Title: Spotlight on Japanese physicians: An exploration of their professional experiences elicited by means of narrative facilitators.

Authors: Stiefel F, Stiefel F, Terui T, Machino T, Ishitani K, Bourquin C

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Short title: Japanese physicians' narratives on professional experience

Abstract

Background: while investigation of physicians' work experience is often limited to issues of satisfaction or burnout, a broader view of their experiences is lacking.

Objective: to explore professional experiences, we asked Japanese physicians (N = 18, 12 men and 6 women) of a general hospital to react to so-called "narrative facilitators".

Methods: the narrative facilitators - inspired by clinical psychology, visual sociology and purpose-designed techniques - oriented physicians' narratives towards clinical practise, relationship with peers and context. Transcribed interviews were subject to thematic analysis.

Results: the thematic analysis of participants' narratives revealed a lonely physician with a tough job, torn between the ideal of patient-centred care and a clinical reality, which limits these aspirations. Patients emerged as anxious and burdensome consumers of medicine. Feeling neither supported by peers nor the institution, physicians also perceived the society as somewhat negligent, delegating its problem to medicine. Communication difficulties, with patients and peers, and the absence of joyful aspects of the profession constituted fundamental elements of their narratives.

Conclusions: comprehensive investigation of physicians' lived professional

experience could become a key to conceive ways to support them.

Keywords: narrative facilitators, physicians, qualitative research, thematic analysis, lived experience

1. Introduction

The overwhelming majority of studies in the medical field focus on patients and patient care; physicians have until now received much less attention (1). There is a body of research on very specific issues, such as the psychological well-being of physicians (e.g., burnout, substance abuse) (2, 3), work and work-life balance (e.g., job satisfaction, demoralization) (4, 5) and the formation of professional identity (e.g., medicine's hidden curriculum, internalization of professional values) (6, 7). However, a comprehensive view of how physicians experience their role, how they perceive the patient and how they apprehend the medical as well as non-medical context is still lacking (1, 8). This is even more important given the rapidly changing work and social environments of physicians which call for approaches allowing to understand their lived experiences (9-11).

As an example and related to this investigation, one study should be especially

mentioned as it addresses the “collapse of morale among hospital physicians in Japan”, linked by the authors to budget constraints, excessive demands and physician shortages, hostile medias, increasing lawsuits, and violence by patients (12). This somehow alarming report was considered to indicate an adequate field to investigate the effects of a changing environment on physicians. More specifically, the study aimed to surpass the sole symptoms of a work environment, such as burnout, job dissatisfaction or demoralization, and to elicit from participating physicians a narrative on “matters of interest and concern” (see below) with regard to their profession (13, 14, 15).

2. Method

2.1 Investigators and setting

The first author (FS, a liaison psychiatrist with a longstanding clinical and research experience), was assisted by his wife (FaS, bachelor of art) in conducting the study, as well as a translator (GH, doctoral thesis of philosophy) who has worked for many years with Japanese physicians (e.g., text editing, translation of Japanese into English or language instruction). The Japanese co-authors TT, TM and KI, all somatic physicians, with two of them trained in the US, were actively involved in the development of the study protocol and informed consent, as well as recruitment of participants. The last author (CB), a social scientist with experience in qualitative research, especially in the field of medicine, co-initiated the study, co-authored the associated grants, and counselled on methodological matters. All co-authors helped throughout repeated discussions

to elaborate on salient elements of the results.

The study benefited from a clinical immersion by the first author who, during six months, participated in medical rounds and volunteer work, supervised a Japanese physician on a weekly basis, provided regular seminars to the staff and had multiple informal contacts with collaborators from HSH. This immersion, comparable in some way to an ethnographic “observing participation”, contributed to feeling more at ease to conduct the interviews and provided information that helped him better understand and encounter the other in its otherness.

HSH was selected because the first author knew the hospital and the co-authors from previous participation in an international palliative care meeting organized by this hospital. HSH is a private hospital, admitting patients without restriction with regard to their insurance status, with an inpatient (243 beds) and outpatient facility, as well as a home care programme (16). Located in the City of Sapporo, HSH is a general hospital, harbouring many medical and surgical disciplines. With 85% of its inpatients suffering from cancer, and an overwhelming majority of deaths due to this disease, HSH actively promotes the integration of palliative care with other medical disciplines (16).

2.2 Participants and interviews

After approval of the study by the ethics committee of HSH, recruitment of participants - which took place between February and July 2016 - aimed to obtain a certain degree of diversity with regard to age, sex, professional experience and medical discipline in order to assemble different perspectives. Since this is an exploratory study, the ambition was not to reach representativeness. Participants

(12 men and 6 women) were aged between 25-44 years (N = 6) and between 45-64 years (N = 12); 5 were junior and 13 senior staff members who worked in oncology/hematology (N = 6), gastroenterology (N = 4), surgery (N = 4), palliative care (N = 3) or emergency medicine (N = 1). The great number of oncologists/haematologists is due to the before mentioned specific dedication of HSH to cancer.

Physicians were approached by TM who informed them of the aims and procedure of the study and provided an information sheet in Japanese. Two of the approached physicians hesitated, but were finally willing to participate; none of them refused.

After informed consent, the interviews took place during working hours and were conducted by FS with the help of the translator (Garry Heterick, GH); GH translated the instructions provided by FS, who introduced the narrative facilitators (see below) by stating “please comment whatever comes to your mind when looking at this …. newspapers headlines, picture, video sequence”; only rarely follow-up questions were asked (e.g., requests for clarification or an invitation to further elaborate when a participant was felt to have more to say). The interviews took place in Japanese, and GH provided an oral translation after each comment of the participants, with FaS taking notes of GH’s translation. The interviews were digitally recorded and transcribed, and then translated and verbatim transcribed in English (by GH). The interviews lasted between 20-40 minutes.

2.3 Facilitating physicians’ narratives

In order to empirically examine physicians’ professional experiences, we ad hoc

developed a method that facilitates and orientates the production of narratives. This method, which we call “narrative facilitators” aims to facilitate the production of narratives of oneself, about oneself and about one’s practices. Four types of facilitators oriented to four general “matters of interest and concern”. We understand by matters of interest and concern the notion that there are not only matters of interest in the field of medicine but also of concern (15), which “alter the affective charge of thinking and presentation of things with connotation of trouble, worry and care” (15, page 87) and impact on experiences and eventually behaviours (15).

Facilitators should put participants at ease to associate on presented material, which simulates some aspects of their work. We have observed in previous, yet unpublished studies (9-17), that physicians tend to rationalize during interviews, avoiding affect-loaded subjects or irrational thoughts, which we thought could be easier provoked by these facilitators (see below). While these facilitators orient participants, they also allow them to direct their narratives to any other topic, to produce counter-discourses and position themselves, to scotomize some of its aspects or to refuse to comment. The four general matters of interest and concern to which facilitators oriented participants’ narratives were identified in the literature (9, 10) and referred to (i) societal aspects of medicine, (ii) the institutional context, (iii) relationship with peers and (iv) clinical practice.

The narrative facilitators were based on techniques inspired by clinical psychology (projective methods) (18) and visual sociology (photo-elicitation) (19, 20) or on purpose-designed techniques (for a detailed description of the facilitators, see Table 1). While these narrative facilitators are thus inspired by existing methodologies, they have been specifically developed for the purpose of

the study, and are thus designed to assess the lived professional experience of physicians (see following paragraphs).

The first facilitator, chosen to address the (i) *societal aspects of medicine*, consisted of a press book with three booklets, with each of them featuring three critical articles on medicine from English editions of Japanese newspapers. We considered that newspaper articles may best orient participants - as if they open a newspaper – to reflect and comment on the environment at large in which medicine is embedded. The choice of articles was based on a review of newspaper addressing different aspects of medicine in Japan. The first three articles raised issues related to the *Japanese health care system,* the second to the *practice of medicine* and the third to *physicians*. In order to allow quick readability and to gain an overview of the topic addressed, in each article - some of which featured coloured photographs -, the headlines or a few sentences were underlined and translated in Japanese.

The second facilitator, chosen to address the (ii) *institutional context,* consisted of a photo-based story showing on one page eight coloured pictures of typical daily activities of a hospital physician: entering a hospital, at his desk, in a meeting, etc. We considered that the photo-story format may best orient participants - as if they see themselves walking through the hospital – to the institutional context and allow them to comment those pictures or elements in the pictures, they consider most relevant.

The third facilitator, chosen to address the (iii) *relationships with peers*, consisted

of quotes from medical students (N = 2) and physicians (N = 7) taken from qualitative studies conducted in Japan (21-23). We considered that these quotes may best orient participants - as if they would hear voices from peers – to comment on the five most frequent types of concerns with regard to peers, identified by Murakami et al. (21): hierarchy, gender differences, overestimation of medical knowledge, underestimation of attitudes, negative role models and relationships with peers. Some of these quotes confirmed whereas others infirmed a given concern, thus allowing participants to oppose, validate or elaborate on the issue at stake.

The fourth facilitator, chosen to address the (iv) *physician's clinical practice,* more specifically four of its essential aspects - working in an office, encountering a patient, gathering with peers and being on one's own -, consisted of four blurred and muted video sequences from two documentaries, lasting about 2 minutes in total and showed on a laptop. We considered that this facilitator may best orient participants towards their inner world, allowing a certain degree of interpretation (blurred and soundless sequences).

The press book was presented first, followed by the photo-based story, quotes and video-sequences.

2.4 Analytic approach of the data

Iterative reading of the notes taken during the interviews by FS and FaS revealed three main characteristics, which oriented the analytic approach.

(i) The facilitators usually oriented participants' narratives in the intended

direction; for example, the quotes addressing relationship with peers or the press book articles on the health care system elicited narratives in line with these topics. However, facilitators did not produce specific and unique topics; for example, the topic “physician” or “patient” was triggered by any of the facilitators, not only by those which specifically putted into play a “physician” or a “patient”. In order to illustrate this observation, examples of comments addressing the topic “patient” triggered by four different narrative facilitators are provided below:

Press book [clinical relationship (ii, increased use of psycho-active drugs in Japan, see Table 1)]: *For a cold, normally, it often doesn’t require drugs, but patients often ask us to prescribe drugs* (participant (P) 17).

Photo-based story [picture 3, patients in a waiting room]: *These patients look lonely, everyone seems to be alone with their disease* (P3).

Quotes [Q1, blamed by a superior in front of a patient]: *The patient’s trust will be lost* (P1).

Videos [sequence iv, physician, alone, pacing in circles]: *Maybe he is worried about giving an explanation to a patient* (P9).

(ii) Some participants found it difficult or even impossible to position themselves with regard to the facilitators due to doubts or insufficient knowledge, lack of experience, concentration and reflection or due to the feeling that the facilitator was not enough contextualized. An example:

General comment after the interview: *Not easy, you know, I rarely use this part of my brain* (P10). Video [sequence 4]: *mmhh, let’s see. Well, mmhh, I would, let’s see, mmhh, it’s difficult to tell what he is thinking about* (P5).

(iii) A minority of participants elaborated on issues, which brought into play various matters of interest and concern, thus providing abundant information. Many participants just reacted with 1-2 sentences (see P9's comment on the video-sequence above). Some examples to illustrate abundant narratives are provided below:

Press book [physicians, ii fraudulent physicians]: *And, well, regarding how we can improve the situation, well, I think we need to build a system in society where someone other than doctors, or someone who is not involved in seeing patients, or well, doctors that don't work at that specific hospital, evaluate and assess the situation. And, well, you see photos like this often on TV, in which they are saying sorry with their heads bowed low […] but these people are not the only ones involved. And I feel that perfunctory apologies like this are useless* (P17). Photo-based story [picture 4, physician at his desk]: *Mmhh […] it looks like he might be filling out an insurance claim […] He's often made to do this kind of work or he is doing something he is forced to do* (P15). Quotes [positive relationship with peers who value each other, viii]: *Can I just talk about myself? Mmhh, well, you know, but I think that an ideal environment, well it doesn't happen all by itself. As you see, mmhh, you try to avoid troubles, well, you know, by not saying 100% of what you want to say, or also by putting up with something, eh, especially in Japan. As you might know, well, we do not like to assert ourselves too much, we do not wish to disturb the harmony and this so-called pressure to conform with others is often at work, so you cannot really say things you would like to say, especially not to senior doctors* (P15). Video [sequence 3, clinicians gathering together]: *Ah, a professor's round, which is common. (Laughter) Well, eh, let's see, in these rounds most of us just followed the professor, blindly, without any clear sense of*

purpose. I feel that these rounds themselves are aimed at displaying the power of the doctor to the patients, or showing off their authority (P7).

2.5 Data analysis

The approach can be conceived as a holistic approach, which “takes the story as a whole and attempts to grasp the overall pattern” (24).

Based on iterative reading of the notes and transcribed interviews, a coding frame was derived from passages of the material (25, 26). For example, “a physician has a heavy workload” or “if you don’t know something: study and learn it” was coded as “physician activity” and “physician’s code of conduct”, respectively. Similar statements were clustered into themes and subthemes (see Table 2). After agreeing on the definitions and names of the categories, analysis of the transcribed interviews was conducted separately by FS and FaS and the results compared. When disagreement existed, a consensus was reached through discussion; this was necessary for less than 5% of the coded material of the first six interviews; for the following interviews no further consensus discussion was necessary.

As a second step, the occurrence of codes in the transcripts was counted, with codes occurring repeatedly counted only once if evoked in the context of the same facilitator or twice or more times when occurring as reactions to different facilitators. Counting was not thought to provide a kind of quantitative analysis of the narrative’s content, but was undertaken to illustrate imbalances of themes and subthemes in the narratives (e.g., the repeated emphasis placed on workload).

The quality of recordings of one of the interviews was insufficient and only the notes taken during the interview were used in the analysis.

3. Results

The evoked topics are presented in a regrouped way, starting with the narratives of the topic “physician”, “medical practice” and “relationship with peers”, followed by “patients” and “the clinical encounter”, and finally “context”. Saturation of the data seemed reached with 18 participants interviews with no new themes felt to emerge.

3.1 Physician, medical practice and peers: a tough job for a lonely fighter

Participants talked about themselves or about physicians as a collective. The dominant narrative featured a physician - when participants referred to themselves - who is closely tied to his/her duties and responsibilities and who faces a heavy, difficult, constraining, stressful and tiring workload that requires, in order to be successfully accomplished, some codes of conduct (e.g., one means of dealing with obstacles is to study harder or, to recognize the limits of medicine). However, in the context of facilitators operating with projective methods (e.g., video-sequences), physicians were at times also characterized as not only being defined by their profession (e.g., a participant remarked that the physician sitting at his desk was searching a holiday destination on the laptop). Referring to the collective, physicians were described as strong personalities but also as self-protective individuals (corporatists and conformists), who enjoy too

much freedom in practising their profession, with some of them lacking reflection, commitment and competence.

With regard to their practice, a patient-centred, interdisciplinary and engaged approach was endorsed but there was an element of concern in that this was difficult to realize, given the constraints imposed by the workload and difficulties in understanding patients' needs. Consequently, a desire for training in clinical communication and shared decision-making, and psycho-social, ethical and cultural aspects of care was expressed. Participants were rather optimistic with regard to progress and benefits of technique and treatment modalities.

The relationship with peers was considered as hierarchical, particularly with regard to age and gender: although considered as equal to men by some (but not by others), the female physician was said to be handicapped by their double role as professional and mother, and, despite improvements in their situation, in need of support. The relationship with peers was characterized by pride and shame (criticized, but considered to be improving), a lack of communication and even as a source of stress. Again codes of conducts were advocated for being part of this working community (e.g., no infighting, respect based on results and skills). Consequently, a desire for better communication, closer relationships and a flattened hierarchy was expressed.

3.2 Patients and clinical encounter: anxiety prevails

While patients appeared in reactions to all of the facilitators, reference to this theme was somewhat rare, with two participants never referring to patients in their narratives. The patient prototype was an anxious consumer of medicine with high expectations who represents, for the physician, a source of anxiety and

constraint, especially when it comes to meet the family or to break bad news. However, the understanding that patients have legitimate demands which surpass a pure biomedical approach was nevertheless conveyed.

Occasionally, the patient-physician relationship emerged in the narratives, most often associated with misunderstandings between physicians, patients and their families. In some narratives the physician-patient relationship was viewed from the perspective of collusions (physicians and patients share a common desire/problem, e.g., the wish for a « quick » fix of symptoms) (27). The ethical and cultural dimensions of the clinical relationship were rarely evoked.

3.3. The context: surrounded but not supported

Participants' narratives referring to the institutional context or health care system were either based on prior or current experiences. These themes emerged also rarely in the narratives, mainly because the visual facilitator featuring the institutional context (photo-based story of a physicians' day in the hospital) was considered as not very inspiring and the mechanisms underlying the health care system were reported as being largely unknown.

The institutional context appeared in the narratives either as a source of expectations or effects, with some institutions considered not to fulfil their roles with regard to policy or as a working environment. Thus, the institutional context was qualified as having a distinctly positive or negative effect on physicians and patients, and/or even being responsible for (hiding) problems. The health care system was viewed as excellent from a patient perspective, but - due to rising costs and clinician shortages -, as having an uncertain future. Generally, evidence-based treatments were considered to have a priority in the health care

system but also, given the limits of Western medicine, diversity and the integration of traditional methods was admitted. Some participants called for a regulation of the health care system, such as with regard to unnecessary treatments or physicians' liberties (e.g., no freedom of choice in terms of discipline or location of work), underlining at the same time that physicians have no impact on the system.

Society as a whole also appeared rarely in the narratives - a part from references to the cultural specificities of Japan – and when evoked was considered as a source of multiple stressors, taboos or increasing medicalization and characterized by a decline in morality that contaminates both physicians and patients. Only very rarely and in contrasting ways did the role of the media and politicians emerge in the narratives.

3.4 Disconfirming cases and narratives

A minority of narratives illustrated that a certain diversity of experiences exists. These marginalized narratives featured, for example, a physician who likes his work, strives for a better work-life balance, has an independent mind and values each person independent of his status, assumes his role as an articulator between the patient and his context and is rather critical towards the role of technique in medicine, as it represses other medical approaches. For a detailed description of all narratives see Table 2.

3.5 Types of facilitators and stance taken by participants

The visual facilitators (photos and videos) elicited a lower amount of narratives than did the written ones (press book and quotes). It might be that the written

form corresponds better to the way physicians function, given their tendency to rationalize (17) or that the visual facilitators did to a lesser degree inspire, since participants are used to the environment put into play.

The stance taken towards the facilitators also differed: some participants demonstrated a defensive attitude; for example, when confronted with the criticism of medicine and physicians (press book), some narratives were limited to a revolt against the (biased) media. Other participants demonstrated pragmatism, for example, advocating the use of robots to palliate shortages (of nurses), positivism when it came to the role of technique in medicine, realism with regard to the impact of the physician on context, reclusion, for example by refusing to comment on a newspaper articles “since reflecting only the opinion of a single journalist”, or fatalism about the future of medicine.

4. Discussion

The bulk of the participants’ narratives focused on what it means to be a physician (“who we are”, “what we do” and “how we function as a working community”). The lonely physician-fighter is working hard and understands that medicine cannot be reduced to the treatment of diseases or symptoms: the endorsement of a patient-centred approach, respect for the limits of medicine and one’s own limits and reference to interdisciplinarity and interprofessionality illustrates this position. Patients, their families and the society as a whole have high expectations towards him and the ever progressing science of medicine, and their demand to be treated as individuals is considered legitimate. In light of this narrative, one might deduce that physicians feel caught or torn between the ideal they strive for and the not-

so-glorious reality: these tensions have been described for other health care settings and (cultural) contexts (28-30).

The different stances among participants towards the facilitators - such as revolt, reclusion, positivism, realism, pragmatism and fatalism -, revealed differences in the ways physicians face tensions. Since participants generally deployed the same stances throughout the interview, it might well be that they reflect a trait acquired during the individual's (professional and/or personal) development. Although very rarely investigated, physicians' traits have been shown, for example, to impact on physician-patient communication (31). Given the consequences these stances have, not only for physicians' well-being, but also for patients, clinical decisions and the health care system, this issue merits further attention.

The physicians' daily activities were described as burdensome, a finding which has been reported in various countries (32-37). However, what might be specific to this sample of physicians is that the narratives revealed no complaints. On the contrary, participants expressed that stress is a part of medical activities and should be conceived as a motor driving professional improvement. This serenity may be due to different factors: as mentioned above, participants work in a setting which actively promotes the development of palliative care and as such recognizes the limits of medicine (16, 28), which may reduce the tensions physicians might experience. A cultural fact might also have played a role: Japanese seem to be inclined toward a certain degree of self-effacement (38), an adherence to external authority (39), and an attitude that favours self-critique

and self-improvement over self-enhancement (40). Finally, the fact that the interviewers were not natives may have inspired participants to present themselves in a favourable light. However, based on the impressions from the clinical immersion of the first author and his many formal and informal contacts, the expressed serenity seemed authentic.

The working conditions for Japanese physicians being known to be rather harsh and associated with negative somatic and psychological consequences (41), this serenity somehow challenges the reported “catastrophic collapse of morale among hospital physicians in Japan” (12). We certainly do not want to minimize the difficulties of the Japanese health care system, such as nurse and physician shortages, financial pressures, the increased medical needs of an aging population, and their impact on physicians (43-45), but a catastrophic morale collapse was not what we have observed in our study. This finding also challenges the study of Murakami et al. (21), who reported that differences in performance between residents is a source of distress; the lack of such distress by participants of our study might be due to the fact that they have more professional experience, an element which has been observed to influence the ability of physicians to cope with adversity (46).

The participants’ focus on the heavy and burdensome work condemned the rewarding sides of the profession to remain in the shadows: for example, being able to diminish suffering or encounter patients, did not emerge in the narratives (only one participant stated that physicians like their work). One can certainly not deduce from this result that none of the experiences in daily clinics are rewarding,

but one has to acknowledge that narratives, whether they reflect a reality or not, play an important role in the production of social reality (6, 24, 39, 47).

Another focus of the narratives was the physicians' working community: while some participants explicitly stated that they felt understood by their peers, the general lack of communication was repeatedly and consistently deplored. The fact that peers are not automatically a source of solidarity or may even be regarded a source of distress (48) has inspired some hospitals to organize and institutionalize peer support (49). It has to be emphasized though, that a lack of communication was not only deplored with regard to peers, but also with patients and their families, and within the institutional context and society as a whole. Consequently, a desire for change was repeatedly expressed and training in communication, recently introduced in Japan, may contribute to improve the situation (50).

The patient emerged in the narratives as a burdensome figure: an anxious consumerist who has, together with his family, high expectations and with whom it is not easy to communicate. Participants' narratives are in line with ethnographic investigations of Japanese patients (51); what appears less prominent in the narratives is, as some participants remarked, that physicians might contribute to this patient figure through collusion (27). The co-construction of narratives and clinical realities between physicians and patients, which reproduce dominant social structures, has been elegantly demonstrated for (Japanese) psychiatry (39), and there is no reason to believe that such a phenomenon does not exist in medicine in general. This burdensome situation

might be accentuated by the increasing judiciarization of medicine, which has also had an effect on physicians in Japan (12). Other countries have deployed in this respect systematic efforts to improve physician-patient communication (52) and have developed institutional measures to deal with patient complaints (53). Finally, it was rather sad to observe that patients emerged in the narratives as burdensome, given the fact that physicians usually choose their career based on pro-social motivations (54); a better preparation of medical students with regard to their future work has already been advocated (33, 55).

Finally, physicians' narratives underlined that they considered themselves to have very limited power to shape the context. While it is certainly true that the institutions, the health care system or the society as a whole impact physicians and their work (33-37, 45, 55), some participants in this study positioned themselves as victims, a position which might hamper initiatives to gain greater autonomy and influence (56).

With regard to the initial aims, we consider that this study provides some insight in how physicians experience their work. The chosen approach and the findings of the study could be used, for example, in under- and post-graduate teaching, to inform what it might mean to be a physician today, as a mean to stimulate reflexivity and debate, or to conduct a kind of "biopsy" in different health care contexts, allowing a comparative view of physicians' work experiences. A discussion of the results with participants could allow to identify most relevant hints to remedy against some of the elicited concerns, be it in form of post-graduate education (e.g. on patient-clinician communication) (50, 52), the set up

of support groups (49) and supervision (17), or institutional means, such as instances, which mediate between clinicians and patients in case of conflict or misunderstandings (53). Such initiatives can diminish physicians' feeling of loneliness and create working conditions (57), which provides more space to express concerns, but also to welcome the joyful aspects of their profession.

5. Limitations of the study

First of all, this is an exploratory study, and thus of limited informative value. The physicians' narratives and the conveyed areas of concern call for further in depth investigations, which could ultimately lead to hypotheses testing.

Second, given the palliative care philosophy, which is actively promoted in the setting the study was conducted, results may not be generalizable. For instance, some participants have stated that the work environment at HSH is friendlier than in previous workplaces (e.g., competition in University Hospitals or physician shortages in rural regions).

Third, with regard to the interpretation of the data, we are aware that we also face limitations; for example, because we might not fully grasp the cultural, psychological or social determinants of the narratives. However, we consider that the six-month immersion of the first author, intensive discussion of the results between co-authors - all of them with different clinical, scientific and cultural backgrounds - and the study of the literature, allowed us to provide some hints of how it feels to be a Japanese physician today.

Finally, material produced by narrative facilitators show similarities and differences when compared to focus group and individual interviews. Probably

the most important difference relies in the more playful way narrative facilitators allow to encounter participants; indeed many clinicians sometime laughed when commenting on facilitators and did not consider the study as a kind of test of their knowledge or experience. On the other hand, narrative facilitators often seem to narrow the choice of what is conveyed, and at times invited to just replicate what is put into play by the facilitator. In addition, depending on topics to investigate, narrative facilitators have to be developed accordingly, which needs a certain effort.

6. Conclusion

Our approach, based on narrative facilitators seems to produce information that differs from that gained by means of targeted questions (e.g., job satisfaction, burn-out). Narrative facilitators could be used in future studies as a way to obtain a comprehensive snapshot of the lived experiences of professionals or as a first step in the design of qualitative interviews. The findings confirmed our view that voice should be given to the physicians. To know about the lived experience of physicians is important for the physicians (57), for patient care (58), the institutions, the health care system and society as a whole. Physicians act and their actions - influenced by matters they are concerned of - might be powerful and have important consequences.

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References

1) Cole TR. The art of medicine: The suffering of physicians. *Lancet* 2009;24:1414-1415

2) Halbesleben JRG, Rather C: Linking physician burnout and patient outcomes: Exploring the dyadic relationship between physicians and patients. Health Care Management Review 2008; 33(1): 29-39

3) Hughes PH, Storr CL, Brandenburg NA, Baldwin DC Jr, Anthony JC, Sheehan DV: Physician substance use by medical speciality. J Addict Dis 1999; 18(2): 23-37

4) Leigh JP, Tancredi DJ and Kravitz RL: Physician career satisfaction within specialities. BMC Health Service Research 2009; 9: 166 doi:10.1186/1472-6963-9-166

5) Cole T, Carlin N. Faculty health and the crisis of meaning: Humanistic diagnosis and treatment. Faculty Health in Academic Medicine 2009:147-156.

6) Margolis E (ed.). The hidden curriculum in higher education. London, Routledge, 2001

7) Kenny N, Shalton W. Lost virtue: Professional character development in medical education. Oxford, Elsevier, 2006

8) Ham C and Alberti KGMM: The medical profession, the public and the government. BMJ 2002; 324(7341): 838-842

9) Stiefel F, Singy: Communications skills in end-of-life care. Swiss National Science Foundation (grant no. SNF/406740-139248)

10) Stiefel F: “Communication skills in end-of-life care” Bonus of excellence Swiss National Science Foundation (grant no. SNF/406740-139248/2)

11) Stiefel F, Bourquin C: Physicians’ discourses with regard to end-of-life communication/care. Käthe Zingg-Schwichtenberg Fonds, and Swiss Academy of Medical Sciences / Leenaards Foundation, Lausanne

12) Yasunaga H: The catastrophic collapse of morale among hospital physicians in Japan. Risk Management and Healthcare Policy 2008;1:1-6

13) Frank AW. Letting stories breathe: A socio-narratology. Chicago, University of Chicago Press, 2010

14) Peters A, Vanstone M, Monteiro S, et al.: Examining the Influence of Context and Professional Culture on Clinical Reasoning Through Rhetorical-Narrative Analysis. Qual Health Res 2016. DOI: 10.1177/10497323166504/8

15) Puig de la Bellacasa M: Matters of care in technoscience Assembling neglected things. Social Studies of Science 2011; 41(1): 85-106

16) Terui T, Koike K, Kusakabe T, Ono K, Mihara H, et al.: Recent Advances in Palliative Cancer Care at a Regional Hospital in Japan. American Journal of Hospice and Palliative Medicine2013 DOI 10.1177/1049909113502118

17) Despland JN, Bernard M, Favre N, Drapeau M, De Roten Y, Stiefel F: Clinicians’ Defences: An Empirical Study. Psychology and Psychotherapy: 2009;82(1):73-81

18) Chabert C and Anzieu D (Eds): Les methods projectives. Paris, PUF, 2004.

19) Margolis E and Pauwels L (Eds): The Sage handbook of visual research methods. London: Sage, 2011

20) Harper D: Visual sociology. New York: Routledge 2012

21) Murakami M, Kawabata H, Maezawe M: The influence of learning environments on medical education: a qualitative research study in one Japanese medical school. South East Asian Journal of Medical Education 2009; 3(2): 45-53

22) Kikukawa M, Nabeta H, Ono M, Emura S, Oda Y, et al.: The characteristics of a good clinical teacher as perceived by resident physicians in Japan: a qualitative study. BMC Medical Education 2013; 100 DOI: 10.1186/1472-6920-13-100

23) Ie K, Tahara M, Murata A, Komiyama M and Onishi H: Factors associated to the career choice of family medicine among Japanese physicians: the dawn of a new era. Asia Pacific Family Medicine 2014; 13: 11 DOI: 10.1186/s12930-014-0011-2

24) Kvale Brinkman SInterViews: Learning the Craft of Qualitative Research Interviewing. 3rd edition. London: Sage 2014

25) Ryan GW, Bernard HR: Techniques to Identify Themes. Field Methods 2003; 15 (1): 85-109

26) Braun V and Clark V: Using thematic analysis in psychology. Qualitative Research in Psychology 2006; 3 (2): 77-101

27) Stiefel F, Nakamura K, Terui T, Ishitani K: Collusions Between Patients and Clinicians in End-of-Life Care: Why Clarity Metters. J Pain Symptom Manage 2017; 53(4): 776-782

28) Stiefel F and Guex P: Palliative Care: At the Frontier of Medical Omnipotence. Annals of Oncology 1996; 7: 135-138

29) Kvas, A, Seljak J: Sources of workplace violence against nurses. Work 2015; 52(1): 177-184

30) Ahmadpanah M, Torabian S, Dastore K, Jahangard L, Haghighi M: Association of occupational burnout and type of personality in Iranian general practitioners. Work 2015; 51(2): 315-319

31) De Vries AMM, de Roten Y, Meystre C, Passchier J, Despland JN, Stiefel F: Clinician characteristics, communication and patient outcome in oncology : a systematic review. Psycho-Oncology 2014; 23:375-381

32) Andersen GR, Aasland OG, Fridner A, Lövseth LT: Harassment among university hospital physicians in four European cities. Results from a cross-sectional study in Norway, Sweden, Iceland and Italy (the HOUPE study). Work 2010; 37(1): 99-110

33) Heuser CC, Gibbins KJ, Herrera CA, Theilen LH, Holmgren CM: Moms in medicine: Job satisfaction among physician-mothers in obstetrics and gynecology. Work 2018; 60(2): 201-207

34) Zuger A: Dissatisfaction with medical practice. New England Journal of Medicine 2004; 350: 69-75

35) Heijstra TM, Rafnsdóttir GL, Jónsdóttir LS: Autonomy and well-being among Nordic male and female hospital physicians. Work 2011; 40(4): 437-443

36) Sundquist J, Johannsson SE: High demand, low control, and impaired general health: working conditions in a sample of Swedish general practitioners. Scandinavian Journal of Public Health 2000; 28: 123-131

37) Estryn-Behar M, Fry C, Guetarni K, Aune I, Machet G, Doppia MA, Lassaunière JM, Muster D, Pelloux P, Prudhomme C: Work week duration, work-family balance and difficulties encountered by female and male

physicians: results from the French SESMAT study. Work 2011; 40(Suppl 1): 83-100

38) Kitayama S, Markus HR, Matsumoto H and Norasakkunkit V: Individual and collective process in the construction of the self: Self-enhancement in the Unites States and self-criticism in Japan. Journal of Personality and Social Psychology 1997; 72: 1245-1267

39) Kitanaka J: Depression in Japan: Psychiatric Cures for a Society in Distress. New Jersey: Princeton University Press, 2012

40) Heine SJ, Takata T, Lehman D: Beyond Self-Presentation: Evidence for Self-Criticism Among Japanese. Personality and Social Psychology Bulletin 2000; 26(1): 71-78

41) Wada K, Yoshikawa T, Goto T, et al.: Lifestyle Habits among Physicians Working at Hospitals in JMAJ 2011; 54(5): 318-324

42) Yuji K, Imoto S, Yamaguchi R, et al.: Forecasting Japan's Physician Shortage in 2035 as the First Full-Fledged Aged Society. PLoS ONE 7(11): e50410.doi:10.1371/journal.pone.0050410

43) Nomura H, Nakayama T: The Japanese health care system. BMJ 2005; 331(7518): 648-649

44) Ito S, Fujita S, Seto K, Kitazawa T, Matsumoto K, Hasegawa T: Occupational stress among healthcare workers in Japan. Work 2014; 49(2): 225-234

45) Muramatsu N and Akiyama H: Japan: Super-Aging Society Preparing for the Future. The Gerontologist 2011; 51(4): 425-432

46) Bogue RJ, Guarneri JG, Reed M, Bradley K and Hughes J: Secrets of Physician Satisfaction. The Physician Executive 2006: 30-39

47) Berger PL, Luckmann T (1967). The social construction of reality: A treatise in the sociology of knowledge. New York: Anchor

48) Cohen JS and Patten S: Well-being in residency training: a survey examining resident physician satisfaction both within and outside of residency training and mental health in Alberta. BMC Medical Education 2005; 5: 21 doi:10.1186/1472-6920-5-21

49) Bergman D, Liljefors I, Palm K: The effects of dialogue groups on physicians' work environment: A matter of gender? Work 2015; 52(2): 407-417

50) Fujimori M, Oba A, Koike M, et al.: Communication Skills Training for Japanese Oncologists on How to Break Bad News. Journal of Cancer Education 2003; 18(4): 194-201

51) Ohnuki-Tierney E: Illness and Culture in Contemporary Japan: An Anthropological View. Cambridge University Press, 2000

52) Bourquin C, Stiefel F, Bernhard J, Bianchi Micheli G, Dietrich L, Hürny C, Wössmer B, Kiss A: Mandatory communication skills training for oncologists: enforcement does not substantially impact satisfaction. Support Care Cancer 2014, 22:2611-2614

53) Schaad B, Bourquin C, Bornet F, et al.: Dissatisfaction of hospital patients, their relatives, and friends: Analysis of accounts collected in a complaints center. Patient Education and Counseling 2015; 98(6): 771-776

54) Skatova A and Ferguson E: Why do different people choose different university degres ? Motivation and the choice of degree.Frontiers in Psychology doi: 10.3389/fpsyg.2014.01244

55) Barondess JA: medicine and professionalism. Archives of Internal Medicine 2003; 163: 145-149

56) Emanuel EJ, Pearson SD: Physician Autonomy and Health Care Reform. JAMA 2012; 307(4): 367-368

57) Andruškienė J, Kuzmienė A, Martinkėnas A, Jurgutis A, Ejlertsson G, Andersson I: Psychosocial work experiences related to health: A study of Lithuanian hospital employees. Work 2016; 53(3): 669-677

58) Weigl M, Hornung S, Angerer P, Siegrist J and Glaser J: The effects of improving hospital physicians working conditions on patient care: a prospective controlled intervention study. BMC health Service Research 2013 13:401 DOI: 10.1186/1472-6963-13-401

Table 1. Narrative stimulators

Material	Content	wide focus of attention	narrow focus of attention
press book	3 booklets composed of 3 articles from English editions of Japanese newspapers [headlines and pictures]	societal aspects of medicine	*physicians* • malpractice (i) • fraudulent physicians (ii) • therapeutic obstinacy (iii) *clinical relationship* • elderly patients fail to welcome robots (i) • Japan's depressing increase in use of psychotropics (ii) • big pharma manipulating the market (iii) *health care system* • wisdom of Japanese traditional medicine (i) • Health care in Japan: not all smile (ii) • Health care system needs a new diagnosis (iii)
photo-based story	8 photographs depicting typical daily activities of a Western physician	institutional context	a man (physician?) in front of a hospital – in a hospital entrance – a patients' waiting room – a man in a white coat at a desk, a man in a white coat looking at a scan while phoning – an interdisciplinary meeting – a man in a locker room getting undressed (white coat)
Quotes	9 quotes from Japanese medical students and physicians from the literature	relationships with peers	*quotes referring to problems related to:* • hierarchy (i) • gender (ii) • over-estimation of medical knowledge (iii) • underestimation of attitudes (iv) • positive and negative role models (v, vi) • negative and positive relationships with colleagues (vii, viii) e.g., "They keep telling everyone awful stories about other departments and colleagues", "I think there is a very good environment where we value our peers, and there is not any infighting"
video sequences	4 videos sequences blurred and mute from two documentaries [2 min]	clinical practice	• a physician at his desk, using a voice recorder and studying documents (i) • a physician speaking with a patient in an ICU, in the background a woman clinician watching (ii) • a group of male clinicians gathering together on a floor and then leaving through a door (iii) • a physician who paces in circles in front of an elevator with a women clinician passing by without noticing each other (iv)

Table 2. Findings of the thematic analysis

THEMES | Subthemes | *contents*	No. of mentions by the participants	No. of occurrences in the participants' narratives
1. PHYSICIANS	**18**	**191**
1.1 Characteristics	17	46
. *self-protective*	*12*	*22*
. *very responsible*	*8*	*10*
. *affirmed personalities*	*7*	*7*
. *profession not his sole identity*	*5*	*6*
. *like their work*	*1*	*1*
1.2 activity	18	93
. *heavy, difficult, stressful, constraining, tiresome*	*18*	*70*
. *not always reflected (use of drugs, technique)*	*11*	*15*
. *too much freedom (patient care)*	*5*	*7*
. *lonely*	*1*	*1*
1.3 codes of conduct	17	46
. *learn and study when facing gaps of knowledge*	*11*	*11*
. *recognize limits (own and those of medicine)*	*11*	*15*
. *follow moral rules*	*8*	*17*
. *be prudent*	*3*	*3*
1.4 Status	6	6
. *figure of authority and power*	*4*	*4*
. *diminished respect*	*2*	*2*
2. MEDICAL PRACTICE	**18**	**109**
2.1 Aims	18	60
. *patient-oriented / not too focused on disease*	*18*	*33*
. *evolving (less over-treatment)*	*6*	*9*
. *engagement, not solely cost-saving*	*5*	*8*
. *interdisciplinary collaboration*	*5*	*7*
. *psychological symptom control*	*2*	*3*
2.2 Techniques	17	28
. *does not replace a human*	*10*	*11*
. *element of progress/benefits*	*5*	*7*
. *facilitates the work of physicians*	*4*	*5*
. *an option to palliate shortages (human/financial)*	*4*	*4*
. *represses other (necessary) approaches*	*1*	*1*
2.3 Desires	12	21
. *stronger focus on patient-centeredness*	*9*	*10*
. *knowledge of certain treatments (psychotropics / Kampo)*	*4*	*4*
. *better care for psychiatric patients*	*3*	*3*
. *adequate work-life balance (for men and women)*	*2*	*2*
. *increased interdisciplinary communication*	*2*	*2*
3. RELATIONSHIPS WITH PEERS	**18**	**142**
3.1 Characteristics	18	72
. *hierarchized*	*13*	*30*
. *at times pride/shame (envy)*	*13*	*18*
. *lack of communication*	*11*	*14*
. *stressful*	*5*	*7*
. *evolving*	*2*	*2*
. *nurses viewed as patient substitutes*	*1*	*1*
3.2 Codes of conduct	16	55
. *no critics/infighting in front of patients*	*15*	*17*
. *honesty*	*13*	*17*
. *respect based on results/skills*	*8*	*11*
. *don't complain*	*5*	*5*
. *report misconduct (might not solve the problem)*	*4*	*4*
. *young physicians at risk of being impertinent*	*1*	*1*
3.3 Desires	7	15
. *more communication / relationships*	*6*	*8*

. *learn from each other (flattened hierarchy)*	*6*	*7*
4. PATIENT	**16**	**67**
4.1 Characteristics	17	52
. *anxious (about health), high expectations*	*13*	*22*
. *consumer*	*11*	*16*
. *subjects/person*	*9*	*13*
. *lonely with their disease*	*1*	*1*
4.2 Effects on physician (by patient and family)	7	15
. *anxiogenic, burdensome, constraining*	*7*	*15*
5. PATIENT-PHYSICIAN RELATIONSHIP	**13**	**35**
5.1 Characteristics	12	25
. *lack of communication/understanding*	*7*	*8*
. *ethical and cultural issues present*	*4*	*6*
. *collusions (desire to satisfy, quick fix)*	*4*	*5*
. *asymmetric*	*3*	*4*
. *burdensome when really engaging*	*2*	*2*
5.2 Code of conduct	*1*	*1*
. *inform patient of everything they have to know*	*1*	*1*
5.3 Desires	6	9
. *more shared decision making and communication*	*5*	*7*
. *training on ethics, attitudes and values*	*1*	*1*
. *delegation of psycho-social issues to other health care professionals*	*1*	*1*
6. INSTITUTIONAL CONTEXT	**18**	**58**
6.1 Expectations	12	28
. *assumes policy with regard to clinics, conduct*	*9*	*14*
. *provides adequate environment (space, facilities)*	*8*	*13*
. *offers child care facilities*	*1*	*1*
6.2 Effects	15	30
. *impact on physician and patients*	*12*	*17*
. *increases or diminishes infighting/gender gap*	*8*	*9*
. *produces opacity (medical errors, problems)*	*4*	*4*
7. HEALTH CARE SYSTEM	**18**	**66**
7.1 Characteristics	15	46
. *financial limits/uncertain future*	*12*	*17*
. *too much freedom with regard to speciality/place of activity*	*7*	*9*
. *allows unnecessary treatments*	*7*	*8*
. *excellent, free access, on the edge treatments*	*7*	*7*
. *no possibility to be influenced by physicians*	*4*	*4*
. *financial limits not reached*	*1*	*1*
7.2 Endorsements	12	20
. *biomedicine and EBM (traditional medicine for minor symptoms)*	*6*	*9*
. *diversity and integration of practices*	*6*	*7*
. *western medicine has limits*	*4*	*4*
8. SOCIETY	**18**	**83**
8.1 Characteristics	17	59
. *Japans' specific culture (value of community, aesthetics)*	*11*	*25*
. *multiple stressors (work, exclusion, abuse of power)*	*11*	*11*
. *difficulties to confront owns / other weaknesses*	*7*	*11*
. *taboos (health, death, related costs, conflictualization)*	*4*	*6*
. *medicalization*	*3*	*3*
. *decline in morality*	*2*	*2*
. *polarity (materialism / animism, economics/community)*	*1*	*1*
8.2 Position of the physician	9	21
. *as independent mind*	*9*	*11*
. *articulates between patient, family, disease, society*	*3*	*6*
. *recognizes values (of each person)*	*3*	*3*
. *refuses to position himself*	*1*	*1*
8.3 Desires	3	3

. *address issues of mortality and cost (from school on)*	*3*	*3*
9. THE WOMAN PHYSICIAN	**17**	**31**
. *carries two roles (physician and mother)*	*11*	*13*
. *equal to man with regard to medical activities*	*4*	*4*
. *should be helped more by men (household)*	*4*	*4*
. *limited to certain tasks/disciplines*	*4*	*4*
. *evolving situation (more supported nowadays)*	*3*	*4*
. *discriminated against by male patients (and physicians)*	*2*	*2*
10. MEDIA	**14**	**25**
10.1 Effects	8	14
. *on participating physician*	*6*	*7*
. *improve the health care system*	*4*	*4*
. *negative for the profession / physician-patient relationship*	*3*	*3*
10.2 Judgment	9	11
. *unfair, biased, incompetent*	*5*	*6*
. *appropriate*	*4*	*4*
. *convey unrealistic images of medical power*	*1*	*1*
11. "POLITICS AND POLITICIANS"	**4**	**4**
. *afraid to address problems of the health care system*	*2*	*2*
. *too centralized*	*1*	*1*
. *conscious about costs and address this issue*	*1*	*1*