

Humanization, the Antidote to Discontent and Frustration in Medicine

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Received: December 09, 2017; **Published:** January 03, 2018

Discontent and frustration infiltrate the medical world. A large proportion of the people who are assisted by the health systems and a large part of the doctors feel discomfort and frustration because of the way in which our society, generator and victim of the dominant culture, currently operates the assistance of the patients (we can propose from half of the century XX and what goes of the XIXth), and creates the conditions to degrade the illusion that the doctors had when they entered as students to this magnificent profession [1].

This reflection aims to think about the life of doctors, their feelings and their psychological state. If the doctor is dissatisfied and sometimes abhors his art, the assistance he will give to his patients will be cold, depersonalized and maybe technically wrong.

We will mention only some of the numerous current publications that refer in all the countries of the West World and several of the East to depression, stress and burnout of a significant number of doctors. In the United States of North America, Shanafelt TD., *et al.* [2] in a study in which more than 7000 doctors responded, found that 45.8% reported at least one symptom of burnout. They also showed that the degree of burnout and dissatisfaction with their life balance was twice as high among physicians as in the general population (< 0.01 for both). In another publication [3] they report that a study of a large group of surgeons showed that 40% suffered from burnout and 30% suffered from depression. In Uruguay Turnes A., *et al.* [4] have proven in a 30-year study of general deaths, that doctors die at younger ages than the general population. The Sindicato Medico del Uruguay (Medical Union of Uruguay) in a recent survey [5] found that 43% of the doctors surveyed have self-perception of suffering severe stress and another 43% moderate stress. Two thirds of those who suffered stress attributed it to the their working conditions. In 1996, more than 70% of the uruguayan intensivists doctors felt that due to their work, the time they devoted to their family and the care and education of their children was insufficient [6]. In a more recent survey carried out by Burghi G., *et al.* [7] to uruguayan intensivists - employed the inventory of Maslach- it was found that 51% had elements of burnout or full burnout. In France, Doppia MA., *et al.* [8] studied burnout in doctors in their country and found that 38.4% of intensivists had this pathology and the figure amounted to 42.4% in non-intensivists. A very interesting fact was that many of the respondents did not perceive their own symptoms compatible with burnout. In the United Kingdom Imo UO [9] conducted an extensive review of the bibliography in PubMed, EBSCO and in the BMJ Journal. Their conclusions were that psychiatric morbidity among physicians oscillated between 17 and 52%, emotional exhaustion between 31 and 54% and symptoms of depersonalization appeared between 17.4 and 44.5%. In Chile Days LA., *et al.* [10] studied the prevalence of burnout among residents of various specialties at the Catholic University of Chile and found that 38.3% of them met burnout criteria. The highest prevalence occurred in surgical specialties and in foreign residents. In India Langade D., *et al.* [11] conducted a survey to evaluate the presence of burnout in physicians (they used the abbreviated Maslach Burnout inventory) and found that 45.02% had elements of this pathology, especially emotional exhaustion and depersonalization. More than 80% reported that their personal accomplishment was insufficient.

The studies mentioned are only a very small sample of the pleiad of communications in this regard. All these authors give figures, frequencies and populations of doctors altered and frustrated, but they rarely show us doctors talking about their lives, showing us their worried faces and their anguish. However, several years ago, two young french persons, Julia and André, travel the world - country by country - looking for individual doctors from each place to talk with them about their problems and ask them why there is such a discomfort in their professional life. Julia Gudefin was previously a doctorate in law and specialist in environmental and water law and Andre Simonnet was an engineering student, but he left this career to devote herself to her passion as a graphic journalist and documentalist. Motivated by the cold and distant assistance (often erroneous) that André received and knowing that almost half of the doctors in his country would leave the profession if they could, and decide to investigate this in many different countries of the world. They got the right

means and changed their project of life and became errant journalists and documentary makers, visiting, recording and filming their interviews that have begun to appear on the Internet recently in several languages with the name of Hippocratic Conferences [12] (www.thehippocratesconferences.com).

I have been a medical teacher (internist, lung specialist and intensivist) and clinical researcher for many years, but almost since 2006 I dedicate myself to medical humanism at the CLAEH School of Medicine in Uruguay. We had a happy meeting with André and Julia in Montevideo in 2016. Our interests coincided. We are people deeply attached to humanistic medicine. Medical humanism takes into account the knowledge, affections, fears, hopes, family relationships and the life project of the people who should be assisted by health problems and too the wellbeing of the doctors. Like many academics, professors, anthropologists and sociologists of the world who are not afraid of risk, we are going against the current of purely biologicist medicine. André and Julia have been in Uruguay, Chile, Brazil, Paraguay and other American countries. After interviewing European doctors, they are currently in Asia: Dubai, the Emirates and then conflicting fields such as Iran and Iraq. Always interviewing doctors... following a route that in its spirit and in the eurasian stage reminds me of "Travels with Herodotus" by Ryszard Kapuscinski [13].

Later in our exchanges through E mail we talked about the causes and consequences of the malaise in medicine and that inspired me to reflect what I write here.

Our utopia is that the doctor must be an excellent clinician -based on scientific knowledge- and a humanist at the same time. Our desire is to unite science, experience with affectivity, empathy and art. Our ideal is to contribute to closing the gap between "the two cultures". We have started very modestly to work for it. Now we ask ourselves: What forces and influences act on the young medical student and then on the doctor so that it evolves from compassionate empathy to disbelief and cynicism? [14,15].

Obviously, there are forces external to the doctor that originate in the influence of: A) dominant culture in today's society at least in the West (a paradigm in which individualism, consumerism and hyper-valorization of wealth and individual social success prevail), B) large welfare organizations (governmental or private, business or cooperative) with the intrinsic attributes of large companies in which the bureaucratic organization and the consideration of the administrative prevails, and often the profit spirit; and in C) gigantic corporations dedicated to the production of drugs and medical instruments that are governed by rigid market laws. Companies must exist and the market is essential. But supply and demand left to chance and to the desire of the powerful only - not regulated - is unfair. And even more so in medicine where health is not an optional product of commerce but a universal right and a good that essentially wants all human beings to be born. In health, if everything is left to supply and demand, the imbalance is brutal. For the patient, the demand that is based on anguish has no limit and does not measure costs. In this way the offer and its prices are not regulated by the "client" because it cannot do without those resources. Needs these goods in any way. Therefore, the price is left absolutely to the avidity of the bidder and can reach incalculable extremes.

The foregoing factors escape our immediate possibilities of change. However, there are other factors that shape, restructure and condition the mind of the doctor and his affectivity on which we can act and we have the responsibility for it. These factors - which we must take into our hands without ignoring the existence and interrelation with the previous ones are: A) the dehumanizing characteristics of the curricula of medical careers with a clear biologicist and scientist predominance, B) the excessive authoritarianism and sense hierarchical of the care teams and teachers, C) the hidden curriculum, and D) the absence of a specifically humanizing training strategy in medical education that protects the initial ideals, sensitivity and empathy of the young students. The vast majority of current curricula for medical education do not give the students efficient resources to combat the negative factors of the health care environment, to strengthen their communication skills and resilience, and face the critical problems of their task: pain, illness, interaction with family of very sick patients and death.

In my opinion, although we cannot ignore the multiple and complex interrelation between "macro" socioeconomic factors and the "micro" specific factors that we are discussing here, even if the unfavorable pressure that originates in the sociocultural, administrative and organizational spheres diminishes and if the large multinational companies producing medical supplies combine economic benefit with a few drops of altruism, as well as a large proportion of doctors would suffer from sustained stress, demotivation and disappointment.

Why?

Because the intrinsic task of interacting and coexisting with pain, illness, the exigency and expectation of the anguished patient and death, erodes itself the medical mind if it is not prepared. This is the factor we can call: formative error.

We will deal with this factor: training of the doctor in techniques, attitudes and behaviors.

Throughout the twentieth century doctors have been acceptably trained in the science of clinical diagnosis and treatment aimed at diseases. The person of the patient or the person of the doctor has not been considered as beings constituted by reason, affection, family, potential development in other areas and life project.

The medical education we will call "20th Century" had little regard for the person's hopes and fears, his psyche, affections, worries, balance and desire for well-being. The medical student was trained to be a kind of imperturbable and powerful false superman. All wrong.

Only at the beginning of the 21st century did the medical programs of Canada, the United States and other countries include humanism, professionalism, and humanities in their written curricula. But in most cases it has only been a paper project. Efficiently carrying it out has only occurred in a small number of institutions well into the 21st century.

The new doctor must be specifically trained in humanism. This includes the experiential cultivation of empathy in the clinical setting and through personal interviews with serious ill patients and outpatients. Interviews in which all dimensions of the human being must be considered [16-19].

The process must include the student's emotional self-analysis, personal and group reflection and good feedback with specially trained people, combat the negative factors of the health care environment and to strengthen their communication skills and resilience.

On the other hand the example must be given continuously (the model role is fundamental) because the student copies everything from the teacher and if the teacher is inhuman and superb the student will also be and finally live stressed and unhappy. Also, the subject of death must be treated. Reflecting on death as a part of life, as the end of something that has been productive and acceptably joyful is not a bad end. The doctor who does not progressively learn to accept his mortality will be stressed a lot and will have disturbing fantasies when a patient dies even if he is not "his patient". Students must learn to give the "bad news" calmly, firmly, with love and consolation, must practice moral reflection and learn that depending on the context there may be "more than one adequate ethical solution for a patient" and that the moral option is never equal to mathematics. And he must finally understand the limitations of medicine and learn to work in uncertainty - and tolerate it - because it is typical of everything human [20]. He must learn that he is not "the obligatory life savior" but "he who receives the one who suffers and assists him as best he can and consoles him". And finally he must be taught and he must learn that seeking balance and well-being - or wiggling toward them - in his life is an obligation. As many doctors have already said in the filming of Julia and André, if the doctor does not have well-being and balance, he cannot give it to others.

In our School of Medicine CLAE (Universidad Centro Latinoamericano de Economía Humana at Punta del Este- Uruguay) all these aspects are part of the official curriculum and are carried out in small group meetings with students and in multiple fieldwork. Our existence would not be justified if these aspects were not part of our teaching as well as the learning of the clinic. On the other hand, if it is assessed that the student does not tolerate work with patients (which is done since the first year), their medical vocation may be reconsidered. Empathy and the art of modulating emotions must be maintained or increased at any price. A doctor in whom empathy has died must abandon patient care [21]. And those who by vocation work in areas of the world where poverty, the ravages of war, hunger and infant mortality are enormous, must be specially motivated people to do so. Each medical person should look for a place of work in which, after having trained well and humanely, it will not cause a constant disturbance.

The well-conducted education/training factor is the most powerful weapon to neutralize the other facts and circumstances that are the enemies of good doctors, that is, those that produce stress, alexithymia and Burnout. All the defective factors must be changed. The formative training is at our hands, at the hand of the medical educators.

Declaration of Interest

None.

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Volume 4 Issue 1 January 2018

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