “thwarted belongingness and perceived burdensomeness (and hopelessness about these states) [21]” in conjunction with capability, as the most dangerous combination of variables predicting suicide potential. Physicians reporting suicidal ideation often lack personal supports [22]. Those who recently considered suicide were found to be “five times more likely to report personal problems, three times more likely to report financial problems, and roughly two times more likely to report health or work problems as compared with those not thinking about suicide [23].

Some 300-400 U.S. physicians die by suicide every year [24]--the loss of a doctor a day [25]. Suicide rates for male physicians are 70% higher than the general population (including other professionals). The numbers for women physicians are even higher: 250-400% greater than comparable professionals [26]. Isolation, loss of meaning and unwillingness to tolerate the vulnerability involved in seeking care for oneself, particularly soul care, is one of the key factors in why the medical profession consistently hovers near the top of occupations with the highest risk of death by suicide.

Suffering in isolation is an especially serious problem for physicians in so far as evidence suggests that physi-

cians do not adequately recognize and treat depression in their patients [26] let alone in themselves. Dr. Christine Moutier reported in a psychological autopsy that of those physicians who died from suicide, relatively few were being treated by psychiatrists yet they were 20-40 times more likely than the general population to have taken benzodiazepines, barbiturates or antipsychotics prior to death. They were also three times more likely to have been experiencing problems at work [26].

Is it possible to truly care for another’s health if one is not receptive to the same kind of care? Interestingly, as part of Christine Moutier’s research at a large University Medical program, when faculty physicians and medical students were able to complete on-line questionnaires and engage in anonymous dialogues with counselors about their personal situation it resulted in a 40% increase in medical students seeking help and 230 referrals of doctors for treatment. Since the program began 11 years ago, there has been only one death by suicide among the faculty physicians compared to 13 who suicided during over the previous 15 years [26].

The Physician as Person

Dr. Damon Dagnon, in an article in the Canadian Journal of Medical Education, reflecting on the person of the physician, identified three key “principles” which are essential to the discussion of physician resilience and patient care. All three are congruent with and may be significantly enhanced by a perspective which considers the spiritual life of the physician as a critical variable in both physician resiliency, vocational satisfaction and quality of medical care for the patient.

“The first principle of the “physician as person” is that encounters with patients occur primarily between two people

Drawing from his own experiences, he writes,

My defining and life-changing moment came when my three-year-old son died from cancer. Today, not one shift goes by that my tragic life experience hasn’t affected at least one patient encounter on a daily basis. I am a different doctor having experienced the extreme challenges of living in a hospital with a critically ill child, and, following his death, continuing to struggle with the hole that is forever in my heart. Listening to patients’ personal stories of their illness, I often find myself sitting on the side of their ER bed trying to make a more human connection with the person (the patient) beside me [27].

Above all, the healing partnership, in contrast to being merely a technical procedure, is sustained by its personal quality. The difference between authentic dialogue with the patient and the monologue of technical doing is that monologue leaves the entire burden of success irrationally on the physician as an expert and a “human doing” rather than a human *being* in communion with God and the person.

The Power of Relationship

A man with terminal cancer insisted that he wanted his physicians to help him end his life rather than face the prospects of helplessness and painful death with his incurable cancer. Psychiatrists who were sent to talk with him failed to convince him otherwise. Being knowledgeable and insistent about what he wanted, and having all his critical mental faculties intact, while in the hospital he managed to cut the brachial arteries in each of his arms. He was saved against his will and afterwards a young psychiatric resident came to talk with him.

Rather than eclipsing him behind diagnostic categories and theories he encountered him as a person. When he found out he was a professor of philosophy, he did a remarkable thing. He asked him if he would be willing to teach him what he was learning about dying. He became a co-pilgrim willing to learn from this man's vulnerability and mindfulness of the mystery each of us will face. He allowed himself to be affected by the deeper spiritual meaning emerging from this man's personhood which had been hidden and unnamed within the desire to kill himself.

This invitation to genuine relationship reoriented everything. No longer alone, without purpose, and unable to contribute, the man's attentive mindfulness of approaching death in the face of his suffering and helplessness had potential for revealing new meaning in personal relationship. Medically speaking, he was still terminal. Pain remained in his body, but he was no longer suicidally oriented in his soul. In death, he was turned toward life again. The psychiatric resident's willingness to be vulnerable and have an authentic dialogue with his patient as a real person, proved transformative for both of them.

Is dying simply a matter of asking for technical assistance to carry out one's wishes? Or could it be that like all of our suffering, both doctor and patient are knowingly and unknowingly crying out for a response to the deeper spiritual questions of the human heart that lives for meaning, purpose and to be visible for an other in love? What if the physician overlooks this dimension? What if the physician is overlooking this deeper reality in his or her own life? How does this affect the healing partnership?

In between the ontological bookends of our coming into created existence and exiting it in death, we discover the unfathomable joy and gratefulness for the privilege and response-ability of life and love that go immeasurably beyond what science can predict and control. As the philosopher Ludwig Wittgenstein observed, "It is not *how* things are in the world that is mystical, but *that* it exists [28]". This is the profound question our hearts yearn to approach in the vulnerability that lies at the heart of every intimate encounter.

A second principle of the physician as person framework, Dagnon describes as

"The power of being vulnerable, of opening up and letting patients and colleagues see your imperfect humanity - apologizing, having tears, and sharing moments of pain - cannot be overstated and further reinforces the physician as person".

He writes,

It is no coincidence that humanity and humility share the same Latin roots. Yes, it is our duty as physicians to care for our patients and focus on their needs, but somehow in that commitment, we run the risk of losing out on being able to communicate our uncertainties, disappointments, failures, and challenges. As a bereaved parent, looking back at my experiences in the hospital years ago, the most powerful connections I made with certain doctors was in large part due to their ability to be vulnerable with my wife and me. Towards the end of my son's life, they did not have any answers and made some mistakes, and because they were vulnerable with us, we shared the burden of the difficulties together [27].

Failing this, the physician who does not recognize God as the healer and death as the revealer of humility, ends up in a struggle focused on denying death by acting as if everything is up to him or her, opening the door to burnout and spiritual isolation. This is something that happens equally to us who proclaim God with our lips, but continue to unconsciously function otherwise - a situation which Parker Palmer calls "functional atheism [29]".

Dr. Atul Gawande in his N.Y. Times well-written and humane bestseller *Being Mortal: Medicine and What Matters in the End*, describes how recurring dreams captured this unconscious fear of vulnerability in him.

"I am in a profession that has succeeded because of its ability to fix. If your problem is fixable, we know just what to do. But if it's not? The fact that we have had no adequate answers to this question is troubling and has caused callousness, inhumanity, and extraordinary suffering. Dying and death confront every new doctor and nurse. The first times, some cry. Some shut down. Some hardly notice. When I saw my first death, I was too guarded to cry. But I dream about them. I had recurring nightmares in which I'd find my patients' corpses in my house-in my own bed. 'How did he get here?' I'd wonder in panic. I knew I would be in huge trouble, maybe criminal trouble, if I didn't get the body back to the hospital without getting caught. I'd try to lift it into the back of my car, but it would be too heavy. Or I'd get it in, only to find blood seeping out like black oil until it overflowed the trunk. Or I'd actually get the corpse to the hospital and onto a gurney, and I'd push it down hall after hall, trying and failing to find the room where the

person used to be. “Hey!” someone would shout and start chasing me. I’d wake up next to my wife in the dark, clammy and tachycardic”.

I will forever be grateful to my friend and colleague George Zubowicz, MD, who afforded me the gift of friendship and witnessing the power of watchfulness, repentance and love as he shared his experience of what I call humiliation [30] under the direction of the cancer who was his teacher in his final days.

Respected and beloved, George was a psychiatrist who had begun his career as a thoracic surgeon and later served many years as medical director of the Bradley Center psychiatric hospital and on the out-patient staff of the Pastoral Institute where we became friends. We would stop by each other’s office occasionally for conversations about psychotherapy, good books and to talk about the mysteries of life. [This was before increasing corporate financial expectations and managed care requirements eliminated the time for personal connections in between patients!].

I knew some of his remarkable life history from our conversations together - how he had traded most of his possessions as a boy to buy books to satisfy his voracious intellectual appetite after he had devoured a Dostoevsky novel with intense interest. He was equally on fire for athletic prowess. Once he shared with me that when he was training for the Olympics, something was revealed to him in an unforgettable way. He had been pushing himself to the limit physically in his training when he heard an audible voice within him that said quietly and with an authority that did not coerce or force, “You can continue, but you will die”. He stopped.

Ever the scientist, practical explorer and closet mystic, he was still discovering things about the limits of human power and the importance of vulnerability and compassion in his life by undergoing self-examination up to his last breath. Like St. Augustine, he had learned the value of ‘becoming a question for myself’. Under the onslaught of cancer, which relentlessly sapped away the last of his physical strength daily, his mind remained vigilant for every lesson he could learn.

Having discovered early in life that his body would be obedient to his will to the point of sacrificing itself entirely, what did it now mean that his will remained strong while his body refused to obey it? He was powerless to cure himself or to prolong his life. In his last days, on my visits with him we would talk together about what he was learning in the undiscovered country along a road less travelled. This man, who had been still competing and winning senior Olympic swim meets in Europe in his eighties, who as they say “had never been sick a day in his life”, described what he was now experiencing as his body grew weaker and weaker.

At one point, I said to him, “It seems to me that your biggest surprise in all this is that your ‘I’ which does not

feel weak at all, can exist in this body which cannot even find the strength to make it to the bathroom”.

He responded with excitement and vigor from his frail body, in his thick Russian accent and rational analytical approach, “That is correct. You understand me exactly!” Then he told me, “You know I had a contract for many years with the nursing home. I would visit each room and ask the person, ‘How are you doing?’ and the person would say, ‘Fine.’ And I would write this in my book and go on to the next one. You hardly have time to do more than that, but now that I have had this weakness, I realize that I did not *really* ask them how they were. This is because they were sick and helpless and I had never felt this in my life”. In a different voice, softer, but with humility, compassion and a kind of wistfulness, he continued, “Now I understand what this means. Can you imagine that?”

Then in a clear, impassioned and sober voice, with a touch of remorse he added, “For fifty years I have been a psychiatrist, and I did not really know how to ask people how they are in a way that *really* means it”. The importance of vulnerability and compassion in resilience and sustaining the healing partnership cannot be overemphasized.

Along with humility, vulnerability and person-to-person relationship, the third principle of Dagnon’s framework is

“that the physician’s personal and professional life should avoid being compartmentalized”.

He writes,

As physicians, it is unhealthy to be a different person in the professional context than who we are in the personal context. It is also not natural or wholesome, and yet it can be frequently found as an insidious and powerful part of physician culture. Listening to patients, taking a history, performing a physical exam, embarking on a management plan, and communicating the essential parts of a clinical encounter must not be a mechanistic or strictly professional interaction that is separated from ourselves as people. To do these tasks effectively, a humanistic approach that makes a connection with the person (the patient) in front of you is what’s needed, and in my opinion, highly valuable [27].

All medicines, whether physical and psychological, come with side-effects. What protects us from pain and loss, including all the passions and temptations we use to avoid reality which are the subject of spiritual struggles of conscience, create blocks to the deeper life of love and meaning for which we yearn. This is because our deeper personal life is not acquired by achieving optimal physical health, a longer life span, satisfaction of physical appetites and egoistic desires, but by overcoming the self-centered willfulness and egoism of

individualistic false selves in favor of love and care for others which gives meaning to life.

Austrian psychiatrist Viktor Frankl who survived the German concentration camp, points to the existential heart of the healing relationship when he observes that “the more one forgets himself-by giving himself... to another person to love --the more human he is and the more he actualizes himself [31]. It is this essential action of loving the patient which, as Dr. Peabody observed, that is the secret to caring for the patient and to the vocational satisfaction of the physician. Otherwise, as Frankl emphasizes, we cannot truly “see” the patient.

“No one can become fully aware of the very essence of another human being unless he loves him. By his love he is enabled to see the essential traits and features in the beloved person; and even more, he sees that which is potential in him, which is not yet actualized but yet ought to be actualized [31]”.

Dr. Leonard Goldner was the James B. Duke Professor and later, Chairman Emeritus of the Duke University Medical Center Orthopedics Department and an internationally acclaimed surgeon and author. In a 2001 article from the *American Journal of Orthopedics*, he reflected on the humanity of physicians and the vital importance of the relationship of care established with each patient as well as balance in the physician’s life, which are hallmarks of resilience. He titled his reflections, “Attitude” and recognized that “You owe your patients full-time care, but you also owe time to yourself and your family [32]”. He recognized a need for ongoing self-examination and humility when he suggests,

You must be able to analyze your feelings, your fatigue symptoms, and your physical and emotional capabilities. You must also recognize that, occasionally, your patient’s problems are not solvable. [But what a patient can expect] is to receive your personal interest, undivided attention, a courteous, positive response to questions, a ‘hands-on’ examination, and an explanation of a tentative diagnosis [32].

He points to the person of the physician and reminds his colleagues that empathy, personal relationship and compassion are central to the physician’s well-being and must be evident in even the smallest of gestures with patients because what the patient hears accounts for only 10% of the total information imparted, and the overall attitude, body movements, eye contact, method of greeting the patient, and way of talking while either standing or sitting account for 50% of the physician impression on the patient [32].

Finally, he asks physicians to always remember when communication with a patient becomes difficult, “the patient is sick, not you”.

Among the attributes in his obituary, published in 2006 in *the Journal of Bone and Joint Surgery*, it was

noted that

Dr. Goldner was a complete physician. He taught how to evaluate patients through talking to them and also listening to them, learning not only about their complaints and mechanism of injury but also about their work, family, social behavior and desires and expectations. He never looked at radiographs or other images until he had obtained a complete history and performed a very thorough examination. By his practice, Dr. Goldner proved that a warm and compassionate engagement with the patient was 90% responsible for gaining the respect of the patient even if a precise diagnosis was not made. He demonstrated that appropriate facial expressions, body movement, a calm voice, and an overall friendly attitude were the main ingredients of a good and lasting doctor-patient relationship. He never appeared hurried or rushed and his colleagues never heard him speak in an angry or harsh voice to a patient, nurse, attendant or to anyone around him.

That’s how I remember him as well. When he found out that my grandfather had sold his house to pay my mother’s medical bills, he refused to charge her for his professional services for the rest of her life – an extraordinary gesture that continued for some fifteen years and was my first living icon of the “holy unmercenary physician” before I discovered saints Cosmas and Damian. His wife visited my mother regularly in the nursing home until her death and their caring relationship, more than any physical medicine, were part of what sustained her hope in the face of a relentless series of medical defeats. At her funeral his sober humility and the quiet words he spoke to me I will never forget. “Jean was the sickest patient we ever treated at Duke Medical Center and it broke my heart that nothing we ever did helped her”.

What Drs. Dagnon, Zubowicz, Gawande, Goldner have articulated and embodied-the virtues of humility, vulnerability, and compassion remain the essential means for sustaining the highest quality care in the healing partnership and the most reliable path for fulfilling the vocation of the good physician which together, are the best foundation for resiliency in the face of increasing corporate demands for maximizing efficiency to support fiscal solvency.

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