The lived experience of physicians: A call for research

While on the one hand we are witnessing the implementation of standardized care, the increasing influence of economic rationality and measurement of efficacy in health care systems, the promotion of evidence-based medicine (EBM) and the scientification/technologization of the art of medicine, a new paradigm has on the other hand emerged. In this paradigm, the patient is placed in the "centre" *(patient-centredness)* and should be approached as a whole person through practicing compassionate and empathic medical care, and sharing power and responsibility[1]. What we tend to forget in this story, however, is that the physician is also involved as a whole person, subjected to his "inner" (psychic) and "outer world" (context), and is thus an essential part of the provided care.

There is evidence that physicians working in different settings worldwide experience crises (e. g. of meaning, values or identity) and suffer (e. g. from anxiety, depression or drug dependency and alcoholism)[2,3]. For example, a 2008 article reported a "catastrophic collapse of morale" among hospital physicians in Japan; according to the authors, physicians' loss of morale has various but not unrelated possible causes including *budget constraints, shortage of physicians, long working hours, hostile medias, increasing lawsuits or violence by patients*[4]. When examining these causes, which are definitely not limited to Japanese society and culture, they seem to be also linked to changes in the rights and duties of both physicians and patients. The fact that the satisfaction of patients and their relatives appears to be of ever-increasing importance for hospital managers in the United States and most European countries and that hospital "users" are now

Friedrich Stiefel, MD
Head of the Service of Liaison Psychiatry, University Hospital of Lausanne (CHUV)

Céline Bourquin, PhD
Senior research fellow at the Service of Liaison Psychiatry, University Hospital of Lausanne (CHUV)

invited to voice their potential complaints about medical care in dedicated places reflect these changes[5,6]. To put it differently, the health care context has evolved and the physician, being part of this evolution, also deserves specific attention, be it from a scientific, clinical or health care policy perspective.

Thinking about physicianhood

As Mc Namara and Boudreau remind us, there is an important distinction between a "person" and a "patient", the patient being defined as "a person who suffers from an injury or disease; a sick person", and the state of "patienthood" resides within a whole person[7]. From the same perspective, "physicianhood" should refer to the healer, to the expert, as well as to the person. The following example from the oncology setting illustrates the complexity of the state of physicianhood in caregiving. In a qualitative study of oncologists' approaches to end-of-life care, Vicki et al. distinguished between two different "kinds" of oncologists based on descriptions of the most recent death of one of their inpatients[8,9]. On the one hand, oncologists who viewed their role as encompassing both biomedical and psychosocial aspects of cancer care described a clear method of communication about end-of-life care and reported an ability to positively influence patients' and families' coping with death. These oncologists, who adopted a broad view of their role, did not consider progression of the disease as a personal failure, and they perceived the provision of end-of-life care as very satisfying. On the other hand, oncologists who adopted primarily a biomedical role reported having a more distant relationship with patients and families, a sense of failure in not being able to alter the course of the disease, and an absence of collegial support. They did not feel that they could influence patients' coping and acceptance of death, and they made few recommendations about end-of-life treatment options in encounters with patients and families.

Physicians' defence and communication strategies

Like all physicians, oncologists are subjected to various influences – from their "inner" and "outer world" – that shape them and their lived experience accordingly. With regard to the "inner world", only a few studies have investigated the psychological challenges that physicians face[10]: What we observe is that topics like the limits of medical power and the transition from curative to palliative care are difficult challenges to handle for oncologists, as are also patients' emotions, such as sadness, anxiety and anger, or their imagined or real expectations. Depending on the oncologist's psychological structure – is he for example a very conscious or even anxious person – these challenges might mobilize so-called defence mechanisms, as those observed in cancer patients facing a life-threatening situation, such as denial (parts of the reality are filtered out) or rationalization (emotional aspects of the situation are not perceived). Defence mechanisms may protect the physician from immediate psychological suffering, but they might also hamper his perception of the patient's needs and in the long run increase feelings of isolation and burnout[11]. In addition, defence mechanisms are an indicator of the level of

stress a physician is subjected to. In a study, financially supported by Oncosuisse, we discovered that during an interview with a simulated patient in a palliative situation, on average one defence mechanism per minute is triggered[12]. In a subsequent study with real patients, we now intend to investigate what kind of communication strategies oncologists use in these situations and how patients perceive these strategies[13–15]. Despite the fact that the physician's "inner world" has important consequences for him, the patient and the health care (including decision-making processes), research addressing the physician himself is rare; for example, prior to the above-mentioned investigation, the study of defence mechanisms was restricted to patients, even in research on psychotherapy, where there is a heightened awareness of interpersonal processes. In other words, the physician as a subject and object of scientific interest is a very stimulating, clinically relevant, and barely investigated field of research.

Context and dominant discourses

With regard to the "outer world" of physicians, a similar observation can be made: The physician's context is widely neglected in research. There have been some studies on the socialization processes and the "hidden curriculum" that both impact students' development during medical education[16–18]; but many contextual factors remain uninvestigated, such as the various and often conflicting constraints – the pressure to produce cost-effectiveness and the demand for empathic communication, the standardization of care and the call for patient-centredness, etc. – or the dominant discourses physicians are subjected to. Contextual factors related to the medical apparatus as well as the societal dominant discourses on medicine, disease, physicians, and patients shape collective beliefs and, ultimately, influence the practice of medicine. For example, the evolving representation of the cancer patient, nowadays encouraged to be a triumphant "survivor"[19], or the competing types of cancer with regard to visibility, illustrated by the prominence and dominance of breast cancer in the popular and biomedical imaginary which has led to the "breast-cancerization" of cancer survivorship[20], have an impact on what patients experience and how they are encountered by physicians. Such representations might not only shape the perceptions of types of cancer and divide them into "good cancers" and "bad cancers" but also surpass them and segregate "good patients" from "bad patients"[21]; good ones being for example the pure and innocent patient with breast cancer – a figure who is also attractive with regard to fundraising – and bad ones being an ashamed and silenced patient with a seemingly self-inflicted cancer of the oral cavity due to alcohol and tobacco abuse.

A call for physician-centred research

Again, whereas social representations of disease and aspects of care have been studied in patients and healthy populations, the physicians' representations remain neglected, even though they are an important part of this interwoven tissue of collective beliefs, experiences, and behaviours. We have noticed that when physicians are invited to express themselves on issues of end-of-life care, which is an especially sensitive topic exposed to dominant discourses and rhetoric on death and dying, they do not spontaneously report contextual factors[22,23].

Are these factors perceived but remain unvoiced, or are they scotomized? What we know is that there is a lack of attention to the contextual content of physicians' representations and to the various determinants of their experiences and behaviours, which is maintained by the researchers and the physicians. We therefore believe that medicine, and especially oncology, which is at a crossroad of societal representations with regard to the threat of disease[19,20], should benefit from critical research – especially by the social sciences – investigating the "inner" and "outer world" of the physician. Such "physician-centred" research could produce most valuable information for patients, physicians, the health care systems and society as a whole.

Friedrich Stiefel, MD
Friedrich Stiefel, born in Wädenswil near Zurich, is the head of the Service of Liaison Psychiatry at the University Hospital of Lausanne (CHUV) since 2006 and full professor at the University of Lausanne. His clinical work covers the whole range of liaison psychiatry with a special focus in psycho-oncology. His current research focuses on communication between physicians and patients and psychotherapeutic interventions for patients with serious illnesses.
Tel. +41 (0)21 314 10 84
frederic.stiefel@chuv.ch
www.chuv.ch/psychiatrie/fiches-psychiatrie_details.htm?fiche_id=310

Céline Bourquin, PhD
Céline Bourquin is a senior research fellow at the Service of Liaison Psychiatry at the University Hospital of Lausanne (CHUV). She studied history, linguistics, and anthropology at the University of Neuchâtel and completed a doctorate in life sciences at the University of Lausanne in 2012. Her research interests focus on clinical communication, especially with regard to breaking bad news, communication in cancer care, and end-of-life communication.
Tel. +41 (0)21 314 42 31
celine.bourquin@chuv.ch

References

1. Hutchinson TA ed. *Whole Person Care: A New Paradigm for the 21st Century.* New York, New York, USA: Springer; 2011.
2. Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA.* 2001;19:3007–3014.
3. Cole TR. The art of medicine: the suffering of physicians. *Lancet.* 2009;24:1414–1415.
4. Yasunaga H. The catastrophic collapse of morale among hospital physicians in Japan. *Risk Manag Health Policy.* 2008;1:1–6.
5. Jangland E, Gunningberg L, Carlsson M. Patients' and relatives' complaints about encounters and communication in health care: evidence for quality improvement. *Patient Educ Couns.* 2009;75:199–204.
6. Schaad B, Bourquin C, Bornet F, Currat T, Saraga M, Panese F, Stiefel F. Dissatisfaction of hospital patients, their relatives, and friends: analysis of accounts collected in a complaints center. *Patient Educ Couns.* In press.
7. Mc Namara H, Boudreau JD. Teaching whole person care in medical school. In: Hutchinson TA, ed., *Whole Person Care: A New Paradigm for the 21st Century.* New York, New York, USA: Springer; 2011:183–200.
8. Vicki AJ, Mack J, Matsuyama R, Lakoma MD, Sullivan AM, Arnold RM, Weeks JC, Block SD. A qualitative study of oncologists' approaches to end-of-life care. *J Palliat Med.* 2008;11:893–906.
9. Von Gunten CF. Oncologists and end-of-life care. *J Palliat Med.* 2008;11:813.
10. Stiefel F, Krenz S. Psychological challenges for the oncology clinician who has to break bad news. In: Surbone A, Zwitter M, Rajer M, Stiefel R, eds. *New Challenges in Communication with Cancer Patients.* Berlin, Germany: Springer; 2012:51–62.
11. Bernard M, de Roten Y, Despland JN, Stiefel F. Communication skills training and clinicians' defenses in oncology: an exploratory, controlled study. *Psycho-Oncology.* 2010;19:209–215.
12. Stiefel F, Despland JN, de Roten Y. Effects of communication skills training on oncology clinicians' communication styles and defense mechanisms. Oncosuisse grant, Project number: 01595-08-2004.
13. Despland JN, Stiefel F, de Vries M, de Roten Y, Luthi F. Communication in cancer care: the relationship between clinician's defense mechanisms, patient satisfaction and information recall. Oncosuisse grant, Project number: 02338-02-2009.
14. Despland JN, Stiefel F, de Vries M, de Roten Y. Communication in cancer care: the relationship between clinician's defense mechanisms, patient satisfaction and information recall. Oncosuisse grant, Project number: 02828-08-2011.
15. Stiefel F, Bourquin C. Communication in cancer care: what is good for the patient? – the cancer patient perspective. Swiss Cancer Research foundation grant, Project number: 3459-08-2014.
16. Becker HS, Geer B, Hughes E, Strauss AL. *Boys in White: Student Culture in Medical School.* London, UK: Transaction Publishers; 1977.
17. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med.* 1994;69:861–871.
18. Kenny N, Shelton W. *Lost Virtue: Professional Character Development in Medical Education.* Oxford, UK: Elsevier; 2006.
19. Bell K. Remaking the self: trauma, teachable moments, and the biopolitics of cancer survivorship. *Cult Med Psychiatry.* 2012;36:584–600.
20. Bell K. The breast-cancer-ization of cancer survivorship: implications for experiences of the disease. *Soc Sci Med.* 2014;110:56–63.
21. Stiefel F, Bourquin C. Good cancers–bad cancers, good patients–bad patients? *J Thorac Oncol.* 2015;10:407–408.
22. Stiefel F, Singy P. Communication skills in end-of-life care. Swiss National Science Foundation, Project number: 406740-139248.
23. Stiefel F. Communication skills in end-of-life care. Swiss National Science Foundation, Bonus of excellence, Project number: 406740-139248/2.