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**DOCTORING AS A HUMAN EXPERIENCE:  
ON DEVELOPING A HEALING PARTNERSHIP - The Doctor's Soul**

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**Introduction**

In an earlier article, "Patients' experiences" (Banner 2001), I considered the process (stages) of becoming a patient, that suffering is much more than pain, and explored the subjectivity of decision making by patients. All these point up the need for inputs from patients. These should be our advisors/ counselors/ teachers - these people who have experienced illness and who understand their experiences. These advisors are essential in understanding and improving patient care, as well as in medical education, policy development and research (Reiser 1993). I illustrate the notions presented in this article with the experiences I shared with a patient named Stanley, who had severe and complex illnesses.

In a second article (Banner 2002a), I discussed The Doctor-Patient Relationship as a partnership in which the physician is a consultant to patients, helping them decide on the best course for addressing their problems.

In a third article (Banner 2002b), Caring for the Human Spirit, the Patient's Soul, I explored a variety of ways in which spiritual awareness can be a part of healing in medical practice.

We have seen how illness is more than just a collection of symptoms a patient experiences. It can shake patients to the core, raising doubts about their future and forcing them to question the meaning of life in general, and their life in particular. Patients can be devastated and overwhelmed and give up or they can search and find and grow.

Illness can force doctors to re-examine themselves and their lives, just as it does to their patients. Since the practice of medicine offers so much potential for growth, creativity, meaning and beauty, it is tragic that there is so much unhappiness and lack of fulfillment in doctors.

While there are many explanations for that one thing is clear: there is physicians educate and treat ourselves we see and feel - without compassion

**Physician heal  
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this, Reiser and Rosen feel something wrong with how we and respond to the suffering and without empathy, ignoring

our own needs to be sensitive. We hold feelings in, go it alone and hide, rather than recognise and deal with our own vulnerability. Couple this with our driving perfectionism, unforgivingly high standards, and a tremendous need for mastering control and we get lonely and frightened workaholics. How can we take good care of patients, really good humanistic care, if we don't take care of ourselves?

**Stress**

M. E. Daly (1987) says it is fashionable, even scientific, to blame all our problems on stress. Thomas (1983) gently derides the current concentration on stress, saying that for him stress

represents nothing more than "the condition of being a Human Being". Anisman-Saltman says, "life is meant to be stressful. . . the only people who experience no stress are dead."

Then let us stop blaming everything on stress and examine other factors as well.

### **Moral Health**

Daly (1987) uses a moral focus: "As the caregiver attends the care receiver, applying whatever arts and sciences the situation demands, and shares meaning with, and produces value in, the care-receiver, while the care receiver becomes better in terms of returning to health, the caregiver gets better in terms of deepening interiority or moral health."

### **Doctors' Views of Their Problems and Happiness**

What about directly questioning physicians about their own satisfaction? Reames and Dunston interviewed 19 physicians in a mid-sized, Midwestern community. Their results separated physicians into three groups, based on how they viewed their problems and whether they felt satisfied or unhappy.

*Group one: Problems unsolveable and physicians unhappy.* Consisting mainly of subspecialists, these doctors felt that they were losing control over their problems. They were worried about the threats of financial loss and malpractice suits. They were also so devoted to medicine that they ignored other sources of reward, security, ego gratification and enjoyment of life. They felt entrapped, powerless and hopeless.

*Group two: Problems solveable, but physicians unhappy.* These doctors saw medicine as a business and saw the doctor-patient relationship as negative, based on mistrust caused by the threat of malpractice. They felt fatigued secondary to long hours.

*Group Three: Satisfied physicians.* These doctors, mainly in primary care, had made internal adjustments, adapting their attitudes, changing their expectations and reordering their priorities. They felt a sense of security against malpractice suits and little ambition to be wealthy. They were satisfied with their physician-patient relationships. They put medicine in perspective and searched for satisfactions beyond medicine. (Reames and Dunstone).

### **Healthy Approaches to Physician Stress**

The responses to Quill and Williamson's open-ended questionnaire (1990) may not be representative of physicians in general but they are still illuminating. They organized the general requirements for personal growth into five areas:

1. *Self awareness* is achieved by personal exploration of the emotional and existential sides of physicianhood.
2. *Recognition of the human need for sharing feelings and responsibilities and for feeling connected to others* is important to growth. Without these, the physician operates in isolation. This breeds an exaggerated sense of personal responsibility and power, feelings of being overburdened and eventually leads to burnout.
3. *Self care* requires that work be kept in perspective. Professional responsibilities must be balanced with time for family, friends and self.
4. *Developing a personal philosophy* requires prioritizing values and goals and time management. Doctors who master these skills experience greater meaning and self control, rather than reacting to the most pressing demand of the moment.
5. *Non-traditional coping skills*, such as limit setting and reframing problems and relationships, help doctors develop a more realistic view of both medicine's and their own personal limits and potentials.

(See Table 1, Specific Adaptations for Increasing Self Awareness.)

Quill and Williamson also show how these approaches could be applied to specific common physician dilemmas.

1. *Death and mortality* - reframing death from a "villain", to be fought at all costs, to a "friend" who can provide relief from suffering. A physician can care for, rather than try to cure, a severely ill patient. We might see death as the respected adversary/ warrior in the Japanese tradition.
2. *Mistakes* - Doctors must learn to distinguish mistakes from unsatisfying or bad outcomes.

**Table 1. Specific Adaptations for Increasing Self-Awareness\***

*Keeping a personal journal, provocative book reading, religious practices, continuing education outside medicine, personal psychotherapy, metaphysical exploration (meditation, yoga)*

Specific Adaptations to Promoting the Sharing of Feelings and Responsibilities

*Protect informal time to spend with family, friends*

*Storytelling, discussing difficult issues, laughing over human foibles, complaining*

*Group interests outside of medicine*

*Clubs, teams, courses*

*Experiential courses/self—awareness groups*

*Balint groups, human dimensions of medical education courses, Society of General Internal Medicine*

*Task Force on the Doctor and Patient Course*

*Consultations and Referrals*

*Using multidisciplinary health care teams*

*Getting help with domestic or professional tasks*

Specific Adaptations for Promoting Self-care

*Attention to scheduling*

*Limiting on—call and weekend work, scheduling and taking frequent vacations, limiting evening work,*

*Taking minibreaks during the day, taking moments to “get ready” to see next patient, protecting time*

*to be with family or friends*

*Expressing feelings*

*Grieving one’s losses, experiencing joy in victories, laughing at one’s foibles*

*Regular sleep, meals, and time alone*

*Interests and friendships outside of medicine*

*Sports, music, cooking, gardening, theater, community events, religious activities)*

*Regular medical and dental care*

*Regular physical stimulation (exercise, sex, massage)*

*Regular attention to self-awareness and sharing*

Specific Adaptations in Developing a Personal Philosophy

*Allocating time to clarify details*

*Developing short-term and long-term goals (realistic)*

*Prioritizing goals reflective of both professional and personal values*

*Developing a time-management system*

*Excluding low-priority commitments*

*Engaging in faculty development programs for values clarification and time-management training*

\*Adapted from Quill and Williamson 1990

3. *Uncertainty* - Doctors can share the responsibility of decision making with patients and colleagues and get help when stuck.

4. *Demands from patients* - By recognizing that a patient's demands for medicine, time, procedures, or more care are often cries for help or desires for connection, physicians can do their best to meet the underlying requests rather than the surface ones, can set limits, and can more successfully negotiate the patients' demands.

5. *Demands of external economic factors*. Doctors must learn to separate "needs" from "wants."

6. *Time demands* - By clarifying values and setting goals, time management plans follow.

Quill and Williamson (1990) observe:

Healthy approaches to life as a physician often begin after medical school and residency. . .

There is substantial need for a more aggressive outreach to established physicians who are experiencing difficulties in coping with the stresses of today's medical life. Such outreach must begin with a basic restatement of values and priorities by prestigious national medical societies, national and regional medical meetings, faculty development programs and continuing medical education programs.

All physicians need opportunities to regularly express their needs, share, support, reflect, problem solve, and grow in a safe environment. Self-awareness, sharing, self care, and the importance of developing a personal philosophy must be reaffirmed as basic abilities of the well balanced physician (Quill and Williamson 1990).

*In the case of Stanley, a patient of mine with terminal illness described in earlier articles in IJHC, were it not for the personal growth and approaches I have learned with time, how could I properly care for either him or myself?*

### Groups

Williamson suggests "that opportunities for talking with peers, in a safe environment should be a sanctioned, regular aspect of all levels of medical education practice." She separates groups into two models: "support groups (where the focus is on personal experiences of professional life and the facilitators concentrate on participants' adjustment) and Balint groups (where a case is presented briefly and a psychodynamic expert is present who reflects how management difficulties relate to the personal issues of participating physicians). While Balint groups are used widely in family medicine residency and training programs. . . and while faculty development courses in medical interviewing and related skills. . ." are offered by the Society of General Internal Medicine and its allied organizations, it may be time to consider support groups as a regular feature of medical education since "It is the combination of technical and self-knowledge that transforms the physician from technician to healer." (Williamson 1991)

I would like to see combinations of both models, including non-physician health care professionals, while emphasizing healing and utilizing patients as teachers.

### Humor

The use of humor to help ourselves and our patients achieve good health should also be analyzed and used. How do we learn to take our jobs seriously, but ourselves lightly?

Opportunityisnowhere

(Goodman 1990) Do we recognize that he who laughs. . . lasts? Can we turn our frustration into humor rather than rage, thereby dissipating it? (Berman 1993) Can we use reframing?

### **Success**

In thinking of success, it might be helpful to keep in mind this poem by Ralph Waldo Emerson:

To laugh often and much;  
 To win the respect of intelligent people and the affection of children;  
 To earn the appreciation of honest critics, and endure the betrayal of false friends;  
 To appreciate beauty;  
 To find the best in others;  
 To leave the world a better place, whether by a healthy child, a garden patch, or  
 a redeemed social condition;  
 To know one life has breathed easier because you have lived:  
 This is to have succeeded (Smullin 1991).

**Renewal** A patient wrote a letter to a medical student, describing her final hospital stay with metastatic cancer. Here is an excerpt:

For his own salvation, the physician needs to learn to retreat deep within himself for renewal; he should spend time climbing mountains, sailing, funning wild rivers, living alone in the wilderness. He should spend much time with small children so as not to forget their direct simplicity, he should not forget that the very old are frequently very wise.

(Reiser and Rosen, from Rosenberg 1985)

For myself, I say, "Thank God for family, friends, music, reading, walking by the beach, and bike riding in nature. I also am grateful for caring patients. After changing from group to single doctor practice, I noticed patients being much more interested in my own health, enjoyment and leisure time/ renewal activities - if only for the selfish reason that then I would be 'strong enough' to care for them."

**Sudden Intimacies** Let me close by sharing insights of Michael Radetsky, M.D., which also resonate with my own experiences.

What fulfills the physician? Certainly the diagnostic challenge, the financial security, the altruistic glow, and the grateful thanks all provide a measure of satisfaction. But all too often, success becomes bracketed by failure, a deluge of new information erodes the sense of professional mastery, money ceases to compensate fully for the time and toil, the good one attempts to do goes awry, and the thankfulness of patients becomes admixed with fear and suspicion.

No, for me fulfillment comes from the sudden intimacies with total strangers - those moments when the human barrier cracks open to reveal what is most secret and inarticulate. . . And who else has such a chance to realize that it matters less whether a moment is one of supreme sadness or supreme joy than it does that the moment itself is supreme?

This is the physician's privilege: to be lifted out of the dross of common days in order to experience such clarity of feelings. . . Then, the world is seen in its proper proportions, and the tenuous miracle of existence is underscored. Surely, it must profit us to feel this deeply,

with the hope that somehow, in the sweep of that feeling, we might yet learn to appreciate the wondrous happenings of our own lives (Radetsky 1985).

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