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*Physician, Heal Thyself:
Coaching the Health Care Provider*

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Physician, Heal Thyself: Coaching the Health Care Provider

Harry R. Gibbs

Although physicians as a group¹ enjoy a longer lifespan than individuals from many other professions, they experience a higher incidence of preventable deaths such as suicide, accidents, and murder. In addition anxiety, depression, and burnout are significant problems in this population. A major factor in creating this type of suffering is the discord between the prevailing view of what it takes to be a good physician and the essential components of what makes us human beings. The conflict between these two seemingly opposite portrayals creates a game that is unwinnable. By reexamining the story of the “ideal” physician, we can create a new game that reconnects the health care provider with the humanity of both the patient and the doctor, and can result in a more balanced approach to the treatment of illness.

How would you feel if you spent half of your life doing something that you didn't like to do? Many of us find ourselves in that situation every day. Work occupies approximately 50% of our waking hours on this planet, and yet we do not get up every morning eager to get to the office. In his recent book, Daniel Pink (2009) points out that while we may be successful in our jobs and careers, we are frequently not motivated as much as we could be. Polls conducted by the Gallup Organization show that there is a major distinction between job satisfaction and employee engagement (www.gallup.com). Somehow, we have gotten to the point where we are committing a major portion of our time to activities that bring more pain than pleasure into our lives.

I believe that part of this dilemma arises from the fact that, in the domain of work, we frequently find ourselves doing things that have little or no connection to what we care about. As illustrated by Pink, the majority of our motivation is internal, not external. When we know what we care about, we are committed to actions that address these concerns. Many organizations have grand mission and vision statements which promise a better existence for everyone. Yet, when employees are interviewed, they often do not see any connection between their specific job and these glowing declarations. This feeling of disconnection affects performance, and creates stress. Almost every major corporation is currently dealing with the issue of “work/life balance” as if, somehow, they are two separate entities. A strong link between the personal and communal cares of the workforce, and the goals and concerns of the organization is vital for success.

¹Although this article concentrates on issues surrounding physicians, the principles are applicable to many who provide frontline health care, as well as those involved in medical research and education

If this is true, then you would think that the world of health care would be a great place to live. You have the opportunity to interact directly with other human beings in a most intimate and crucial domain—that of life itself. However, there is a significant amount of suffering among health care providers. How can one be miserable when dealing with human life itself? In this article, we will explore this interesting paradox.

THE FACTS

Compared to the general population, physicians enjoy a longer lifespan. This is not an unexpected finding. Mortality is certainly linked to socioeconomic status, and physicians usually enjoy being on the upper end of this spectrum. Moreover, they have greater awareness of the value of healthier lifestyles and habits, and also usually have easier access to the health care system. This advantage is not shared by all physicians, however. African-American male physicians live longer than other African-American males, yet their mean age of death is younger than White male physicians, White professionals, or White males in the general population (Cole, Goodrich, & Gritz, 2009). Nevertheless, when compared to race-specific groups, physicians live longer.

A closer look at these statistics reveals a more disturbing story. While physicians enjoy a longer life span, there is a distinct difference in how they die. Compared to the general population, there is an elevated risk of preventable death such as suicide, accidents, and murder. Lindeman (Lindeman, Laara, Hakko, & Lonnqvist, 1996) found the suicide rate for male physicians to be between 10% and 300% greater than the general population; the rate for females was between 200% and 500% greater. A later study by Schernhammer and Colditz (2004) demonstrated similar findings, with an even greater risk for female physicians.

Even if it doesn't kill you, being a physician can hurt you. According to a number of studies, between 30 and 60% of physicians report significant stress and burnout (Cole, Goodrich, & Gritz, 2009, p. 18). Shindler (Schindler, Novack, Cohen, Yager, Wang, Shaheen, Guze, Wilkerson, & Drossman, 2006) reported that academic medical faculty reported more symptoms associated with depression than the general population. Anxiety was also an issue, with male physicians having anxiety scores 28% above the norm, and women having slightly higher levels. Even more disturbing was the fact that the highest levels were seen in younger providers.

THE CAUSE

On the surface, it would appear that there should be a clear alignment between the desire on the part of physicians to help people and the noble profession of health care provider. Based upon what we know about how humans operate in the world, this connection should result in satisfaction and fulfillment. The statistics above, however, seem to demonstrate otherwise. What is going on?

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Many etiologies for physician stress and burnout have been identified. Some of these include the strain of making life and death decisions, increased workload, the long journey of education, pressure to publish in academia, extreme expectations of patients, litigation concerns, and a host of other stressors. All of these certainly play a role. However, the fact that not all providers are affected in this manner suggests another possibility. One of the world's worst medical disasters was the 1918 Spanish flu epidemic, which was caused by Type A influenza virus H1N1. This global pandemic killed anywhere between 20 and 100 million people. But not everyone died. The mortality of those actually infected was estimated at between 2% and 20%. Why didn't the virus kill everyone that it touched? Because there was something about the individuals infected that played a role in the course of the disease. Similarly, not all physicians commit suicide, become depressed, or display symptoms of burnout, despite similar working conditions. Therefore, there must be some intrinsic factors that influence the impact a health care environment has on individual practitioners.

THE DISCORD

Human beings are biological, emotional, linguistic, and historical creatures. As such, we are hard-wired into certain behaviors that meet certain needs which are required for our continued survival as a species. Our biology requires us to eat, drink, reproduce, age, and die; our emotions provide us with motivation and prudence; our language is the vehicle for communication and connection; our history gives us a database that enables us to map out the future. Numerous studies have shown that we are at our best, and most centered, when all of these facets are aligned. As Jonathan Haidt (2006, p. 238) put it:

We were shaped by individual selection to be selfish creatures who struggle for resources, pleasure, and prestige, and we were shaped by group selection to be hive creatures who long to lose ourselves in something larger. We are social creatures who need love and attachments, and we are industrious creatures with needs for effectance, able to enter a state of vital engagement with our work.

I believe that the phrase "vital engagement with our work" is a key to understanding the environment of the health care provider. We are hard-wired to be human, and can only vitally engage in activities that are aligned with our humanity. However, Western society has created a world view of health care that differs markedly from our actual experience. Unfortunately, physicians are caught up in this story, and are attempting to live it. It is this cognitive discord that causes internal stress and adverse external behaviors.

A TALE OF TWO PROVIDERS

Haidt (2006) likens the human mind to someone riding an elephant. The "rider" is the cognitive, verbal, controlling portion of the

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brain, which is a relative newcomer to mammalian biology, yet thinks it is in control. However, it is the “elephant,” the unconscious automatic part of our mind, which has been guiding humans along the evolutionary path of survival for ages, that dictates most of our behavior. When the rider and the elephant are going in the same direction, all is well. When there is a disagreement, the elephant wins most of the time, which can certainly disturb the rider.

In the modern Western world we have created a story about what an effective and competent health care provider looks like, and the physician’s rider tries to head off in that direction. Why? Because the story makes sense and therefore aligns with the provider’s cares and commitments. As a physician, I want to help people to the best of my ability, and this story provides a standard which I and others can use to determine if we have achieved our goal. Unfortunately, the story does not describe the human experience. This is not where the elephant wants to go or is even capable of going. Table 1 depicts some of the major differences between what we tell ourselves about our providers and what our experiences show.

Interestingly, although traditional Western medical training emphasizes knowledge, ... patients... report a higher level of trust in providers who admit their humanity and declare that, at times, they do not have all of the answers.

Table 1. Two contrasting stories

The Physician Story	The Human Story
A physician knows	Humans do not know
A physician does not make mistakes	Humans are imperfect creatures
Findings are significant	Results are meaningful
Medicine lives in data	Humans live in stories
Medicine is a serious profession	Humans have moods and emotions
The goal is longer life	The journey involves a good life
A physician must sacrifice	Humans need renewal
A physician is isolated	Humans are connected
A physician is cerebral	Humans are somatic
The practice of medicine is about the patient/provider interaction	The practice of medicine is about the human moment

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Knowing versus not knowing

Our historical perception of physicians through radio and television programs is that they are all-knowing. From the quiet, reserved Dr. Kildare to the flawed but engaging Dr. House, physicians have all of the answers. Medical school training emphasizes knowledge in diagnoses, management, and prevention. Yet the practice of medicine, while based upon experimental statistics and clinical observations, is still relatively empirical. Not all treatments work in all patients, and sometimes patients experience remarkable recoveries despite treatment. Interestingly, although traditional

Western medical training emphasizes knowledge, my experience with patients is that they report a higher level of trust in providers who admit their humanity and declare that, at times, they do not have all of the answers.

Perfection versus imperfection

I once had a young surgeon say to me, “If I am not perfect, patients will die.” My response was, “And if you are perfect, patients will die.” Death is a part of the life cycle, and, as far as I know, nothing that we do will prevent that. The idea that we can achieve perfection in anything is insanity, and yet we expect this of our doctors, nurses, religious leaders, and political leaders. Setting the bar at perfection forces failure and disappointment.

Significance versus meaning

When the Human Genome Project was completed in 2003, it was hailed as a major significant achievement. According to the popular press, we would now be able to cure cancer, reduce heart disease, eliminate birth defects, and immunize everyone against infections. Without a doubt, we have learned a lot from this project. But in reality we have started a journey, not completed a trip. The function of over 95% of our DNA is still not clear, and we have a long way to go before cancer joins leprosy as a wholly curable disease.

Data versus stories

Scientific research creates large volumes of data. However, data is meaningless if it does not provide useful information. I remember having a conversation with a patient who was extremely depressed and angry. When asked why, she stated that she had just come from seeing her oncologist and had been told that an experimental therapy she was taking did not appear to be effective. When I tried to discuss the various aspects of clinical trials, she said, “But you don’t understand. He told me that there was 20% chance that it would work, and it didn’t work.” From the standpoint of data, I am sure that the oncologist was accurately describing a 20% response rate, which obviously includes the 80% of patients who do not respond. However, the story that lived in this patient centered on the 20%, not the 80%.

I don’t know of anyone who quit smoking because of statistics, but I do know of a large number of people who quit because of stories related to their own health or the health of loved ones and acquaintances.

Moods and emotions

Physicians are usually portrayed as emotionally restrained individuals, who are capable of bringing new life into the world in the morning and dealing with end-of-life issues in the afternoon. They are described as being calm, rational, and able to handle the full range of patient emotions with equanimity. Human beings,

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however, are emotional beings, and doctors are no exception. While their outward appearance may be one of calm, they feel the impact of each patient's experience just as exquisitely as anyone else.

Long life versus good life

Medical success is traditionally measured in terms of symptom relief and survival duration. Yet the human experience is a quest for daily happiness, success, and connection. The concept of *quality of life* is only now beginning to seep into Western medical education and practice. Globally, life extension as a primary goal is not present in all cultures, nor is it of primary importance in all patients.

Sacrifice versus renewal

The experience of overwork seems to be a matter of public pride and private shame for many physicians. Medical trainees still brag about how many hours they can go without sleep while being on call. In addition, studies have shown that physicians are more likely to ignore their own care despite a greater knowledge base about healthy and unhealthy life styles. The human experience demands self-renewal. Re-energizing physically, emotionally, and spiritually is required for optimum performance, and yet these activities are frequently diminished in a typical clinical setting.

Isolation versus connection

It is difficult for a physician to stop being a physician. In most social interactions I will, at some time, be approached by someone who says, "I know you are a doctor. Can I ask you a question?" I have also been on at least two flights during which the flight attendant requested the services of anyone on board who was a physician or other health care provider. I have never heard an attendant ask for an accountant on these flights. This feeling of constantly having to have your medical bag at your side results in an inability to relax and simply be a human being like everyone else. Moreover, there are few areas of safety where physicians can express their own personal concerns, fears, and questions.

Cerebral versus somatic

The world of medicine is one of thought. And yet human beings live in their bodies. We walk, we talk, we dance, we play, we work, and we move. The overemphasis on thinking can be detrimental to the patient as well as the provider. Only recently have we begun to look at the physical setup of our health care institutions (such as physical access, ergonomics, and signage) as an important part of the health care experience. In addition, studies have shown that physician performance decreases dramatically when the body is not cared for. Smith-Coggins, Rosekind, Hurd, and Buccino (1994) reported that performance in Emergency Medicine physicians can even be affected by when they get sleep during the day.

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Patient/provider interaction versus the human moment

As our society becomes more diverse, communication between doctor and patient is becoming more complex. This is partially due to our perception of how this encounter should be managed: the patient provides information, and the doctor provides advice and recommendations. Unfortunately, this rigid definition of the encounter does not work when the patient and the provider see the world differently. All too often, what the patient considers important information is interpreted by the doctor as irrelevant or not important. What the doctor considers critical advice is viewed by the patient as undoable or even harmful. Communication is not the passing back and forth of data and directives. It is a moment of human-to-human contact, with the purpose of defining actions that create a desired future that is shared by the patient and the provider.

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COACHING PHYSICIANS

Magnificent opportunity is available for coaches in the health care arena. Clearly, many dedicated and effective physicians are suffering. Yet, there is reluctance for providers to seek help. Many physicians are afraid of the stigma associated with seeking professional help. They are afraid that their careers will suffer, or they may even lose their license to practice. However, it appears to be much more acceptable to work with a coach than to see a therapist or psychiatrist. Coaching provides an opening for meaningful interaction. But what do you coach?

Start a conversation

This is the place to begin. Allow physicians to put their care and concerns into words. We cannot face what we cannot articulate. The simple act of converting thoughts and emotions into words is a powerful activity that allows us to observe ourselves. I have found that, for many physicians, the conversation frequently begins with their skepticism. There is a feeling that many external forces exist to interfere with their desire to help their patients, such as hospitals, regulatory agencies, insurance companies, grant agencies, lawyers, the media, patients, and even other health care providers. Faced with all of these perceived powerful obstacles, there is a sense of helplessness and frustration. The moods of resignation and resentment permeate the conversations of many health care providers, and can serve to resist the flow of meaningful conversations. It is important for the coach to remember, however, that skepticism does not mean that the coachee is not engaged. As Rosamund and Benjamin Zander (2000, p. 39) have stated, "A cynic, after all, is a passionate person who does not want to be disappointed again." Knowing that skepticism is a survival mechanism triggered by a fear of safety allows the coach to accept the behavior for what it is and not judge the client as being uncooperative.

So where does this issue of safety reside? Members of the Harvard Negotiation Project (Stone, Patton, & Heen, 1999) feel that every difficult conversation is really composed of three conversations:

1. The “What Happened” conversation: our narrative of what we believe are the facts surrounding the issue, as well as assessments about the actions and perceived intentions of others involved.
2. The “Feelings” conversation: usually an internal conversation about our emotions around this issue.
3. The “Identity” conversation: another internal conversation about what this event means to us, our perception of who we are, our judgments about good or bad, right or wrong, and our sense of worth.

As we have discussed earlier, there is a public perception of the appropriate identity of a “good” physician, and we in the health care field strive daily to maintain that identity. It is this third conversation that, I believe, is the trigger for the resignation, resentment, and cynicism that is observed in the health care arena. It is also an opportunity to build trust.

Open a space for trust

Trust is an assessment that you will take care of my concerns in some domain in the future. Unfortunately, trust is somewhat difficult to come by in health care. Academic medicine is a highly competitive playing field, with rewards and recognition given out based upon individual achievements using limited resources. As a medical student I remember that, when given a reading assignment in a particular class, other students would actually go to the medical library and hide copies of the assigned reference book, or even use a razor blade to cut out an article in a journal so as to gain a competitive edge. On the clinical side, one needs only to watch daytime television and notice the numerous ads for law firms offering to sue doctors and pharmaceutical companies. As a coach, you must somehow convey to the client that you want to play a different game. For me, the key is listening. By creating an opportunity for non-judgmental listening, you begin to lay a foundation upon which trust can be built. As you listen, try to hear all three conversations, not just the narrative.

Expose the story

In the 1980s, Humberto Maturana (Maturana & Varela, 1987) demonstrated that human beings are closed systems. As biological entities, we walk through the world being triggered by the environment in ways that are determined by our individual structure. Everyone has a unique response to these triggers, which is why no two people experience the same event in exactly the same way. For example, although we all (for the most part) have the same electrical and chemical responses to tissue damage, our sensation of

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pain and its severity is extremely individualized. For many physicians, the cognitive dissonance created by the requirements of the ideal physician and the biological limitations of human beings trigger tension, doubt, and fear, which result in the behavioral responses and defensive mechanisms discussed earlier. The downward spiral created by constantly trying to deal with what should be, rather than what is, causes the moods of resignation and resentment, which exacerbates dysfunctional behaviors.

Fortunately, we can change the results by removing the trigger. The story of the ideal physician is simply that, a story. It is an assessment that has been embodied by the health care provider that, when analyzed, cannot be very well grounded in fact. Humans are finite beings. They are born, they live, and they die. They will continue to do so. Health care providers can do many things to extend life (a little bit), improve its quality, and reduce suffering, but the cycle goes on. We can choose to continue to chase the ideal of medical perfection, or we can accept the fact that this is an imperfect world and the best we can do is the best that we can do. Once we are aware of the story, we can create a new one. Awareness creates choice.

It should be noted, however, that awareness is more than just knowledge. The “ideal physician” story is a very powerful one, and is one that pervades our society. Stories such as this can still trigger behavior despite knowledge to the contrary. As noted by Budd and Rothstein (2000), we still romantically embrace a beautiful sunset even though we know that the sun doesn’t actually set, but rather the Earth is rotating in its orbit. These powerful stories do not just live in our head; they are in our hearts and bodies as well. Pointing out that the story is just a story is only the first step in coaching.

Declare the game as unwinnable

Robert Dunham, founder and program leader at the Institute for Generative Leadership, frequently uses a form of game theory to help clients reframe difficult issues in a manner that allows for new possibilities. In the context of health care, the game that is frequently played is “Perfection.” The goal of the clinical game is simple: cure every patient. In academic medicine it is: make amazing discoveries that will change history. Who are the players in this game? Everybody! What are the rules? No mistakes, no guessing, and no limitations of capacity. By the way, resources are limited. When looked at in this manner, it is easy to see that the dice are loaded, and there is really no way to win this game. If perfection is the standard, then failure is inevitable.

Design a new game

Despite the tone of this article, there are many health care providers who enjoy their work and have incorporated it into their lives in a healthy, balanced way. Since they operate in the same health care arena as those professionals who are struggling, it is apparent

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that they are playing a different game. It is a game that accepts imperfection, acknowledges capacity, manages limited resources, and recognizes humanity. One method to assist physicians and scientists in designing a new game is to point out the humanity in individuals they admire and respect. An exercise that I have used successfully in leadership training sessions is to ask participants to think of a mentor or someone they know personally and admire. They write down what makes this person so special to them. Invariably, the listed traits are usually human ones, such as compassion and insight, and not material ones such as wealth accumulation.

Practice, practice, practice

Medicine is one of those fields that attract individuals who like to use their brains, and that is a wonderful thing. However, as we have noted, the story of the ideal physician is one that we have embodied, not just memorized. The day we finish our formal training is also the day we have learned the most current medical knowledge available. Yet no one would want to have their brain tumor removed by someone who just completed formal training. Clinical and scientific expertise is only attained after many hours, days, weeks, and years of practice. Our institution has recently initiated regular voluntary meditation classes for faculty members. These sessions provide an opportunity for physicians and scientists to practice centering and relaxation, two skills which have been shown to reduce stress and improve emotional health.

CONCLUSIONS

It is possible for an effective physician to live outside of omniscience, to accept imperfection, to mold data into meaningful stories that have value to the patient, to be aware of and embrace moods and emotions as predispositions to action, to partner with patients in the pursuit of a good life, to welcome self-renewal, to connect with others, to pay attention to the body, and to be human. In this game, both the rider and the elephant are journeying down the same path.

According to Lewis, Amini, and Lannon (2000), the authors of *A General Theory of Love*, we are predisposed to seek out love and connection. There is no better landscape for this than in the practice of medicine. But this connection will only be achieved if we view health care as a predominantly human experience. This can only have meaning if it includes all of our strengths and weaknesses, and lives within our acceptance of our mortality. Physicians are not the protectors of the realm or warriors in the battle. We are merely participants in the dance.

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