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Review Article

Discomfort in Medicine

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Abstract

Arnold-Forster et al have recently pointed out their concern for the progressive deterioration of the mental health of doctors and for the neglect or ignorance that the medical health organizations in which they work have for their affective problems. They point out several causal factors, not only for the mental suffering of doctors, but also for the fact that the following is not taken into account: 1) the idea of the doctor as an exceptional being in society, 2) the social conviction that they must deny themselves and give themselves to others, 3) the dominant concept that their mental health and all their affective problems are their own responsibility, signs of disaffection, and are not the responsibility of the system in which they work. This brings us back to the topic of "discomfort in medicine" that we have addressed earlier. We propose to frame the affective disorders and discomfort of doctors and their causes in a larger psycho-social-professional framework, which is multicausal, currently dominates Western culture and which results in the deterioration of human behavior. In medicine, this results in the dehumanization of medical care, patient care and the health of doctors. They are not isolated events, but dependent on each other. Mutual causality includes the effects of the exponential increase in knowledge in science and technology, the accentuation of medical corporatism, the fragmentation of medical assistance, and the almost total loss of the holistic conception of the patient.

We propose that only by following the tradition of a few precursors who have refounded Medical Humanism in the 20th century and including the compulsory training in medical humanism in the academic curricula (as we have already started in our medical school) can some favorable changes for the well-being of patients and doctors -in no short time-be achieved.

Introduction

In a recent publication [1], academic authorities from renowned Saxon institutions-*Centre for History in Public Health, John Hopkins University, Yale University, and the University of Michigan*-refer to four fundamental and persistent causes of the increasing discomfort and poor mental health of doctors: a) being considered an exceptional person in society; b) the demand that because of their vocation they must deny themselves; c) the perception of their affective and mental health disorders as their own individual responsibility and lack of adaptability -often stigmatizing and separating them from organizations-, and d) the absence of institutional intent to study in depth the general structural problem of healthcare, possibly responsible for most of their ailments.

This timely analysis, which could be interpreted as a cry for help, could be completed and better understood if it were conceived within a larger framework that is determined by the evolution of Western society and culture in the last century, and the inevitable influence of its power to shape the conception of the human being and make values such as power, triumph, wealth and individualism prevail over more fraternal values linked to the well-being of each and all.

For almost 20 years we have been engaged in a task of humanistic training of medical students. Humanism that is focused on three directions: the deep knowledge of the human being, the cultivation of respect, empathy and compassion (with patients, among themselves and with everyone), and the fullest possible development of each one and of all. It is a difficult undertaking because it goes against the most powerful and inclement current of Western society, which has forgotten these values and replaced them with their opposites [2]. However, there are nuclei of resistance and creation toward the humane to which our entire group of medical humanism teachers adheres with fervor and enthusiasm. We simply choose this position and not the other, despite our human imperfection, because it is the only one that makes us feel well and we believe it is the only way to slowly approach a rescue of the multidimensional human being.

This article by Arnold motivates us to return to a previous work dedicated to reflecting on the disappointment and frustration of doctors. This phenomenon that occurs coincides and is intertwined with the dehumanization of the treatment of patients and the damage this causes [3].

We will reflect on additional factors to those pointed out by Arnold-Forster et al [1] that broaden the frame and, we believe, make it more understandable without opposing to them, since all of them combined better show us the multiple combination of causes-consequences in a complex medical world that leads to the suffering of doctors and patients. The resulting web of interrelationships can seem like inextricable chaos since they all relate to each other. However, according to Lorenz [4], all alleged "chaos" is not chaotic but only a highly complex system in which multiple cause-effects are concatenated in very different ways. In no way will I try to expose the mechanism of chaos (whether I'm a doctor or not), but I will modestly provide some clarifications that I hope will enrich the original proposal [1].

Some of the new additional factors that we propose to analyze have been generated in the origin and evolution of humanity and human groups and have always been in force. But most respond to or are closely related to the economic, socio-psychological, anthropological and cultural evolution that has led to the "social imaginary" in the sense given by P Burke [5] that has dominated the West since the 20th century and that is the backbone of all medicine. Each factor, like all human events, has two faces like Janus [6]: one promising benefits, and another of potential ruin and decadence for the doctor and the patient. We will accentuate only the dark face because it is the one that collaborates in the creation of the indicated wrongs, and it is the one we must correct, but that does not prevent us from expressly recognizing the potential benefits of the light face.

What kind of factors will we discuss? 1) Anthropological: derived from our nature and evolution as a human group; 2) Scientific-technical: related to the exponential increase in knowledge and technique, and their application to medicine, an expansion that led to the fragmentation of care and the abandonment of the holistic model that was replaced by somatic-biologist medicine [7]; 3) Humanistic: which are a consequence of the previous one: progressive dehumanization and depersonalization of the care and attention received by patients [3]; 4) Business and related to the care organization: the emergence and multiplication of large bureaucratic care organizations, and 5) Professional: the transformation of medicine into a profession, a transcendent change that still tries to moralize its practice but has the counterweight of a rise in corporatism [8].

Analysis of each factor

1. ***"Anthropological" factor:*** human beings have always had some ancestral fears (sometimes dreads), among which 3 stand out: fear of pain, illness and death. From remote times, when the civilizations of Mesopotamia, Egypt and Greece flourished and thousands of years before, communities designed someone whose mission was to relieve pain and try to cure diseases with a primitive magical/holistic conception –body and spirit– which was misguided or integrated into nature [9]. That figure whose ancestral name we ignore but who was later called sorcerer, shaman, priest and, finally, doctor (us), was always extraordinary. It must have been, and must be, "ontologically" extraordinary by necessity because they are "the one who heals". At first, many of the ailments were attributed to supernatural and invisible powers against which ordinary beings could do nothing. However, if someone was "invested" in power and was "appointed" the healer, they automatically became extraordinary. If they lacked this

investiture, they could not "cure" and no one would believe that they could try it successfully. This belief and investiture emerged many thousands of years ago. However, even today, people who consult a doctor go to them because they rationally trust in the power of "scientific knowledge", but at an unconscious level they are still the shaman of centuries ago. If it were not so, deep trust would not be deposited in them. I think that most probably, the doctor will always be considered an "exceptional citizen", even if there are complaints against them, they are reviled or sued. This category of "exceptional" is also the reason why they are generally rich and a conspicuous element of the community. That is the "retribution" they receive, dictated by the unwritten "mini social contract" between them and society. They will never lose this category and that is why they must find another solution or compensation to the first factor of their suffering mentioned by Arnold-Forster and collaborators [1]. These authors point out that doctors are required to "renounce themselves". The paradox is that once "invested", "they gain power" but "lose their lives". Perhaps in this, part of the responsibility is in the "medical corpus" itself (us) for not having found the fair measure of the exhibition of our power, and for having asked too much in exchange for the power to heal.

2. ***Scientific-technical factor:*** The advances in knowledge made possible by science in the last century and its application through technology have been enormous and revolutionary, and applied to medicine they have collaborated in saving thousands of lives. However, they have been cofactors of unfavorable changes for the well-being of the doctor and the patient [10]. As the knowledge and instruments suitable for multiple procedures increased, it became impossible for a single doctor to dominate the entire growing scope of their profession, and the establishment of specialties became a necessity. The specialist "began to see" only a part of each patient, which meant that care was done in parts and the patient lost "their" doctor, the one with whom they established trust and who knew their life. The relationship between doctor and patient changed, became more circumstantial, impersonal and distant. Medicine began losing its holistic conception of the patient. The loss of the holistic conception of the doctor as a person also initiated, although this went unnoticed. Seduced by science and technology -which gave them more real power, more "magical" power, and more economic gain-the doctor focused on the functioning, dysfunction and healing of the systems, and gradually forgot the person who housed those systems. They lost relationship with the person, and by losing this relationship they were forgetting their emotional side (they didn't have time for themselves). Their employers -leaders of the organizations to which they started belonging–also learned to ignore them as a whole and vulnerable person. In short, the somatic/biologist and administrative concept modulated the new identity of patients but also the new personal and professional identity of the doctor. In this process we can find one of the roots of the third factor of medical suffering pointed out by Arnold-Forster et al.
3. ***Humanistic factor:*** The dehumanization of medical care, outlined in the previous paragraph, derives in many ways from the organizational and conceptual changes in care that coincide with the increase in knowledge and technique. Now, in retrospective, it does not seem to have been very foreseeable that the doctor/patient relationship would deteriorate, and that the holistic conception would become biologist driven by these changes and by the increase in power and wealth of the doctor. A wall of silence and isolation arose between the patient and their doctor, which meant that the patient could no longer find an echo for their personal problems (anxieties, affections, fears, interrelationships, social role) and gradually became a set of systems or a "thing": dehumanized. The second consequence can be interpreted as a "mirror" of the previous one. I make the hypothesis that the doctor, bounded by time, "dazzled" by biological science, could no longer see the whole person in front of them and stopped exercising their affectivity, sensitivity and empathy. And those losses surely-acting in the long run and shaping their character-contributed to their demotivation, apathy and disenchantment.
4. ***Assistance business factor:*** In the 20th century, large assistance companies emerge. A well-thought-out healthcare company guided by a human conception that accompanies the administrative system and good management is good and necessary. But what we wish here is to point out the character of "commercial company" and not of "assistance company" that the majority have. Surely there are both types, but the limit that exists between the welfare motivation and the economic motivation (both now sharing the bureaucracy) is very fragile. In general, when the owners of companies (insurance, for example) establish their plans, they do not see the suffering of those who consult, and they do not see their employees (doctors) as carnal beings whose mental health suffers and who often reach burnout. Their estimates are rather based on time, numbers, money and performance. On this factor we agree completely with Arnold-Forster et al, who present it excellently.

5. ***Professional factor:*** The professionalization of medicine. In the midst of the extraordinary transformations that began in the mid-nineteenth century that was already described, and influenced by them and by the irregular and heterogeneous situation of the practice of medicine in the United States, the Society of American Physicians establishes in 1846 the professionalization of medicine. According to Wynia [8], this was the first successful attempt in the professionalization process because for the first time, the 4 necessary postulates were fulfilled: a) establish norms of practice; b) normalize the obligatory ethical behaviors; c) create committees to judge misconducts and d) achieve the acceptance of the majority of the medical body. Since then, medicine is a profession and at the same time it began to be based on science. The normative moral aspects which establish a deep ethical commitment of the doctor with their profession, have been very well pointed out by Cruess et al [11-12] and appearin the Physician Carter [13]. But there is another side to this process: physicians -now formal professionals-ascend in social status. They are no longer the despised charlatans of the 17th and 18th centuries and, sheltered in this social recognition, begin to corporately defend their new status that grants them possibilities of prestige and fortune. This "protective and corporate" part of professionalism, strongly marked by authors from sociology and which is reflected in parts of Pardell's publications [14], greatly increased the asymmetry between doctor and patient, broke the social contract and turned the doctor into an even more exceptional being. Now they are not only "the one who knows", but "the one who can". Professor José Pedro Barrán [15] has studied this phenomenon that was exacerbated in Uruguay, and surely in many parts of the Americas, approximately between 1900 and 1930. Result: the doctor "wins", but the doctor "loses". Because of the change, more is demanded of them, and surely, in exchange for their new privileges, more will be demanded of them in every sense. Thus, the conditions continue to be created for the exacerbation of the doctor's discomfort while the care and attention to patients is dehumanized.

Some focal remedies for the doctor's suffering

There are currently some initiatives that try to remedy the lack of consideration for the mental health problems of doctors caused by work. In some countries, including Uruguay [16], clinics or psychological care systems have emerged to attend to doctors' individual problems and to counteract the institutional neglect of doctors' health. At the same time, Arnold-Forster et al point out that in Saxon countries a reaction that directs attention to doctors' mental health problems has also started. In this regard, a movement has been initiated by the American Medical Association and other entities in the United States and the United Kingdom [1], which tries to delve deeper into the causes of the dehumanization and suffering of physicians and to find remedies.

Systemic reactions to discomfort and medical degradation

While all these phenomena that developed as interrelated processes were taking place, since the beginning of the 20th century there were a certain number of doctors, professors, and philosophers of medicine who revived the humanistic movement opposed to the degradation of the profession and medical care, which were the backbone of the return of holistic medicine [17], compassionate and focused on the human being as a whole (both doctor and patient). Pioneers of this "human restoration" were Meyer [18] and Engel [7], and thinkers like Pellegrino [19] and Lain Entralgo [20]. They were followed by others [21-27], and the movement has increased significantly in the 21st century with the advent of two holistic currents: "Patient-centered medicine" [28] and "Person-centered medicine" [28].

In sum

At the beginning of the 21st century we witnessed two omnipresent processes in medicine: One, the disastrous and very generalized process that resulted in the dehumanization of care of the sick human being and that of the doctor himself, and the other, symmetrical but of the opposite sign -which we can call restorative-that is born and grows trying to put the patient back in the center of assistance and concern of medicine and to return the doctor to his vital balance.

But addressing the structural problems at the root of doctors' health discomfort and inhumane patient care is increasingly difficult. For this, very vigorous initiatives are needed, structured by the essence of what is human. If these movements prosper, they will

only see good results in the long term. These are initiatives that aim to unravel the structural problem in its root causes and need the courage to stop seeing the affective or mental disorders of the doctor as individual cases and of individual responsibility, and normalizing the exclusive dedication to the patient's soma and the unrecognition of the person as sick (care dehumanization). As part of the recreation of human medicine, "Medical Humanism" has been incorporated into many medical curricula in favor of new doctors being more humanistic. However, in only a few cases it materializes in practice because the resistance is enormous. In our medical career at CLAEH University, Medical Humanism has been a compulsory subject for 16 years [30]. Its practice is experiential and reflective and is studied from 1st to 4th year. Its main objectives are two: 1) the humanization of the patient through: a) considering and treating them in all their multidimensionality with empathy and respect, as well as their family; b) taking into account their feelings and preferences; c) train the student in communication and in the development of the necessary skills to communicate bad news, manage the limitation of therapeutics (so as not to fall into therapeutic stubbornness), and in the knowledge of "living will", abortion, euthanasia, and other associated critical processes. It also includes the study, prevention and management of the hidden curriculum and of violence and disruption in care environments, and 2) the humanization of the life of the medical student through: a) stimulating their awakening to the biopsychosocial culture of medical practice and the humanization of care; b) stimulate the habit of debating and building in groups (with adequate feedback); c) encourage reflection and critical thinking about themselves, their practice, their feelings and emotions about the feelings of others; d) promote the development of fraternity; d) make young people recognize and value their originality, sensitivity, affectivity and their ability to manage; d) prepare the students so that when they are doctors, they will be able to make a healthy balance -difficult but essential- between dedication to patients and dedication to themselves, and e) help them learn to make good use of their exceptionality, of their power to heal, and avoid the temptation of feeling too powerful and seeking only their benefit.

Our ongoing fight is for a cultural change. It will be difficult and prolonged, and it is imperative that it be continued by others, since nothing will change for the doctor or for the patient if we do not maintain it against all obstacles. The experiences narrated by the students show a good personal evaluation of their humanistic training and encourage us to continue on this path [31].

The doctor who lacks a certain level of well-being and enjoyment cannot create well-being and hope in anyone.

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Volume 3 Issue 1 July 2022