IMPROVING THE SATISFACTION AND WELL-BEING OF INCOMING PRIMARY CARE PHYSICIANS: SHARING THE PRACTICAL WISDOM OF RETIRED PHYSICIANS VIA VISUAL CHALLENGE CARDS

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ABSTRACT

Improving the Satisfaction and Well-Being
of Incoming Primary Care Physicians:
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Retired Physicians via Visual
Challenge Cards

Doctor of Medical Humanities Dissertation by

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The decreased well-being of primary care physicians (PCPs) in our health care system over the last few decades has been of increasing concern to many. To obtain improved insight into the experiences with their professional dissatisfaction and decreased personal well-being following a literature review, a qualitative study was conducted through in-depth interviews with 10 retired PCPs. These experienced physicians shared insights into the vulnerabilities they encountered throughout their careers in primary care. Drawing on arts-informed research methods, the study findings were translated into visual challenge cards. These cards can serve as a valuable pedagogical tool for aspiring PCPs, allowing them to learn from the experiences of their retired peers and potentially mitigate the challenges that have plagued previous generations of PCPs.

ACKNOWLEDGEMENTS

I am hugely grateful to the primary care physicians who shared their wisdom for the benefit of those following them into primary care practice. Their words expressed the joys and sorrows they encountered over their many decades of practice. Their dedication to reducing suffering in their patients was exemplary. I also give profound thanks to my two guides throughout this process, Dr. Merel Visse and Dr. Liana Piehler. They generously bestowed upon me their ongoing encouragement, wisdom, and support, enabling me to complete this work.

DEDICATION

To my husband, Chuck, who dedicated so much of his life to reducing suffering in others. And to my father, Wilber, and my daughter Cara and her husband, Jon, who also chose to devote themselves to caring for the well-being of others. They have made this world a better place.

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INTRODUCTION

Overview of the Problem

The current state of physician well-being is concerning. The professional satisfaction and personal well-being of physicians has decreased significantly over the past few years. The American Medical Association (AMA) uses the term *burnout* to describe this, defining it as a long-term stress reaction that can include emotional exhaustion, depersonalization (i.e. lack of empathy for, or negative attitudes toward, patients) and a feeling of decreased personal achievement (AMA, 2023). The percentage of physicians identifying themselves as suffering from burnout rose from 42% in 2020 to 47% in 2021 (Kane, 2022). Fifty-four percent of those physicians rated their burnout as having a strong or severe impact on their lives (Kane, 2022). In a 2022 survey of nearly 10,000 physicians, 53% stated that they suffered from burnout, with 65% reporting that it had negatively impacted their relationships (Kane, 2023). Of physicians surveyed, 23% reported that they suffered from depression, compared to 15% five years prior (Kane, 2023). The AMA (2023) asserted that "physician burnout is an epidemic in the U.S. health care system, emotional exhaustion and depersonalization at least once per week."

This study examines experiences with burnout in primary care physicians (PCPs), including family physicians, general internists, general pediatricians, and geriatricians. The study focuses on what PCPs learned retrospectively from practice in order to share their wisdom with incoming physicians via a pedagogical tool. A 2023 Medscape study revealed that the gatekeepers to our medical care have been most affected among all physicians by burnout. It showed that five years ago, 47% of family physicians stated that

they were burned out, compared with 57% now. Additionally, 46% of internists stated they were burned out then as compared to 60% now (Kane, 2023).

Consequences of Burnout in Physicians

Burnout's effects of exhaustion, depersonalization, and a feeling of "what's the use?" have been linked to serious negative consequences for physicians personally. These include higher malpractice risk; more frequent disruptive physician behavior; higher turnover in physicians and staff members; and higher rates of physician divorce, alcohol and drug use, and addiction (Drummond, 2014). Rates of suicide among physicians have also increased, with 300 to 400 physicians now dying of suicide annually (Shepherd et al., 2020).

One cannot deny that the impact of COVID-19 has added to the stress physicians are put under. But it is acknowledged that COVID-19 is not considered to be the primary cause of physician burnout, as these statistical increases began at least a decade ago (Soloway, 2022). Suggested solutions to resolving this dilemma have been many, yet its prevalence and impact continue to expand.

When we observe the consequences of burnout in such a high number of PCPs, we should consider its impact on the number of physicians choosing to become PCPs instead of specialists. In 2010, one in three doctors was practicing primary care. In 2020, only one in five medical school graduates chose primary care (Gotbaum, 2023).

Consequences of Burnout in the Non-Physician Population

Some may consider burnout exclusive to the practice of medicine, but others identify it as a problem that increasingly confronts all in our society. *The New York Times* described how workers across the board are being forced "into the mold of machines

rather than allowing work to be part of the creative capacity and flourishing of unique persons" (Warren, 2022). Is it machines that we want taking care of us? It appears that while this reality affects much of our society, it is especially troubling when it affects those assigned to care for our health. The sense of satisfaction that once sustained them appears to be decreasing at a concerning rate.

As we witness this increase in physician dissatisfaction, we also must acknowledge that the patient (who is all of us) will also increasingly suffer if this is not better managed. As medicine becomes more corporatized, increasingly governed by the quantity of patients seen, procedures and tests ordered, and forms completed rather than the quality of care produced, patient satisfaction will decrease (Macnaughton & Ahmed, 2023). The consequences of physician dissatisfaction have caused administrators to "struggle with physician shortages, high turnover rates and quality and safety of patient care" (Soloway, 2022). This has impaired the ability of institutions to render quality care. It has resulted in lower patient satisfaction rates, higher medication error rates, decreased access to care, increased health care costs, and an overall reduction in quality of care for patients (Thomas et al., 2018), as well as a reduction in the workforce itself. A study conducted by the Association of American Medical Colleges projected a shortage of up to 139,000 physicians by 2033 (Hochwald, 2023). Who will care for us in the absence of adequate numbers of PCPs? This reality calls upon us, at this particular time, to more carefully attend to those responsible for ushering us into the health care system.

I recently met with a physician who had practiced primary care for many decades. They had just begun dialysis treatment. When asked to summarize their experience of being a patient within the current health care system, they commented, "It's 'wham, bam,

thank you ma'am'" (slang for quick, rough, and unemotional sex). Even though this is just one experience, is this how we want our care delivered? Winston Churchill long ago cautioned that "those who fail to learn from history are doomed to repeat it." Why are we not learning from the wisdom of those who have recently lived this "history"? Perhaps we can. Perhaps if we listen more carefully to the words of those who provided our care over the last few decades, we can better care for those providing care in the future, ultimately better serving their patients as well.

Central Question

What is the practical wisdom of retired PCPs, and how can their experiences be translated in a pedagogical tool of visual images (challenge cards) for incoming PCPs to foster their satisfaction and well-being?

By delving into the lived experiences of PCPs and understanding the conditions that foster their well-being, this study aims to provide actionable insights for individuals and organizations to cultivate well-being in everyday practices. Instead of over-relying on established theoretical frameworks on satisfaction and well-being, this research employs an inductive approach to explore the rich nuances of PCPs' experiences, offering a nuanced understanding of the factors influencing their well-being from the bottom up.

Theoretical Concepts

The Vulnerability of Primary Care Physicians

Traditionally, physicians were the ones who sought to relieve suffering in those they served. At the same time, the work they did often gave them a sense of satisfaction that compensated for the long training and frequently rigorous work schedules that many endured. Today, however, an increasing number of physicians are no longer thriving. In

their attempts to meet the satisfaction of patients, colleagues, and society, doctors are professionally and personally vulnerable to burnout. This vulnerability appears to contribute to 68% of family physicians and 73% of general internists stating that they would not choose the same specialty again (Bodenheimer & Sinsky, 2014). These concerning figures show that the gatekeepers to our care will only diminish in efficacy and in number if we don't address the issues troubling them. Additionally, 68% of physicians have stated that burnout has had a negative effect on their relationships (Kane, 2022). This rate of dissatisfaction is double that found in the general U.S. population (Dillon et al., 2019).

Clearly, PCPs are suffering, often keeping them in a dark and isolated space if they are not attended to. Is this where we want our physicians to reside? Different bodies seek answers to this less than desirable location that many physicians appear to reside in, sharing their concerns in professional journals such as *JAMA* (Thomas, 2018) and the *New England Journal of Medicine* (Soloway, 2022; Wright, 2018). Yet the level of physician dissatisfaction continues to rise (Kane, 2022). Physicians seem to be vulnerable both professionally and personally, as my dissertation will demonstrate. While we acknowledge that every human being is vulnerable, and that vulnerability is not necessarily a negative thing, being prone to exceptional hurt or an unusual level of suffering is not desirable. Albert Einstein counseled that "Insanity is doing the same thing over and over and expecting a different result." We must seek different ways of addressing these vulnerable practitioners, as the ever more complex and dynamic environment in which they practice will most probably only continue to more rapidly exacerbate these situations.

The Value of Practical Wisdom (Phronesis)

While the teaching of medicine has traditionally relied on guidelines and principles, the ever-growing number of rule-based approaches to decision-making in practicing medicine have made this increasingly unmanageable (Conroy et al., 2021). Additionally, the rapidly increasing and ever-closer codification of medicine further complicates the work of caring for patients (Kotzee et al., 2016). A different approach grounded in practical wisdom, that of *phronesis*, which is also referred to as "good sense" or "horse sense," has been shown to be of value in making medical decisions (Conroy et al., 2021). Conroy et al. (2021) stated that phronesis "support[s] the process of arriving at decisions that are right for the range of cases and contexts that practitioners are faced with."

Phronesis, a concept that Aristotle (350 B.C.E.) discussed in his ethical treatise *Virtues and Vices*,

> is characterized as the wisdom to take counsel, judge the goods and evils and all things in if they are desirable and to be avoided, to use all the available goods finely, to behave rightly in society, to observed due occasions, to employ both speech and action with sagacity, to have expert knowledge of all things that are useful . . . [it]is a true and reasoned state of capacity to act with regard to things that are good or bad for man.

This type of practical wisdom comes from the everyday dilemmas and decisions of medical practice. It cannot be taught but must be acquired by experiencing life and virtue (Finn, 2022). Aristotle advised that

> although the young may be experts in geometry and mathematics and similar branches of knowledge, we do not consider that a young man can have Prudence. The reason is that Prudence [phronesis] includes a knowledge of particular facts, and this is derived from experience, which a young man does not possess; for experience is the fruit of years. it requires a pursuit of continual learning.

Lombardo (2010) described this wisdom we might use as a

> holistic and integrative understanding of the world around us . . . [it] is not narrow or specialized knowledge but a broad and deep knowledge that is expansive and encompassing . . . [it] sees the forest and not simply the trees . . . [it] searches to the horizon and beyond and identifies what is significant in life.

While we have traditionally collected and used biomedical knowledge from experienced physicians to educate our incoming physicians, acquiring more guidelines and principles of this type appears insufficient to address this problem. Accessing practical wisdom gained through "previous practice dilemmas and decisions experienced by practitioners" offers another way (Conroy et al., 2021). Yet the practical wisdom regarding professional satisfaction and personal well-being acquired from decades of practice appears to seldom be located despite being free for the asking. Retired physicians, with their troves of phronesis or practical wisdom, may be a valuable resource here. They no longer function in a business setting, so they are in a unique position to be open regarding the challenges they faced during their years in practice: they may no longer fear repercussions (Wong, 2020). Their wisdom may be of significant value not only in assisting younger physicians to improve their satisfaction and well-being, but also in improving patient care.

In this dissertation, I choose to focus on the wisdom contributing directly to the well-being of incoming PCPs. Can we afford to wait until these incoming physicians have acquired the years of experience necessary to maintain their well-being? Or can we use the phronesis of retired physicians to lessen the suffering of new physicians caused by the increasingly complex and uncertain environment they will encounter as they practice? Perhaps this may ultimately help all of us in our pursuit of good health. While biomedical advances are designed to promote health, "the same narrow text often considers insightful stories emotional, unscientific, and superfluous" (Kopchinsky, 2020, p. 67). Kopchinsky added that "medical training often minimizes exchange and therefore separates rather than enjoins physicians to patients" (p. 67). With increasing frequency, it is acknowledged that to render good patient care, the physician should not only be trained in the biomedical model, but also be receptive to and familiar with the patient's voice or narrative.

The Value of Collecting and Depicting Primary Care Physician Narratives

Physician exposure to patient narratives is only part of the equation that results in optimal patient care. Exposure to the narratives or stories of the physician must also be included if we are to optimize the care of both long term. How can narrative assist here? Each physician "narrative begs communication with others for relief and comfort while at the same time craving some kind of safety from its isolation and despair" (Kopchinsky, 2020, p. 63). The narratives of retired physicians may serve as especially valuable resources from which we can explore the issues that lead to physician suffering. Ignoring these sources of wisdom can result in the wasting of valuable information and the subsequent harming of physicians unnecessarily.

This study employed the arts, particularly the visual arts, to help convey wisdom to incoming physicians, enabling them to successfully understand and adapt to the realities that may lie ahead. Once one collects the narratives of retired physicians, their wisdom, one may be concerned that it is difficult to use this wisdom effectively. Here is where the arts may prove particularly useful. The arts "can enhance the interpretative processes by bringing new sensory experiences, enhancing perception, engendering empathy, and evoking emotions" (Eisner, 2008, cited in Daykin & Stickley, 2010). Recent research has shown that "aesthetic experiences—and the arts—are hard-wired in all of us. They are evolutionary imperatives, encoded in our DNA as an essential part of our humanity. And they are fundamental to our health, well-being, and learning" (Magsamen, 2019). In the late 1990s, Semir Zeki, neuroscientist at the University College of London, coined the term *neuroaesthetics* to describe the intersection of brain science and the arts. This recently formed field has demonstrated that "aesthetic experiences enter the brain through the portal of the senses, and—whether we're aware of it or not—profoundly impact our biological circuitry . . . developing arts-based solutions that address real-world problems" (Magsamen, 2019).

I am particularly interested in the visual arts. What does the visual modality offer here? It offers visual images, or *challenge cards*, that, through this study, I created to deepen the exploration, reflection, and understanding of the vulnerabilities often confronting incoming PCPs. The cards strive to decrease the harm to physician well-being during those times when biomedical training alone has not adequately prepared them for the realities of practice. They serve as catalysts to more compassionate (self-)

inquiry by depicting the lived experiences of those who have practiced primary care for decades.

Chapter 2

RESEARCH METHODOLOGY

This chapter presents the qualitative research methodology of this study and the feasibility of its research.

Methodology

This study aimed to gather the practical wisdom of retired physicians to develop a pedagogical tool that supports incoming physicians to better understand how to respond to professional and personal dilemmas. It was conducted as a qualitative study with an arts-based component. The six components included: literature review, sample and data collection, data analysis, development of challenge cards, quality criteria, and ethical considerations.

Literature Review

Literature was reviewed (via Scholar Search, Google Scholar, ChatGPT - 2012 to 2024) regarding physician vulnerability, the use of phronesis in medical education and decision-making, and the use of narrative. Keywords include: (a) “physician” cross-referenced with “burnout,” “vulnerability,” “narratives,” “consequences,” “exit interviews,” “intervention,” “management,” “suicide”; (b) “phronesis” and “practical wisdom” cross-referenced with “physician” and “decision-making”; and (c) “arts-based” cross-referenced with “physician” and “well-being.” Articles found through this search were reviewed and manually screened to identify relevant studies.

Sample and Data Collection

The study recruited retired physicians from a variety of practices in the greater Newark, New Jersey, area to participate in in-depth interviews encompassing their

decades of practice. The topic of burnout was neither mentioned nor considered in their recruitment. Both male and female physicians were recruited from a mix of PCPs (those practicing family medicine, general internal medicine, general pediatrics, and general medicine). These "gatekeepers" to care have been shown to have the highest levels of physician burnout (Soloway, 2022). Participants were recruited directly or from referrals from other physicians and were contacted in person, by phone, or by email.

Exit-type interviews were conducted in-person with 10 physicians at each physician's place of choice. Interviews were primarily open-ended with use of prompt questions (Appendix A). Interviews lasted approximately one hour. Participants agreed to an audio-recorded interview by signing the Consent Form (Appendix B). The interviews were later transcribed by a professional transcribing service.

Data Analysis

A manual analysis of the narratives via inductive and open coding (Stake, 2010, p. 151) was conducted. Utilizing triangulation, themes or codes were created solely from the narratives, beginning with the first interview. I and another reader then reread the narrative and applied the list of codes to this narrative. The second narrative was then read and coded by applying the codes from the first narrative and/or by adding additional codes when needed. (When a new code was added, split into two, or had a change in description, a review of how this changed the coding of all previously reviewed narrative took place.) Themes or groups of codes, as well as subthemes, were developed. Sections of the dialogue that support these themes were used as quotations in Chapter 4 of the dissertation.

Development of Challenge Cards

Each of the identified themes was translated into a visual image (challenge card.) Leavy (2020) explained that arts

> simply provide researchers a broader palette of investigative and communicative tools with which to garner and relay a range of social meanings. . . . Visual art can jar people into *seeing* something differently. This kind of consciousness-raising, unleashed by images, may not be possible in textual form. (p. 240)

I use my art to further stimulate deep exploration and improved understanding of the issues that cause decreased physician well-being and satisfaction. The words of wisdom I collected were translated into pictures (challenge cards) that serve as documentation and interpretation of the narratives. They are in the form of drawings designed to concisely depict and convey to incoming physicians the phronesis of the physicians interviewed. As an artist, I agree with the universal adage that "A picture is worth a thousand words." I believe that my "pictures" may accomplish this task more successfully than text could for some users. Horwat stated that "visual storytelling to study, explore, and communicate personal narratives, cultural experiences, and emotional content too nuanced for language . . . [can] foster imaginative engagement that encourages an empathetic connection" (qtd. in Leavy, 2020, p. 255). The users of the cards will, ideally, better understand these issues and realize that they are not unique to any one physician but have been experienced and, perhaps, managed by others in their profession to enhance their well-being.

The accuracy of the challenge cards in depicting themes identified was enhanced via presentation to several previously interviewed retired physicians.

Quality Criteria

To ensure the trustworthiness and rigor of the qualitative findings of my participants, several quality criteria were employed. Credibility was established through prolonged engagement with participants, triangulation of data sources, and member checking. Transferability was enhanced by providing thick descriptions of the context and participants, using purposive sampling. Dependability was ensured by maintaining a detailed record of my activities, also involving review by my committee, and practicing reflexivity. By applying these criteria, the study aimed to produce trustworthy and transferable findings that contribute to a deeper understanding of practical wisdom.

This qualitative study did not aim to produce generalizable findings in the traditional sense. Instead, its purpose was to develop rich, contextualized insights that may be naturalistically generalized to other similar contexts (Stake & Trumbull, 1982). By focusing on this specific group of PCPs and their unique experiences, the study sought to uncover the nuances and complexities of practical wisdom in action that may be meaningful to young PCPs. While the findings may not be directly applicable to all situations, they can serve as a valuable resource for researchers, practitioners, and educators who are interested in fostering PCPs' well-being and satisfaction via transferability.

Ethical Considerations

To ensure ethical conduct, this study's proposal was reviewed and approved by Drew University's Institutional Review Board (Appendix C). To protect participant

confidentiality, pseudonyms were used to mask any identifying information, including age, gender, or clinical affiliations. To prevent any potential emotional distress, participants were assured of their right to pause or withdraw at any time during the interview. Additionally, I closely monitored participant comfort levels throughout the interview process. No apparent distress or discomfort occurred during the interviews. The analysis approach employed in this study is particularly well-suited for exploring the lived experiences of PCPs. By focusing on subjective meaning-making, this method allowed for a comprehensive understanding of the complex factors connected with PCPs' well-being and practical wisdom. This understanding can inform the development of effective interventions and support mechanisms to address the challenges PCPs face.

Researcher Positionality

My family includes retired, practicing, and incoming physicians. Their well-being is important to me. Having observed them over many years, I am intrigued by and concerned with the impact that the rapidly changing health care environment has had on them. I would like to have a role in improving their well-being as well as that of other physicians as they face the current challenges. I believe this will have an impact not only on the physicians, but perhaps also on those they serve.

I conducted face-to-face interviews to gather data because I found this the most satisfactory and productive vehicle for me. Like many people, I suffered from a lack of face-to-face interaction during these COVID-19 years. Post-COVID-19, I can connect on a closer level and I sought this stimulation to aid both in remedying physician dissatisfaction and in adding skills to the toolbox I use to navigate through my own life.

I chose to translate the phronesis of the physicians I interviewed into visual images. As an artist (see Appendix F), I acquire and share my wisdom primarily via the visual. I believed I could create something of value here that had not yet been done. The images I created through this project do not speak to all, as we know that people grasp material in a variety of ways. But I designed these tools to promote deeper reflection and understanding by learners like myself who are often not reached as well as they could be by text alone. My hope is that my images successfully represent the important words of those I interviewed. I believe the cards I created from their wisdom can bring a different perspective to managing this concerning situation. I wish to add in this way to both the management of the burnout dilemma and to my own skills as an artist. When I, and you, seek care in the future, I hope we can be attended to by physicians who themselves have been cared for well.

Chapter 3

LITERATURE REVIEW

This chapter summarizes the current literature regarding professional dissatisfaction and lack of personal well-being among physicians. It begins with a general description of their vulnerabilities and continues with more specific descriptions of these areas most commonly identified in the literature. These include the rapid pace of change; one day contains only 24 hours; isolation and a lack of orientation, mentorship, and leadership training; impostor syndrome (IS); the culture of perfectionism; the threat of malpractice; and the lack of ability to self-care. It concludes by exploring the role that both wisdom and practical wisdom play in addressing vulnerabilities.

Physician Vulnerability

Those who seek care from physicians do so because something in their health or well-being is broken or in need of maintenance. They resort to this visit to repair that which has failed them in some way. The person seeking assistance now becomes a patient, figuratively residing at the feet of a wiser one, awaiting their counsel. This is not a position most people relish.

It is widely acknowledged that the physician with wisdom possesses unique tools that might have the power to heal the patient. If the patient did not believe this was possible, they would not risk baring their inner or outer self to the wise one. Yet this physician is also a human. The patient deeply hopes that the physician is more than a human—perhaps even more like a god, capable of super-human feats. This can produce deep disappointment and anger on the part of the patient when the physician does not fulfill their wishes or meet their expectations. The physician can also have come to

believe that they possess god-like powers. Yet, because the physician is human, their human frailties will inevitably come forth, often accompanied by a diminished sense of self-respect. Physicians are human individuals who are vulnerable, just like "all people are vulnerable: bodily, socially, or otherwise" (Kittay, 2019, p.23).

Going forward, when I refer to the concept of *vulnerability*, I particularly refer to an experienced, psychological vulnerability and am not drawing on philosophical conceptualizations of vulnerability as known, for example, in a feminist care ethics.

Physicians "are human beings caring for people with overwhelming needs, and caring for them with excellence requires years of training, knowledge, skill, attentive listening, compassion, creativity, resourcefulness, ongoing learning, dedication, time, the gift of presence, and more" (Wohlever, 2019, p. xxiii). Our society has produced these physicians for a reason and greatly values them in return for them keeping us well. But we seem to have been insufficiently attentive to their needs, as demonstrated by current statistics and a growing body of literature regarding their increasing levels of distress. We have put many of them in the position of bearing an exhausting and impossible burden. As Kuehn (2023) explained,

> The majority of issues with distress among health care workers relate to good, dedicated people who are in environments in which nobody could thrive. In fact, they're almost performing at a superhuman level to do as well as they are.

Physicians recently have been compared to the proverbial "canary in the coal mine," unable to survive in a toxic environment despite its initially healthy state. "You can't take the canary, teach it to be more resilient, and stick it back in the same coal mine and expect it to survive. You need to focus on the coal mine" (Kuehn, 2023).

How do we keep vulnerable physicians from succumbing to the pitfalls that currently exist in this environment? In an ideal world, they could continue as they currently are (the equivalent of remaining in the coal mine) until those in power improve the aspects of the health care environment that deplete its workers. These aspects may reside in the system itself, in the professionalism promoted in the practice of medicine, in health care institutions, or in physicians themselves. To effect change in any aspect beyond those under the control of the individual physician will take time, and waiting for this will not allow those currently struggling to thrive now. Inaction will most likely result in increasing levels of burnout. Therefore, it behooves physicians to seriously explore and hopefully improve upon what they can do personally to decrease vulnerabilities that may harm them. Vulnerabilities that cause them hurt will never fully vanish, as these are part of the human condition. However, if physicians increase their capacity to respond to these kinds of challenges or potentially risky disputations, they can better stabilize or balance these vulnerabilities with their capabilities.

A review of the current literature on physician burnout reveals, in no particular order of importance, the following components that cause significant and/or increasing vulnerability among physicians: the rapid pace of change; one day contains only 24 hours; isolation and a lack of orientation, mentorship, and leadership training; the prevalence of IS; a culture of perfectionism and the constant measurement against it; the ongoing threat of malpractice claims; a lack of ability to self-care; and being a person of color, or of the female gender, or not being of American origin. Female physicians, those of color, and those from different countries of origin are identified as being more vulnerable in a variety of ways than White male American physicians. This dissertation

focuses on vulnerabilities that apply across all genders, skin shades and countries of origin. Thus, it will not address this important bias issue, as I believe it is significant and complex enough to merit separate study.

The causes and effects noted in the literature of these vulnerabilities will be reviewed in this chapter. The role of wisdom, and of practical wisdom, will then be examined with the aim of better using these to address vulnerabilities PCPs identified during this study.

The Rapid Pace of Change

The rapid pace of change that we are currently experiencing affects everyone. In Yuval Noah Harari's (2019) popular book, *21 Lessons for the 21st Century*, he explores the pace of change and its consequences for our future. He noted that while we can't know for sure what impact machine learning and automation will have on us in the future, paying insufficient attention to it now will surely bring less than desirable consequences to many important aspects of our lives (p. 22).

Within the practice of medicine, this is particularly acute. No longer do most doctors practice individually or in small groups. Nearly seven out of 10 now work either for a hospital or corporation (Abelson, 2023). Abelson (2023) noted that the recently accelerated practice of corporate giants purchasing PCPs also illustrates the profound changes taking place within medicine. She states that these business transactions take place because "primary care doctors oversee vast numbers of patients who bring business and profits to a hospital system, a health insurer, or a pharmacy outfit eyeing expansion." To me, this puts the PCP and other physicians in a work environment where it may be difficult to remain true to their calling. The goal of the physician has classically been to

render care to patients, but due to corporate takeovers, the goal of those they work for has shifted toward revenue production. Physician training most probably did not adequately prepare them for the level of adaptability that will be required to thrive well in the current environment.

Add to this that the field of medicine is poised to undergo profound changes because of the rapid rise of biotechnology and infotech. For example, in contrast to what many believed in the past, we have now found that artificial intelligence (AI) may be better than humans at jobs that demand intuition about other people (Harari, 2019, p. 22). The computer, using biochemical algorithms to decipher emotions and desires, may be able to serve patients better than individual physicians can (Harari, 2019, p. 22). Many types of miscommunications and errors that now occur will lessen with these new developments. These and other benefits to humans are likely to be tremendous. Yet they will come at a cost. One area of particular concern is the loss of jobs as humans are replaced by computers that may outperform them. U.S. Surgeon General Vivek H. Murthy (2020) warned us:

> All of this is happening so fast that few of us even realize what these changes are doing to our social lives, skills and spirits. In fact, we are being tossed like twigs in a stiff breeze, unable to get our bearings as we unwittingly lose sight of what matters and who matters to us. We still have wiring for connection within us, but the more time and attention we lavish on racing to be current, the greater the risk we run that our innate social systems will falter and fail us due to neglect. (p. 101)

As the practicing physicians of today and of the future will be more dependent on computers and AI to keep pace with the changes, they also will relinquish increasing

amounts of the responsibility for patient care to the computer. Some wonder if, ultimately, the human provider might not even be needed at all.

An additional factor affecting physicians is the rate of doubling of medical knowledge. Page (2023) reported that we have reached the most rapid rate ever, with the amount of medical knowledge available doubling every 73 days. This daunting figure makes a mere human unable to keep pace. Page quoted John Ioannidis, professor of medicine at Stanford University School of Medicine, who stated, "Most doctors are feeling lost about keeping up to date." One can see that this heavy load of information especially affects generalists, as they require a broader scope of information to keep current. Yes, one must acknowledge that this large amount of new information may result in improved patient care, but if not well-managed, can also overwhelm those responsible for knowing it.

> Complicating this doubling of medical knowledge is the reality that advances in medical practice and health policy may be making their way separately, and with little coordination, they may clash at the level of the practicing primary care physician, leading to health policies that promote outdated standards and impede clinical practice. (Laiteerapong & Huang, 2015)

Laiteerapong and Huang (2015) stressed that if this not improved upon, physicians may find it a "great challenge" to maintain standards of care that focus on the individual patient while they are attempting to comply with "new health policies that emphasize population health management."

One need only recall the chaos and its repercussions that occurred when the electronic health record (EHR) was introduced in medical practices across the country.

We can all agree that the EHR provided much benefit to patients as well as to physicians. But some physicians found the transition so intolerable that they retired from practice years before they had planned to do so. Murthy (2020) again warned us:

> Humans are meant to adapt and evolve, but we need time to process new information and systems of behavior, to adjust to new societal rules and expectations. New technologies used to take a long time to test, develop and catch on. Now, the pace is constantly accelerating. This dizzying speed means that we barely have time to get used to one innovation before it's replaced by multiple new apps, devices, or platforms. (p. 100).

We know that these upheavals affecting the practice of medicine will only be accelerating. A heightened awareness of this and its importance to physician well-being will not eliminate its detrimental effects. However, it hopefully will help physicians to cope better with the adverse consequences of these rapid changes and to develop tools to minimize their detrimental effects, improving both physician well-being and job satisfaction.

One Day Contains Only 24 Hours

One day is not very long if one has more to do than can be done in the hours available. Add to this the fact that physicians must also take time to recharge, whether with personal time or sleep. Yet physicians are often shortchanged when their work duties demand such a large amount of time that little is left for a personal life. Two areas in particular appear to have recently made physicians more vulnerable to the effects of having insufficient non-working time: the average time period within which they see a

suggested or mandated quantity of patients, and the amount of time they must spend accommodating the EHR and other similar factors that add time to their working day.

Words of the highly regarded William Osler, who gave the first grand rounds at the opening of the Brigham Hospital in 1913, are summarized in Jerome Groopman's (2007) *How Doctors Think*:

> Osler essentially said that if you listen to the patient, he is telling you the diagnosis. There is no doubt that procedures are important, or that the specialized technology we have these days is vital in caring for a patient. . . . But I believe that this technology also has taken us away from the patient's story. . . . And once you remove yourself from the patient's story, you no longer are truly a doctor. (p. 16)

Yet how can physicians absorb that story in a time frame now often mandated for these gatekeepers to medical care? Consider one physician's perspective on this:

> My focus is on which diagnoses would be most dangerous to miss and how behind I am with my other patients. I often tune out the personal stuff . . . to provide a one-line simplification of a person's suffering. . . . Modern medicine has trained me and my fellow doctors to pin patients down, like beetles to be examined on a bulletin board. Their free motion impairs our taxonomy of them. Unsurprisingly, patients do not feel well understood while pinned on the paper roll of an exam table. But how else can we cover everything we must in an appointment lasting 30 minutes or less? (Siddiqui, 2022)

Currently, this "30 minutes or less" has shrunk to an average of eighteen minutes (Neprash et al., 2023). Prasad et al. (2019) stated that 67% of clinicians studied feel that

they need more time for new patients, and 53% need additional time for follow-up visits. They explained that "Time pressure in new patient visits was associated with lack of control, clinician stress, and intent to leave [the profession]. Time pressure in follow-up visits was associated with chaotic workplaces and burnout." Women physicians and general internists experienced these symptoms more commonly. This lack of adequate time can create what is often referred to as a *moral injury* in these physicians, "a term typically applied to combat soldiers that the Department of Veterans Affairs defines as a response to acting or witnessing behaviors that go against an individual's values and moral beliefs" (Brown, 2021). Physicians know well what constitutes good care, yet condensed visit times can not only result in less optimal care for patients but also produce moral injury to the physicians.

As the physician seeks information during the patient encounter, a decreased visit length can result in serious implications for the patient if the physician is unable to obtain an accurate diagnosis due to lack of time. We can all agree that forming an accurate understanding of why the patient came to the physician is important, and that a misunderstanding of what brought the patient in for the visit in the first place can have serious consequences. Words from a patient, presented by Broyard (2001), illustrate this:

> My ideal doctor would be . . . leading me through my purgatory or inferno, pointing out the sights as we go . . . I imagine [him] . . . entering my condition, looking around at it from the inside like a benevolent landlord with a tenant, trying to see how he could make the premises more livable for me. He would see the genius of my illness. He would mingle his daemon with mine; we would wrestle with my fate together. To most physicians, my illness is a routine incident

> in their rounds, while for me it's the crisis of my life. I would feel better if I at least had a doctor who perceived this incongruity . . . known in the literature as "empathic witnessing" . . . . The patient is always on the brink of revelation, and he needs someone who can recognize it when it comes (p. 169).

Because the EHR has often added a new sense of distance between the patient and the doctor, many patients already feel that communication between the two has become more difficult. When the time per visit further pushes the physician to rush the interaction, patients may struggle to be accurately heard. Broyard (2001) quoted another patient regarding this, "Since technology deprives me of the intimacy of my illness, makes it not mine but something that belongs to science, I wish my doctor could somehow restore it to me and make it personal again" (p. 170). This is not an easy task in the short time suggested for many visits. It follows that a lack of sufficient time can impose increased stress on a physician who now understands that they are providing a less than satisfactory product to the patient. This can cause a potentially serious outcome.

Interestingly, on average, a physician interrupts a patient's story within 11 seconds of the patient's attempt to tell it (Phillips et al., 2019). One might acknowledge that this results in more efficient collection of some data for the physician. It is hard to imagine, however, that this results in a more effective diagnosis and treatment. This interruption within seconds of the patient's opening statement might easily prevent a successful connection or adequate exchange of information. And from the patient perspective, Murphy (2020) reminded us that "for doctors and patients, misunderstanding can literally be a matter of life and death." This is not a small burden placed on the shoulders of the physician faced with a continual mandate to attend to a patient's

thoughts and concerns in an increasingly smaller box of time. There is no doubt that condensed visit mandates increase productivity in terms of number of patients seen and thus revenue earned. Yet this comes at a cost that appears to weigh heavily on the individual physician. Research demonstrates that when the physician is often forced to shorten or abort patient encounters, both the physician and the patient will suffer the consequences. Broyard's (2001) wise words are once again worth considering here:

> [The physician] can turn our lives into good or bad stories, regardless of the diagnosis. If my doctor would allow me, I would be glad to help him here, to take him on as *my* patient. Perhaps later, when he is older, he'll have learned how to converse. Astute as he is, he doesn't yet understand that all cures are partly "talking cures." Every patient needs mouth-to-mouth resuscitation, for talk is the kiss of life. . . . In learning to talk to his patients, the doctor may talk himself back into loving his work. He has little to lose and much to gain by letting the sick man into his heart. If he does, they can share, as few others can, the wonder, terror, and exaltation of being on the edge of being, between the natural and the supernatural. (p. 171)

An additional but no less significant issue increasing vulnerability in physicians is that one day holds only 24 hours. In addition to providing care to patients, most physicians also desire to have a life outside of work. Unfortunately, a personal life, while capable of granting one great pleasure, can also add to physician stress if there is not sufficient time and/or energy outside of work to devote to it. This outside-of-work life commonly includes: a relationship with a spouse or significant other; children and raising and caring for a family; personal health and fitness; finances (such as paying off debt,

saving money, a mortgage, buying in as a partner in one's group); wider family responsibilities (aging parents, etc.); and hobbies, friends, and interests outside of medicine (Drummond, 2014, p. 35). Drummond (2014) noted that often, many other stresses add to the time and energy needed to partake in this, including "separation or divorce, birth of a child, problems with children (special needs, behavioral issues), financial hardships, personal health issues, or wider family issues like health of a parent" (p. 36). Drummond (2014) observed that, for many physicians, there is a huge imbalance between the time spent at work or on work activities and the time spent on one's personal life (p. 27).

If most of the physician's time is spent on work-related issues, is there sufficient time remaining for a personal life? While work-life balance has always been a dilemma for many physicians, widespread use of the EHR has altered this positively in certain ways but has damaged it in other ways (Dillon et al., 2019). Dillon et al. (2019) described the EHR as "the fire hose that never turned off," and "a nightmare." They observed that it occupies many hours once one leaves work, requiring "pajama time" to adequately answer in-basket messages and progress notes that one had no time to address at work. They described "pajama time" as those hours when you are home in your pajamas yet are "still finishing your work for the day." Interestingly, these additional hours are not generally compensated for (Wright & Katz, 2018).

> Time-motion studies show that
>
> for every hour physicians spend with patients, they spend one to two more hours finishing notes, documenting phone calls, ordering tests, reviewing results, responding to patient requests, prescribing meds, and communicating with staff

> . . . physicians are working a staggering number of hours at night, and this has enabled organizations to continuously increase productivity targets without changing the infrastructure or support system, effectively adding a whole extra work-week hidden within a month. (Wright & Katz, 2018)

Wright and Katz (2018) identified those at the highest risk of this as "the frontline or gatekeeping specialties of general internal medicine, family medicine, emergency medicine, and neurology." Dillon et al. (2019) noted that this puts these gatekeepers at high risk of leaving the profession, warning that "It does not matter how resilient or positive you are, the work environment, especially in primary care, will eventually be a problem." It is concerning that "the cost of replacing a physician is estimated to be $500,000 to $1 million . . . [and] beyond the financial toll . . . physicians with symptoms of burnout are more likely to report having made a medical error in the past three months" (Dillon et al., 2019). Are physicians asking for too much to have a reasonable work-life balance? A quote from a medical resident illustrates this:

> To be able to take care of our patients, we need to take care of ourselves. We are not asking to be able to drive luxury cars or go on crazy vacations. All we are asking for is to be able to live a decent life amongst the 80 hours that we are working a week. (Hurt, 2023)

Whang (2022) noted that in a 2022 study, 70% of physicians expressed that they felt dissatisfied with their work life balance. Five years earlier, this figure was 54%. Increased time and productivity measures, as well as administrative burdens, have placed the gatekeepers to our care in peril (Beckman et al., 2012). Is this how we want to treat those responsible for caring for us? Some feel that "the grip of financial self-interest in

US health care is becoming a stranglehold, with dangerous and pervasive consequences" (Berwick, 2023). Berwick (2023) continued,

> Greed harms the cultures of compassion and professionalism that are bedrocks to healing care . . . Professionals find themselves trapped in record keeping, coding behaviors, and productivity imperatives that belie the reasons many went into health care in the first place. "Moral injury" is the harvest, with demoralization and disengagement to follow.

When the need for a personal life enters this picture, one can see why many physicians are caught in a double bind where achieving a healthy balance between their personal and work life is a never-ending struggle. There are only 24 hours in a day. What does this do to the personal life of the physician? When one lives by the rule that "the patient comes first," there may not be much left for anyone else, including the physician themself.

Isolation and a Lack of Orientation, Mentorship, and Leadership Training

"Just as a mother ushers her child into the world, so the doctor must usher the patient out of the ordinary world into whatever place awaits him. The physician is the patient's only familiar in a foreign country" (Broyard, 2001, p. 172). I would like to adapt this quotation by applying it to physicians who have finished their training and are beginning a practice. I alter it to read, "Just as a mother ushers her child into the world, so the experienced and wise physician must usher the newly minted physician out of the ordinary world into the world of patient care. The mentoring physician is the newly minted physician's only familiar in a foreign country."

We can agree that, during medical training, our future doctors are generally well "ushered." Additionally, while the value of connection with peers and "ushers" (in the form of sound physician orientation, mentorship, and leadership) appears to be recognized during this time, once physicians have graduated from these programs, connections with colleagues often appear to unravel as post-training life unfolds (Ofei-Dodoo et al., 2021). This can be due in part to the natural process of separation that takes place when leaving this type of training that often involved a great deal of group work. Unfortunately, many new clinical settings offer fewer opportunities to connect with colleagues (Ofei-Dodoo et al., 2021). Removing new physicians from their connections with colleagues without providing new opportunities for interaction and support can aggravate the effects of loss of community that they may have experienced post-training.

Add to this the current "epidemic of loneliness and isolation" among Americans declared by Vivek Murthy (2023a), our U.S. surgeon general in his advisory. In his book *Together: The Healing Power of Human Connection in a Sometimes Lonely World*, Murthy (2020) noted that in a 2018 national survey by U.S. health insurer Cigna, one-fifth of respondents said they rarely or never feel close to people (p. 10). He continued to discuss that in a 2018 report by the Henry J. Kaiser Family Foundation, 22% of all adults in the United States say they often or always feel lonely or socially isolated, and a 2018 AARP study using the UCLA loneliness scale found that one in three American adults over the age of 45 are lonely (Murthy, 2020, p. 10).

Murthy (2023b) added to these statistics his own experience where, as a physician, he made a "critical mistake: I had largely neglected my friendships during my tenure, convincing myself that I had to focus on work and I couldn't do both." This

observation serves to remind physicians that they are not immune to this ailment. The combination of leaving the often socially well-engaged atmosphere of training, with the propensity many of us Americans possess to suffer from loneliness, results is an area of vulnerability for physicians. Add to this the realities that the repercussions COVID-19 forced onto physicians (masking, fear of contamination from other people, etc.) and we see the need to be aware of these effects on them.

For physicians, additional factors add to the "epidemic of loneliness." When a physician enters a new practice, their orientation to it can range from excellent to non-existent. One can imagine the wasted energy and sense of isolation this promotes if the physician is left to undergo much of the orientation to the workings of the practice and its environment alone. The business world has long appreciated the value of a thorough orientation. This is not always the case in medicine and can cause significant and unnecessary stress on the physician as they attempt to understand how to function in their new surroundings.

Additionally, in the business world, the significant value of a good mentor is generally acknowledged. Dillon et al. (2019) determined that there is lack of sufficient mentoring among physicians. A newly onboarded physician without a strong mentor can be unnecessarily adrift, spending much time and energy trying to accurately understand the complex and fast-paced environment facing them. The value of a strong mentor can be apparent in many aspects of the physician's practice, but especially in decreasing the sense of isolation one might feel when they begin a practice. Additionally, physicians who have lacked mentors may also not be aware of the importance of themselves mentoring others. Mentoring and being mentored can often be a mutually beneficial

relationship, helping to secure the mentor and mentee individually and to protect them against loneliness (Murthy, 2020, p. 216).

A few seemingly insignificant factors may also contribute to this aspect of physician vulnerability. Many physicians commonly eat lunch (if they do allow themselves a lunch) at their desks while working on their computers. Often this meal appears to be rapidly ingested with little thought given to any type of replenishment other than that of calories. Whatever the reasons for this, it can be a lost opportunity for meaningful peer interactions and reenergizing which, considered in the long term, might make practice less isolating. A physician explained the importance of this practice: "These interactions lighten the burden of practicing. . . . Discussions . . . of difficult cases ameliorate . . . loneliness. . . . Shared wisdom and joint decision making in these exchanges bring intellectual stimulation and reassurance, increased joy, and decreased anxiety" (Menzin, 2023).

Another factor may be the layout of physician offices. Offices with great distance between colleagues can add to a feeling of life lived in a silo, with little opportunity to share with peers the daily challenges physicians may face. Murthy (2020) warned us:

> When we don't honor our connection to the community, to each other, and to ourselves, we don't do well. In the workplace when we violate human nature, we create a crisis that causes disengagement, depression, and loneliness. This comes in part from not honoring people's humanity and not honoring their unique contribution as human beings. (p. 233).

I would add that when we "violate human nature" by not attending to the level of isolation in the design of the environment in which physicians practice, we are

dishonoring their humanity and their contributions. Why would we want to do this? Menzin (2023) warned us, “I am worried about how new doctors will find opportunities for learning, collegiality, support, and friendship in the larger community of medicine. As burnout rates skyrocket in primary care, creating this scaffolding for young physicians is crucial.”

Also consider that many PCPs no longer go to the hospital to care for their patients because this aspect of their care has been taken over by hospitalists. Time spent at the hospital was frequently a time where socializing among peers and co-workers was routine. With the use of more hospitalists, peer-to-peer interactions occur much less often for many PCPs. This has certainly helped our delivery of health care in some ways, but it has isolated and thus deprived some physicians of the interactions with peers and co-workers that they benefited from in the past.

Consider Murthy’s (2020) counsel here when he served as a physician treating dying patients. He observed that what these patients talked about was the relationships they had been part of:

> The ones that brought them great joy. The relationships they wished they’d been present for. The ones that broke their hearts. In the final moments, when only the most meaningful strands of life remain, it’s the human connections that rise to the top. (p. 284).

All humans, physicians included, value relationships.

Finally, an additional factor in this area is the lack of leadership training and its consequences that are often found in medical practice. Dillon et al. (2019) reported that there is neither sufficient time nor compensation for leadership training among

physicians. They described leadership training as often composed of this: “Now you are a leader . . . figure it out.” They suggested more training, mentorship, and stipends to improve leadership. Why are we allowing this important component to languish? This comes at a cost to our health care system. It also comes at a cost to individual physicians who, at times, are not sufficiently prepared to take on these important roles and thus not as effective as they could and should be. All lose here.

Thus, it behooves physicians to be aware of these vulnerabilities to better recognize the role that isolation and less-than-adequate orientation, mentoring, and leadership preparation play in their lives. Murthy (2020) reminded us that without doing this, a continuing feeling of loneliness will produce poor results, as “shame and fear conspire to turn loneliness into a self-perpetuating condition, triggering self-doubt, which in turn lowers self-esteem and discourages us from reaching out for help” (p. 10). He added that “many people use drugs, alcohol and sex to numb the emotional pain of loneliness,” affecting not only personal health but also the health of society. He recommended that this can be interrupted by the individual if they acknowledge the vital need that all of us have for social connections. Beckman et al. (2012) supported addressing loneliness by advising physicians to understand their need to develop emotionally safe connections where they can be reassured that they are not alone in their feelings, where they can “pause, reflect and disclose their complex and profound experiences.” A prescription for this form of medicine may benefit some physicians.

Impostor Syndrome

As with perfectionism, this vulnerability frequently appears in physicians and can make practice more stressful and difficult than necessary. Impostor phenomenon, now

often referred to as (IS), was first described in the 1970s by psychologists Suzanne Imes and Pauline Rose Clance in this way:

> Imposter phenomenon occurs among high achievers who are unable to internalize and accept their success. . . . They often attribute their accomplishments to luck rather than ability, and they fear that others will eventually unmask them as a fraud. . . . Though it isn't an official medical diagnosis, psychologists and others acknowledge that it is a very real and specific form of intellectual self-doubt . . . generally accompanied by anxiety and often, depression (Weir, 2013).

Researchers at Stanford Medicine recently conducted the largest study to date that examines IS in physicians. Three thousand physicians between the ages of 29 and 65 participated, and researchers concluded that nearly 1 in 4 had "frequent or intense IS experiences" (Shanafelt et al., 2022). They also concluded that, among U.S. workers, physicians are more likely than others to feel the effects of IS. Adjusting for age, gender, relationship status, and hours worked per week, physicians were at a 30% increased risk of reporting IS compared with all other U.S. non-physicians. Shanafelt et al. (2022) strongly correlated this with "both the emotional exhaustion and depersonalization domains of burnout as well with suicidal thoughts and lack of professional fulfillment." The highest achieving workers in the world feel the most unaccomplished" (Moskal, 2022). Corkindale (2008) confirmed this sentiment:

> [IS, which] …high-achieving, highly successful people often suffer, doesn't equate with low self-esteem or lack of self-confidence…There can be a huge amount of pressure currently not to fail in order to avoid being 'found

> out'…Paradoxically, success also becomes an issue as it brings the added pressure of responsibility and visibility. This leads to an inability to enjoy success.

"For physicians, this feels like you should always be doing more and putting work first," stated Shanafelt, who directs the Stanford Medicine's WellMD and WellPhD Center (Shanafelt et al., 2022). Where did it come from? It appears to be common among medical students (Weir, 2013). Shanafelt et al. (2022) explained, "The available evidence suggests, that for many physicians, Imposter Syndrome experiences develop early in medical school and residency and persist long after training is complete." This syndrome appears to sap those afflicted with it of time and energy, both valuable assets when practicing medicine.

Jamison (2023) explained that the authors of the study "The Impostor Phenomenon in High Achieving Women: Dynamics and Therapeutic Intervention" claimed that women in their sample were particularly prone to "an internal experience of intellectual phoniness," living in perpetual fear that "some significant person will discover that they are indeed intellectual impostors." IS has also been found to be particularly high in incidence among physicians who, among their peers, are underrepresented in age or background, and among those lacking the same prior experiences or interests (Weir, 2013).

The symptoms, however, are the same across the board for all physicians with IS. They "chalk up their achievements to error, timing, or luck and often find themselves feeling like imposters amidst those who deserve to be where they are" (Khan, 2021).

Shanafelt et al. (2022) stated that, compared with the average worker, physicians have been found in other studies to have higher levels of resilience meaning and social

support, but often perpetually prioritize other people's needs over their own. This study shows that physicians have an Achilles' heel. No matter their accomplishment or level of achievement, many physicians feel it is never good enough. The expectation that they should go above and beyond human limitations, work excessive hours, and not seek help contributes to perceived personal shortcomings and deferral of their own needs (Shanafelt et al., 2022).

Weir (2013) explained that "the imposter phenomenon and perfectionism often go hand in hand. So-called imposters think every task they tackle must be done perfectly, and they rarely ask for help." Weir stated that part of the experience appears to be that the person lives in fear of being found out and is generally accompanied by anxiety and at times by depression. Weir added that the syndrome can result in one of two outcomes: "putting off an assignment out of fear that the physician won't be able to complete it to the necessary high standards; or over preparation, where one spends much more time on a task than is necessary."

It is widely acknowledged that the breadth and depth of medical knowledge currently required of physicians is ever growing, and that the pressure to stay current and exacting in the practice of medicine is constant. Consider someone prone to IS residing in this environment with "unrealistic, unsustainable expectations of what it means to be competent" (Khan, 2021). Ultimately, the IS becomes a cycle: "Afraid of being discovered as a fraud, people with impostor feelings go through contortions to do a project perfectly. When they succeed, they begin to believe all that anxiety and effort paid off" (Weir, 2013). For a physician with IS, the time and effort required to continue in this cycle can become exhausting, and ultimately, unmanageable.

The Culture of Perfectionism

Many physicians believe that their responsibilities include the equivalent of carrying mountains rather than climbing them. Peters and King (2012) explained that this attitude, this character trait of perfectionism, is common among physicians, making them "strive for flawlessness, set excessively high standards of performance, and tend to be overly critical of their behavior." Wohlever (2019) stated that many physician perfectionists prefer to ignore the annoying reality that the strong can become weak. She compared these perfectionists to rubber bands that, stretched beyond their limits, snap (p. 6).

Where does this perfectionism originate? Drummond (2014) explained that the behavior leading to perfectionism is deeply programmed into physicians during their intense and lengthy (a minimum of seven years and as many as 17 years for some surgeons) medical education process (p. 41). Shanafelt et al. (2019) discussed that within the cultures of medicine, our health care organizations, and the health care delivery system, pervasive and powerful "shared and fundamental beliefs, normative values, and related social practices . . . are so widely accepted that they are implicit and no longer scrutinized." They provided "identity, order, meaning, and stability . . . preserved over time . . . because it served an adaptive purpose that allowed . . . [this] group to endure through historical challenges" (Shanafelt et al., 2022). This type of culture was formed through a "protracted and deliberate process of professionalization during the 19th century . . . [where] physicians improved their reputation and became associated with humanitarianism, benevolence and commitment to the public good" (Arnold-Foster et al., 2022). Those who practiced medicine were considered to have answered a calling or

commitment unlike that required for any other job, as described in 1890 by Governor Knott to the graduating class of Kentucky School of Medicine:

> No other calling . . . demands a more absolute self-negation than the one you have chosen. No other vocation—not even the sacred ministration of religion itself—requires a more constant exercise of the higher faculties of the human mind, or a more earnest devotion of the purer and nobler attributes of the human soul. (qtd. in Arnold-Foster et al., 2022)

This high level of devotion has secured physicians in the United States high economic and social status. The status comes at a cost, however, which can have profoundly negative consequences on physicians. Arnold-Foster et al. (2022) explained that "physicians are frequently denied basic work-place rights and protections, and their exploitation is rationalized on the basis of the belief that medicine requires self-sacrifice. Their mental and emotional health has therefore been insufficiently protected."

The Lancet (2021) opined on the harm that medical professionalism can cause. It noted that much of this type of thinking is "rooted in an idealized, traditional, and paternalistic foundation of self-sacrifice and service to humanity, in which the perceived good doctor prioritizes the care of their patient over all else." It stated that physicians may suffer the detrimental effects of this over-prioritization of others in the form of mental illness, substance abuse, and suicide. Many surveys show that "physicians are planning to leave an already understaffed workforce after COVID-19, possibly because it has become unsustainable to work as a doctor and to care for oneself and one's family" (*The Lancet*, 2021).

Consider the Hippocratic Oath, which guides physicians and requires them to "always be motivated by the best interest of the patient." How does this impact physicians? Shanafelt et al. (2022) answer this question:

> As physicians, we tend to overwork . . . [and] imply that normal human limitations do not apply to us. . . . We inculcate physicians with a mindset of perfectionism. . . . We teach them that they should always defer self-care and personal relationships as long as needed to meet professional demands. Mistakes are the fault of the individual and are not acceptable. To err is human, but we are superhuman.

No person would deny that they desire perfect results when it comes to their own health care. However, we must first consider the consequences of requiring perfection in our physicians. A study conducted by a team of doctors and published in the *Journal of General Internal Medicine* noted: "If an American physician followed all of the guidelines for preventive, chronic and acute disease care issued by well-known medical groups, that would require nearly 27 hours per day" (Kolata, 2023). Supplement this with the following forces impacting physicians in current practice:

- growing complexity of medical care
- growing demand for medical care
- narrowing insurance networks which have decreased access and eroded continuity of care
- increased physician productivity expectations that have led to shorter clinic visits and decreased time with patients

- new regulatory requirements (meaningful use, e-prescribing, medication reconciliation) and use of EHR that have increased the clerical burden
- an array of metrics (e.g., patient satisfaction, quality measures, how rapidly physicians process inbox messages and close charts, relative value unit generation) introduced to assess physician performance (Shanafelt et al., 2019)

These forces appear to have produced a toxic mix for those with perfectionistic tendencies. Practicing amidst this mix can result in exhaustion, a state we do not wish for those caring for us:

> Current pressures to do more, faster, and with fewer resources all militate against a perfectionist approach, and this can change vulnerable doctors into obsessive and frustrated people who make seemingly impossible demands on themselves and their colleagues. Increased scrutiny from regulatory bodies, the media, and the public all fuel anxiety and fear of making a mistake or having personal weaknesses exposed. If patients expect their doctor to achieve the unachievable, this can result only in a fallen hero. (Peters & King, 2012)

One can thus see how perfectionistic tendencies can make a thriving practice difficult to maintain. The following description illustrates this dilemma well: “There is a hole in your boat so large that bailing as fast as you can does not keep you from sinking. But we often continue to keep bailing because of our training” (Drummond, 2014, p. 20). Drummond (2014) further stated that physician training has “deeply, comprehensively and subconsciously conditioned us” (p. 38). Drummond went on to explain, “It teaches us to see danger everywhere. Everyone is sick until proven otherwise. Each patient encounter offers the opportunity for a missed diagnosis and disaster. The basic act of a differential

diagnosis raises catastrophizing and paranoia to an art form" (p. 49). Medicine, along with law-enforcement and active-duty military service, may be the most stressful career one can choose, as all three have very high burnout rates that "give the individual ultimate responsibility and little control over the outcome" (Drummond, 2014, p. 31). One might agree that the practice of medicine is not easy to begin with, let alone when one has perfectionistic tendencies. Some early warning signs of unhealthy perfectionistic tendencies include:

- all-or-nothing thinking—"no one understands how important this is"
- failure to delegate—"no one will do it as well as I can"
- inability to forgive oneself or others for small mistakes
- procrastination to avoid the possibility of an error
- dissatisfaction with success
- continually striving for yet more achievement without praising others. (Peters & King, 2012)

It behooves physicians to be aware of the perils of perfectionism and thus to remember that they are human. Neither they nor their colleagues can be perfect. Yet our culture has continued to portray physicians as deities. A deity can do no wrong. In reality, and especially in our current environment, physicians need to understand that they will make mistakes. If this is not acknowledged, if perfectionism is consistently expected, this may result in a dethroning of the god—or, as it is known in many cases, physician burnout.

Threat of Malpractice

Consider the title of a recent article in *Medscape*: “Former NFL Pro Chris Maragos Wins $43.5 Million Malpractice Claim Over Knee Care” (McCormack, 2023). The author then quotes a press release issued by Maragos’s lawyers expressing Maragos’s viewpoint following this award: “I hope this decision sends a message to . . . medical staffs that players are people, not just contracts.”

This case involved a physician and a rehab institute that allegedly did not properly treat a meniscus tear in the patient’s knee. Instead, they “prematurely advanced rehabilitation . . . [when they] should have advised [him] . . . to limit his activities” (McCormack, 2023). While the award appears extreme in this case, it is used here to illustrate the impact that headlines and awards of this dollar amount might have on physician practices. It is also used to show how these kinds of articles raise the expectations some patients may have when they believe that they were not treated or cured as well as they had hoped for. Consider this quote: “The malpractice charge suggests that we are incompetent and therefore, ‘bad doctors’ . . . [but] litigation is about compensation, not competence” (Charles, 2001). Clearly justified at times, at other times malpractice claims may entangle physicians unfairly in a web of consequences that can cause significant harm to both the physician and our health care system.

> An AMA publication describes that the threat of medical liability hovers over physicians like a cloud and imposes rising costs on the nation’s health system. . . . One in three physicians, 34 percent, have had a medical liability lawsuit filed against them at some point in their careers. . . . Nearly half of physicians 55 and older report having been sued. . . . In most claims, the plaintiffs

> do not prevail [in cases closed between 2006-2015]. . . . Sixty-eight percent of those claims were dropped, dismissed or withdrawn. . . . Nonetheless, those claims . . . imposed an average of more than $30,000 in defense costs. . . . Of the 7 percent of medical liability claims decided by a trial verdict, the vast majority—88 percent—were won by defendants. . . . Research . . . [estimates] that defensive medicine costs the nation's health system at least tens of billions of dollars each year. (O'Reilly, 2018)

Physicians are confronted by the reality of these troubling statistics every time they see a patient. Does a patient ever visit (and agree to pay) a doctor if they are not suffering in some way? Patients present the physician with the task of healing them in exchange for their financial reimbursement. They come seeking a cure for their suffering—sometimes realistic, sometimes not. This is no small burden that rests on the shoulders of those being tasked with this healing. One can imagine how the physician may disappoint a patient if the patient does not possess a realistic expectation of what the physician can offer them.

Drummond (2014) provided a description of many patients:

> Our "clients" are sick, hurting, injured, scared, and sometimes in the very act of dying. Every visit is veiled by a mist of these negative emotions. . . . No one [of we physicians] can make it through training and into private practice without being traumatized by horrific events along the way. . . . We have all seen things happen we wish we hadn't. . . . Each of us has one or more traumatic experiences from our past that are capable of blowing a "normal" day to pieces when

> circumstances align themselves to remind us of the original incident. . . . Each of us knows that every patient could be the next missed diagnosis. (p. 31).

This description colors the lens through which physicians might come to view each patient encounter if they are practicing under a constant threat of malpractice. And when faced with an unexpected outcome—such as an unanticipated death—one can see that a physician is especially challenged (O'Reilly, 2018). O'Reilly added that if this then turns into an accusation of malpractice, the physician "may feel suddenly overwhelmed and out-of-control, with their ability to function temporarily compromised." It would be difficult amid the current malpractice environment for a physician not to feel as if they are in a vulnerable position and then must adapt their practice with this in mind. This may influence the care rendered to the patient, and not always in a positive way. Additionally, the physician may also end up as the one who suffers. Groopman (2022), in *The New Yorker*, summed up the struggle that the medical profession deals with constantly: "balancing the ego required to take responsibility for another person's life with the humility to acknowledge our capacity for catastrophic error." This "capacity for catastrophic error" can haunt the physician throughout their practice.

Additionally, once physicians are notified that they are being sued for malpractice, they are told to only "talk about the case when their attorney is present, and only with those people who are relevant to the case [as]… everything you say can be used against you" (Sweeney, 2020). While this may be good legal advice, it is not healthy psychological advice and may serve to further isolate the physician, who is often in a state of emotional turmoil following notification that they have been sued (Charles., 2001).

The unfortunate reality is that, at times, medical care produces outcomes the physician had not hoped for. Even if the physician has done everything correctly, if the patient is not satisfied with the results, they may sue anyway. If the outcome is judged to have been caused by care that is below the standard, compensation of some form is certainly appropriate. Yet all poor outcomes that result in claims are not a result of the physician having rendered less than standard care. Rather, some outcomes are due to the reality of the disease process that confronts the physician, and/or to unrealistic expectations of the patient. Conclusions by a judge or jury regarding the care rendered may be considered by the physician to be just or unjust. Even in the 88% of cases where the outcome favors the physician, it still can be extremely traumatic for the physician to have had his judgment and expertise so questioned. This can negatively impact patient interactions in the future and thereby decrease the level of satisfaction derived by the physician during their practice. Groopman (2022) recalled Wellon's words from the book *All That Moves Us*, reminding us that "Sometimes . . . [the physician] is shattered . . . , unable to recover."

The Lack of Ability to Self-Care

Consider the common warning given to parents flying with children: "In an emergency, make sure you strap on your oxygen mask before attempting to help your child." In certain circumstances, a failure by the parent to comply with this directive will result in a child who cannot survive despite any effort of their own. Both lose. Switching a few words in this scenario serves to illustrate a common dilemma in physician practice: Now the "child" represents a patient. The "parent" represents their physician. The physician has learned that "the patient always comes first." So, when the patient needs

help, the physician attempts to do this. But without the physician taking care of their own needs first, the physician is unable to help the patient. As in the oxygen example, both parties lose.

Those in the medical profession have been well schooled that the patient comes first. Yet these providers of care also require care themselves to function well in their roles. Wohlever (2019), in *Recapturing Joy in Medicine*, quoted the wise words of Jack Kornfield, "If your compassion does not include yourself, it is incomplete" (p. 41). Wohlever added, "Meeting your physical, mental, emotional and spiritual needs is essential so you can show up as your best self to care for people. Self-care, then, is a prerequisite to caring for others well. . . . There is no other way" (p. 44). Yet this seems no easy task for many physicians. As Yellowlees (2020) explained, "The 'compulsive triad' of the doctor's personality—doubt, guilt and an exaggerated sense of responsibility—works synergistically with the outdated ethical obligations of the Hippocratic Oath, which contains nothing about caring for oneself or other physicians" (p. xvii).

So where has the selflessness so long promoted by medical professionalism landed present-day physicians? Drummond (2014) counseled fellow physicians: "If you treated your dog like you treat yourself, he would probably move out to the next door neighbor" (p. 64). Amusing, but not so amusing if you examine the statistics surrounding physician mental health. An average of one doctor a day, equivalent to 300 to 400 doctors a year, die by suicide (Shepherd et al., 2020). Shepherd et al. (2020) noted that this phenomenon among doctors has been increasing in recent decades and is associated with burnout and depression. They added that because physicians possess qualities that are

thought to protect them from suicide, such as “marriage, higher socioeconomic status, higher income and postgraduate education,” one might assume their suicide rate would measure below that of nonphysicians. Yet studies show that these qualities may be inadequate to combat the realities of present-day practice, which “include career-related stresses, high rates of burnout and high rates of depression combined with a lack of utilization of mental health resources” (Shepherd et al., 2020).

The National Institute for Occupational Safety and Health division of the Centers for Disease Control and Prevention compared the likelihood of physicians who died from suicide to the likelihood of all workers (nonphysicians) who also took their own lives: “Physicians were greater than 2.5 times more likely to die by suicide than by all other occupations” (Shepherd et al., 2020). Why are physicians so vulnerable to taking their own lives? Prior to 2005, public opinion characterized the medical profession as possessing a mindset of perfectionism that encouraged physicians and those they served to regard physicians as deities (Shanafelt, 2021). An awareness or concern about the mental health of the physician appeared to be seriously lacking:

> This framework discouraged vulnerability with colleagues, encouraged physicians to project that they had everything together, and contributed to a sense of isolation. . . . There were no limits on work, and the concept of boundaries between personal and professional life was considered to be a lack of commitment. . . . physicians should be all-knowing and able to overcome every deficiency of the health care system to ensure optimal care for patients under any circumstances. (Shanafelt, 2021)

Following this era, national studies around 2005–2010, as well as peer-reviewed journals, began to depict the frequency of distress that was occurring among medical students, residents, and practicing physicians. For example, a 2014 Medscape survey determined that 68% of family physicians and 83% of general internists would not choose the same specialty if they could start their careers over again (Bodenheimer & Sinsky, 2014). Given that these specialties represent important gatekeepers to care, this type of information served as a troubling wake-up call.

What was happening? Wohlever explained that physicians generally possessed a deep sense of calling. However, from the very first day of medical school,

> the onslaught begins. The process of mocking and humiliation meant to harden and "help" us detach emotionally from the reality of day-in-and-day-out suffering begins its work in the soul, spirit and psyche of eager and deeply committed med students. . . . Alongside this inner desensitization and devaluing, poor self-care habits are reinforced, as medical students, residents and fellows swallow food between patients, sleep in sitcom chunks of time, and forget what the sun and trees look like. The dizzying pace is relentless, with no lack of patients, questions, charting, reading, testing or real life-and -death emergencies demanding superhuman strength and pluck. . . . Self-care becomes a distance concept. This training takes around ten years, establishing habits that are tough to break. (Wohlever, 2019, p. 48).

When these trained physicians then enter the workforce, the concept that "the patient comes first" is very deeply implanted within them. Shanafelt et al. (2019) depicted the impact of this "patient comes first" medical training and culture on the

personal life of physicians via “broken relationships, problematic alcohol and substance use, depression and suicide.” They also included the impact of this on the decreasing quality of patient care, including an increase in the number of medical errors, a decrease in patient satisfaction, and an increase in unprofessional behavior. They stated that there is an urgent need for the entire health care system to improve the care of and compassion for physicians. Additionally, they stressed the need for our leaders to teach physicians that they deserve and require self-care and compassion. Without addressing their need for self-care, the health care workforce will continue to face the growing challenge of burnout (K. Mate, 2022).

Over the last few years, despite the strong sense of calling to heal others that many physicians possessed, the realities of practice and the dysfunction of the health care system have become more problematic for them, resulting in decreased tolerance of the sacrifice required to fulfill their role. One cannot ignore the impact that the COVID-19 pandemic has contributed to this. Some feel that the harm being done to our physicians is due less to the “grueling conditions they practice under, and more our dwindling faith in the systems for which we work” (Reinhart, 2023). Reinhart (2023) stated that during the pandemic, physicians witnessed our hospitals nearly fall apart because of underinvestment in public health systems and uneven distribution of medical infrastructure. Long-ignored inequalities in the standard of care available to rich and poor Americans became front-page news as bodies were stacked in empty hospital rooms and makeshift morgues. Many health care workers have been traumatized by the futility of their attempts to stem recurrent waves of death, with nearly one-fifth of physicians reporting they knew a colleague who had considered, attempted, or died by suicide

during the first year of the pandemic alone (Reinhart, 2023). Reinhart shared a troubling quote from a physician who quit her job: “For me, doctoring in a broken place required a sustaining belief that the place would become less broken as a result of my efforts . . . I couldn’t sustain that belief any longer.” Reinhart stated that in 2021 alone, “about 117,000 physicians left the workforce, while fewer than 40,000 joined it. This has worsened a chronic physician shortage, leaving many hospitals and clinics struggling.”

Given that health care is a $4 trillion part of our economy, and its workforce is critical in maintaining its effectiveness, we appear unable to reverse this concerning reality. Melnick et al. (2023) warned us:

> Inefficiency, poorly designed workflows and processes, suboptimal teamwork, work overload, isolation, problems with work-life integration, and a professional culture that expects perfection and discourages help-seeking are currently contributing to high levels of occupational distress among clinicians. Although the problem and its impact on the health care delivery system are well-defined, there is minimal evidence regarding effective interventions to drive progress.

Why is this so? The knowledge gap regarding effective interventions is largely attributed to the “near complete absence of federal funding for research to address one of the critical challenges facing the US health care delivery system. . . . There is much discussion regarding burnout, yet little . . . [is] known about to effectively reduce it” (Melnick et al., 2023).

Our surgeon general stated that this chronic stress at work confronting our providers has been linked to a variety of adverse mental health outcomes, including anxiety, depression, and substance use disorders (Sindhu & Adashi, 2022). Those authors

noted that “many physicians eschew mental health treatment, often citing professional stigma and concerns over disclosure to state medical boards as barriers. . . . Few steps have been taken to address the problem” (Sindhu & Adashi, 2022).

In the meantime, some physicians unfortunately seek relief from stress via alcohol or illicit substance abuse. In a recent sample of American physicians, 15.3% reported scores indicative of alcohol abuse or alcohol dependence (Harvey et al., 2021). They found that among physicians, the use of prescription drugs (e.g., benzodiazepines and minor opiates) was higher than in general population estimates and often self-prescribed. Harvey et al. (2021) stated that the lack of early help-seeking among physicians is concerning, given the potential effect of substance misuse on their work performance.

Grinspoon, a Harvard Medical School instructor and Massachusetts General Hospital clinician now more than 15 years into recovery, advised those with addiction issues:

> Your addiction will get addressed at some point. It’s just a question of whether it gets addressed on your terms—if you ask for help—or on everybody else’s terms, like in my case, with the criminal justice system and the medical board involved. That is so much more painful. . . . It’s better to take the hit early and say, “I need help” (as qtd. in Mineo, 2023).

Thus, we ask, ‘Why are some physicians not addressing their addiction issues?” Harvey et al. (2021) stated that physicians with mental health problems may be more reluctant than non-physicians to seek help. Major barriers include “fears regarding confidentiality, the potential consequences for their career, medical registration and licensure, as well as

insufficient time and a belief that they can manage any symptoms by themselves." Harvey et al. further noted that

> Qualitative studies of physicians who have had mental health problems have shown a high prevalence of self-stigma, often driven by views that physicians should be invincible, as well as a fear of discrimination. These factors act as major barriers to seeking help and recovery, alongside considerable cultural stigma among the medical profession.

Summarizing this vulnerability, we see that the lack of physician ability to self-care and/or to seek help when needed can cause serious harm. Medical education and professional organizations have long stressed that the physician is not as worthy as the patient. While the rewards of medical practice often compensated for this in the past, these rewards no longer appear sufficient for many practitioners. Complicating this are the COVID-19 realities that physicians were faced with. Regardless of the causes, the level of suicide among physicians is difficult to accept. The impact of substance abuse on medical errors as well as on the suffering of the addicted physician also remains significant. It seems that some physicians have been unable to apply their own oxygen masks, seriously impacting both themselves and ultimately their patients. We must acknowledge that the well-being of the patient cannot always come before that of the physician. Physicians must acknowledge that they are of value and as worthy of adequate care as their patients are. They must see the wisdom of asking for help when needed.

Jacobs (2021), a physician health psychiatrist, explained that "asking for support isn't a sign of failure. It is a sign that [physicians] are mortal." And, in the wise words of Shakespeare, which are still appropriate these many years later, "Give sorrow words. The

grief that does not speak knits up the o-er wrought heart and bids it break" (qtd. in Wohlever, 2019).

Summary of Vulnerabilities

The vulnerabilities noted in the literature affect physicians in different ways at different times during their practices. An accurate awareness of them and of their prevalence among physicians as early as possible in a physician's journey can serve to promote a deeper personal exploration of these issues. Perhaps that exploration can result in improved management of the vulnerability and lessen the negative impact it will have on the physician going forward.

The Role of Practical Wisdom in Addressing Vulnerability

The vulnerabilities listed above call for action. Where is this to come from? Does wisdom, and practical wisdom in particular, have a role here?

What Is Wisdom?

The Oxford Dictionary describes wisdom as "The quality of having experience, knowledge, and good judgment; the quality of being wise." Lombardo (2010) described wisdom as:

> the continually evolving understanding of and fascination with the big picture of life and what is important, ethical and meaningful; it includes the desire and ability to apply this understanding to enhance the well-being of life, both for oneself and for others.

Lombardo added that "wisdom includes a fascination with learning about the world and a desire to help others." It is a "broad and deep knowledge" that goes beyond the narrow and specialized and sees "the forest and not just the trees. . . . It searches to the horizon

and beyond, and identifies what is really significant in life." Lombardo concluded that wisdom is an ever-evolving state of continual learning, captured in French writer Andre Gide's advice, "Believe those who are seeking the truth; doubt those who have found it.

What Is Practical Wisdom?

Jeste et al. (2019) noted a key distinction between "theoretical wisdom," " which pertains to understanding the deep nature of reality and the human place in it, and a more every day, grounded 'practical wisdom' which is more akin to making good decisions." Those authors noted that the human search for this kind of wisdom has manifested itself since long before we had written records, as evidenced in documents such as the Bible and the Bhagavad Gita. Then and now, it is a source of thriving, of better surviving. It seeks to identify "what is really significant in life . . . combining our inner minds with the world outside of us" and "knowledge with practical application" (Lombardo, 2010). It is a type of wisdom that involves "doing the right thing, at the right time, for the right reasons" (Jeste et al., 2019). Jeste et al. added:

> Practical wisdom, called *phronesis* or prudence in ancient Greek philosophy, is: . . . the wisdom to take counsel, to judge the goods and evils and all the things in life that are desirable and to be avoided, to use all the available goods finely, to behave rightly in society to observe due occasions, to employ both speech and action with sagacity, to have expert knowledge of all things that are useful.

Aristotle, in defining this *phronesis* as a type of wisdom that is practical and not scientific, warned that "it cannot be taught; it comes from life lived and virtue" (Kotzee et al., 2016). In the world of medicine, it is gained through previous practice dilemmas and decisions experienced by practitioners (Conroy et al., 2021). It is not about developing

moral rules and then following them, but about "performing a particular social practice well—being a good friend or parent or doctor or soldier or citizen . . . figuring out the right way to do the right thing in a particular circumstance with a particular person at a particular time" (Schwartz & Sharpe, 2010, p. 5).

Aristotle held that phronesis is a "true and reasoned state of capacity to act with regard to the things that are good or bad for man" (Nicomachean Ethics VI.5). He cautioned that ethics, with moral values "like honesty, kindness, justice, or courage do not prepare the moral actor for moral action." Ethics ensure that one strives for the "correct goal in moral action, but a form of practical moral know-how is required to bring those goals about" (Kotzee et al., 2016). Aristotle's *phronesis* or practical wisdom serves as the possession that "turns virtue into successful action" and "enables moral actors to weigh up the importance of competing goals that they (or others) may have in any moral situation" (Kotzee et al., 2016).

Jeste et al. (2019) described this type of wisdom as a set of skills:

> a process of making wise decisions, a comprehensive body of knowledge, high intelligence guided by moral virtues, and even a social characteristic. Wisdom is perhaps best defined as a uniquely human ability or trait that includes several specific components: social decision making, emotional regulation, prosocial behaviour that is guided by capacities such as empathy and compassion, self-reflection, acceptance of uncertainty, decisiveness, and spirituality.

This wisdom is not solely a possession of individuals. It also can reside in closely knit webs of people, institutions, cultures, events, policies, and practices. These components can interact within the web to enhance the well-being not only of an individual but also of

the stakeholders and of the world it impacts. Aristotle counseled that cultivating wisdom was not only a key to our own happiness but also good for society (Schwartz & Sharpe, 2010, p. 11). And while it was important for society in Aristotle's time, one can also see its importance in ours, especially for the well-being of our society and those physicians who oversee its health.

Currently, our physicians are confronted by three modern psychosocial epidemics dominating our communities: opioid abuse, loneliness, and suicide (Jeste et al., 2019). Jeste et al. (2019) stated that these have several characteristics in common, and consequently may respond to similar interventions:

> Prevention and treatment [of these three epidemics] may be a matter of building certain psychological resources or "vaccines" and a suite of resources which looks very much like the components of wisdom: emotional control over anxiety or fear, empathy and compassion - shifting us from seeing others as a threat, self-reflection, decisiveness amid uncertainty, and spiritually connecting us to a common humanity in which we are welcomed and cherished.

Can the use of wisdom, and practical wisdom specifically, better manage these epidemics? Beginning with their medical education, which primarily focuses on knowledge, we observe that physicians are trained to cure disease "via didactic rules and a dependency on empirical knowledge" (Jameel, 2022). In his study of 211 general practitioners, Jameel (2022) concluded that this type of education ignores important aspects of medicine, referred to as "soft skills" that include "a moral orientation toward flourishing." Jameel stated that "attempts to understand the uncertainty (essential for the practice of medical generalisms), and morality (essential to feeling fulfilled) are foiled

because they cannot be tackled with didactic rules and empirical certainty." He observed that, in contrast to these, practical wisdom that came from biographic narrative interviews with physicians revealed "their thought processes, their priorities, and essentially what made them the doctor they are today." Qualities such as "openness, growth orientation, learning from failure, comfort with uncertainty, a love for humanity, and following the golden rule (do unto others as you would want for yourself)" were shown to be of value.

We have progressed tremendously in our accumulation of scientific knowledge over the last 200 years, leading some to refer to this modern period as the Information Age (Jeste et al., 2019). However, Jeste et al. and some others feel it necessary for society to move beyond mere information to a new "Age of Wisdom." Conroy et al. (2021) stated that "recent scientific research suggests that the science of practical wisdom is not a fuzzy construct but an empirically based field that is ripe for rapid growth." This could be particularly useful in the practice of medicine where "physicians have been primarily motivated by deontological (guideline or rule-based) approaches to decision-making" (Conroy et al., 2021). Conroy et al. stated that the growing number of guidelines or rules (7,000 deontological guidelines by one estimate) have made this prescriptive approach increasingly unmanageable, especially when caring for patients with comorbidities and in difficult contexts. Conroy et al. cautioned that this results in both professional and personal vulnerability of physicians as they strive to meet the expectations not only of those they serve but also of their colleagues and of society.

Physicians want to practice medicine as they have been trained to do. Yet when acknowledging the complicated and sometimes conflicting goals of current medical practice, one can see that the outcome of practicing as one has been trained to has

become increasingly unsatisfactory for some. So, while they may "follow rules and incentives that modern institutions rely on in pursuit of efficiency, accountability, profit, and good performance, these cannot take the place of practical wisdom" (Schwartz & Sharpe, 2010, p. 9). Schwartz and Sharpe (2010) stated that, when applied to practical wisdom, these rules don't "encourage it or nurture it. In fact, they often corrode it" (p. 9). They added that our basic social practices require choices—like "when to be loyal to a friend, or how to be fair, or how to confront risk, or when and how to be angry." The rules and incentives (the carrots and the sticks) will not help us to make better choices here. The practical skill of wisdom is needed to determine what to do in a particular case, in a specific situation. Aristotle held that this was necessary to flourish as a human being (Schwartz & Sharpe, 2010). They noted that one might acquire certain character traits like "loyalty, self-control, courage, fairness, generosity, gentleness, friendliness and truthfulness," today more aptly called "perseverance, integrity, open-mindedness, thoroughness, and kindness" (Schwartz & Sharpe, 2010). They labeled the former traits "excellences," often translated as "virtues." But they believe that the master excellence is practical wisdom, and that none of the other traits can be exercised well without it.

Thus, we turn to Aristotle's *phronesis* or practical wisdom as a model. Physicians can use accumulated wisdom gained through previous practice dilemmas and decisions to aid them in ethical decision making. Schwartz and Sharpe (2010) noted that "the fundamental difficulty in all clinical settings is uncertainty . . . [especially making] the biological side . . . severe because it is often very hard to be sure of a diagnosis or be certain that a specific treatment will work" (p. 6). Added to this are other layers of uncertainty, such as moral and social problems, leaving the physician in the position of

choosing what is best for not only the patient, but also for society. Schwartz and Sharpe counseled that physicians "are not puzzling over a choice between the 'right' thing and the 'wrong thing'" (p. 6). Rather, the common issues they encounter are "choices among right things that clash, or between better and best, or sometimes between bad and worse." The physician must be certain that their choice is "in line with good clinical practice and has a good chance of working" (Conroy et al., 2021). Conroy et al. (2021) added that *phronesis* is "medicine's indispensable virtue, providing an essential connection between seeing or understanding what is right or good and knowing how to do good." Schwartz and Sharpe (2010) stated that the physician must develop an "ability to *perceive* the situation accurately, to have the appropriate *feelings* or desires about it, to *deliberate* about what was appropriate in these circumstances, and to *act*" (p. 5). This appears no easy task unless a strong framework exists and is used.

Some feel that the medical profession is becoming deprofessionalized, decreasing its emphasis on character traits that protect the interests and welfare of patients. Consider a now common physician lament in *The New England Journal of Medicine*, "The Plight of Primary Care, Part 2":

> I had a huge number of patients. I never felt like I got to know them well. I felt like I was under the gun . . . paid on productivity . . . [feeling] . . . like a factory, [with] a focus . . . on business and money making over relationships. . . . it felt like it was creating an antagonism, almost, between patient and provider. It's supposed to be a therapeutic alliance, but the system almost pits providers and patients against each other. (Gotbaum, 2023)

This is of deep concern. Where will we find the tools to combat this? Practical wisdom may be one of these tools, but a study by Malik et al. (2020) found that "existing notions of the phronesis process have been limited by a lack of empirical study." Yet Malik et al. believe that the acquisition of practical wisdom should be one of these tools and should be developed in the early formative years of medical education. They stated that a scaffolding or framework on which to build this is necessary to support its development.

Kaldjian et al. (2023) suggested a "*phronesis*-based framework of goals, concrete circumstances, virtues, deliberation and motivation to act." Malik et al. (2020), in reviewing Kaldjian et al.'s "well-cited study," stressed and expanded on the importance of the motivation component in this decision-making process. They recommended that, rather than being applied at the end of the process, this should be applied throughout the entire framework. They stated that motivation is "constructed as initiating the process and maintaining the momentum of . . . a *phronesis*-based approach." They added that motivation is a highly complex but necessary concept, "required for leading in, continuing, and completing the actions of the ethical decision taken."

Malik et al. (2020) conducted a study that collected narratives from medical students and practicing doctors at various stages of their careers (excluding retirement) to determine whether *phronesis* provided the capacity for "deliberation, judgement and discernment in difficult moral situations." To understand the meaning of ethical decision-making in the interviewees' practices, they used doctors' narratives, which would "offer a way to access the meanings to participants in the form of virtues they are grappling with in their practice." They found that

> the interviewee's actions are based on an engaged, embodied and enacted judgement that links knowledge, experience and virtue, and a dialectical relationship between patient's desires, circumstances and virtues fostering a morally right action. . . . Sometimes tension exists between a clinical concept of health (focusing on eliminating the physiologically abnormal state) and a well-being concept (focusing on the subjective experience of the patient) . . . [which] can be mitigated by using Kaldjian's framework.

Malik et al. concluded that awareness of, openness to, and exploration of physician narratives is of significant value in the acquisition of phronesis, in strengthening one's virtues to better serve both one's patients and oneself.

How can this gathered phronesis, narrative or otherwise, affect a physician's practice? Exploring the topics "practical wisdom" and "physicians" via the new and controversial ChatGPT (OpenAI, 2023) produced a number of suggestions. Medical training may want to consider these to promote the use of practical wisdom in enhancing the care of both the patient and the physician:

> Diagnosing and treating patients based on their uniqueness as individuals via a deep understanding of medical knowledge and the ability to apply it effectively in real-life situations; acknowledging the increasing complexity of medicine while navigating "ethical challenges with compassion, integrity and a patient-centered approach." This will consider "not only the medical aspects, but also the patient's values, wishes and overall well-being when making decisions"; and contextualizing awareness by "recognizing and appreciating the unique circumstances and contexts in which medical care is provided." This awareness

> would consider factors such as "socio-economic background, cultural beliefs, and personal circumstances when formulating treatment plans." This aims to help physicians match their goals to those of individual patients, promoting better outcomes for both; improving communication, enhancing the understanding of information shared by physicians and patients and their families. Listening can be improved, empathy increased, and complex medical issues more clearly conveyed. The goal is shared decision-making and fostering of a strong physician-patient relationship; and promoting continuous learning, by recognizing "the importance of lifelong learning and self-reflection." Keeping current will enable provision of the best possible care as well as inform doctors of new perspectives. "A practice of actively seeking feedback, and reflection on their own practice, will serve to continually improve their clinical judgement and decision-making skills." (OpenAI, 2023)

Aristotle's counsel that *phronesis* is "the path to *eudaimonia* (flourishing)" may still be useful in our striving for better care for all even centuries after Aristotle's gave this advice (Jameel, 2022). Lombardo (2010) counseled those who seek flourishing to practice "self-responsibility," where they "feel responsible for our own future and also feel that we have the required self-efficacy—the ability to realize our goals." Lombardo added that this, in turn, "generates hope (positive feelings about the future), optimism, and an expansive, rich consciousness of the future; the reverse mind-set generates helplessness, depression, and a closed and limited sense of the future."

In summary, a number of authors have supported the use of practical wisdom, or phronesis, as needed now in medicine to best resolve the morally difficult situations

physicians are confronted with (Conroy et al., 2021). Conroy et al. (2021) referred to this as

> medicine's "indispensable virtue", providing an essential connection between seeing or understanding what is right or good and knowing how to do it. . . . It helps to put virtues in the "proper order of priority and to make the right and good decision in the most difficult situation."

Acquiring stories and narratives from communities of physicians that possess this "indispensable virtue" may provide physicians with a better understanding of what core values are important and thus best applicable in our current settings, resulting in better outcomes for patient and physician alike.

Chapter 4

FINDINGS

The Essential Elements

The *essential elements* for PCPs emerged as the participants expressed their experiences and opinions during the interviews. They include four elements reported as important to their thriving: developing and maintaining long-term personal relationships with patients and those who care for them, achieving personal growth through physician/patient interactions, having a positive impact on patients' lives, and maintaining self-respect.

Long-Term Personal Relationships

Each physician interviewed described personal relationships to be of major importance in their decision to enter and remain in primary care. These relationships were what made their practices worthwhile. One physician described it thus:

> That's it. Relationships . . . I think they're still the best part of what I did the past 40 years. I still see my patients. I run into my patients downtown. They tell me how they're doing. The family and stuff like that. They don't tell me about their medical problems. (Participant F)

Often existing over extended periods of time, these relationships provided a type of important nourishment for these physicians. In one participant's words:

> And I'm realizing it now as I'm retiring and people are commenting to me about what their perspective is on our experience, our relationship is it. The depth of involvement in people's lives longitudinally, that was very attractive to me. I would never have been a great ER physician or somebody who needs to make a

> snap decision. My personality is much more suited to being a little more thoughtful, a little more evolving, developing those relationships. (Participant E)

The position that PCPs reside in allows them an unusual benefit, highly valued by many of the participants:

> I enjoyed the social interaction with patients long term. Being in primary care, it's a lot of long-term stuff. So, you really get to be involved with families for long periods, and some of these patients I had for 30, 40 years, and you really get to know them through their life cycles. (Participant F)

Personal Growth Through Physician/Patient Interactions

One can see how the longevity available to these participants allowed more depth and complexity to develop within their patient-doctor relationships. The resulting connections that were formed over the course of many years were of great value to the participants because they saw these as a benefit not only to the patient but also to themselves. This was particularly apparent in responses obtained from family practitioners who, most frequently among the primary care doctors, cared for different members and/or generations of the same family. One physician described the personal impact of this:

> Following people over the course of time. I followed first-generation, second-generation families, and even some third-generation families by the time I finished. So having that longitudinal effect on people's lives was the best part of practice. [For example] I picked up a family member. [Then] I picked up the family and took care of them and there were medical problems all the way through—a family of five with muscular dystrophy. I lost one of those children to muscular dystrophy at their age 21. Took care of the second child and [lost] that

child to muscular dystrophy at about age 20. There was a 40-year history with that family, losing two children to muscular dystrophy over the course of years. . . . [The sum of that relationship] was a real positive. (Participant G)

Another spoke of the reciprocal nature of these types of interactions:

[The best part of my practice was] all the relationships that I had with my patients—absolutely. Because they were ongoing for 37 years. I got to know them. I got to know their families. I got to know what their situations were. I got [them] young, and then grew old with them. When in medical school, I loved the ER, I loved the ICU. Yeah . . . you started somebody on a drip or you gave them a medicine and immediately saw the result made them better. [In internal medicine], you give somebody Lipitor for their cholesterol, and you are looking [at them] living extra years. You followed them serially. Yeah . . . I knew—internal medicine: that's what I'd love. [I'd] get them through illnesses, get them through hard times, just like they would give me a pat on the back every now and then [which] got me through if I was having a rough day. So . . . the relationships absolutely. There are many. One [was] a couple that had two daughters, one who was developmentally delayed, and was probably working at a 3-year-old level, but when I retired, she was in her 50s. [I] got them and the father through cancer. So yeah, it was a good relationship. We still keep in contact, . . . even though I'm retired. (Participant B)

These experiences with patients didn't only help participants to heal others, but also shaped the physicians themselves into better humans in many aspects of their lives

(in their roles as parents, spouses, family members, and friends). This process of mutual learning from these connections is emphasized in the following comment:

> In my practice, the biggest gift of practicing medicine is, as I told my kids, that I became a better person. Because of the patients I took care of. Pieces of them became a part of me. Pieces of them made me a better father, a better doctor, a better husband, a better friend. At every age—17, 21, 30—I was totally a different person. And it happened because of the ability to have interactions with my patients that made them a part of my life, they became a part of me. And me with them. So, it went both ways. (Participant H)

Having a Positive Impact on Patients' Lives

Connections with patients fed the physicians and served to sustain them throughout their decades of practice because they believed they were making a difference in the lives of the patients. This "making of a difference" occurred not only when they could positively affect or cure the disease in a patient, but also when that was not possible. In that case, they could offer care or support for the patient. One physician explained,

> My patients—talking to them, hearing about their lives, doing what I can to help them, making their lives better. I mean, you know, just helping them breathe easier, helping them get through the best way I could. Cheering them when I could, comforting them when I couldn't. Caring for my patients was the most valuable and rewarding thing about being a doctor. (Participant G)

Another stressed the importance of making an impact on the life of another despite the challenges that being a PCP brought:

> And the thing about it, with all its foibles and the financial questions and insecurity and even all of the turmoil that I've recently kind of encountered—I don't question my daily purpose. Why? . . . when I sit knee to knee with somebody and again, whether it's a dog bite or cancer, I come home from a day knowing that I have made a contribution. (Participant I)

While professional and financial gratification were important, the participants consistently stated that the rewards gleaned from making a difference in a patient's life were the most important aspect of thriving well. The relationships were described as serving both the doctor and the patient. Participants explained their relationships as being interchanges, affecting the interests of both. They experienced transformation through these patient interactions because they produced mutual learning and value finding. One physician illustrated this:

> I was fed by interacting with patients . . . it just felt good to comfort them and care for them and to be respected by them in return. It was a two-way street. This was another level of connecting with people, I guess, where it was a more intimate kind of relationship than one would normally have. (Participant G)

Self-Respect

Interactions with patients didn't only help participants to heal others but also gave the PCPs a sense of self-respect that they found to be of significant value. Having a direct impact on the life of a patient, ranging from simple reassurance or relief of pain to life-altering effects, provided them with self-respect that enabled them to thrive. When they could maintain relationships that produced this, they enjoyed the benefits of this as well as the respect of those around them. One spoke of such an example, "When I see her, . . .

[one patient] always says to me, ‘Oh, you know, you’re the one who kind of saved my life’” (Participant E). Another explained the importance of this sense of self-respect gained from being of value to others. “I just think that people don’t realize the long-term rewards you get for being in primary care. I think I made a lot of difference in people’s lives over the course of my career” (Participant F). Those words illustrate the impact that a sense of self-respect had on participants. A different participant opined, “So, what do I look back on as being rewarding? It was the fact that people sort of said, ‘You know, this guy is helping people. He is owed some respect.’ The sense . . . that people respected me for what I did” (Participant C). Another noted the impact that a healthy sense of self-respect had on them:

> I felt that most of my career, if I’d seen 30 patients during the day, that probably 25 of them were better off for having seen me that day. So, you had a good feel about what you did most of the time. Not always, sometimes, but most of the time you felt at the end of the day you could shave yourself very easily [meaning that one could feel comfortable facing oneself in the mirror]. It was a good day. (Participant G)

Summary of Essential Elements

In summary, participants felt that these four components were key to producing and maintaining professional satisfaction and personal well-being: strong and enduring relationships with patients, personal growth, positive impacts on patients’ lives, and a sense of self-respect. Each was an integral part of the essential elements they required to thrive well over decades of practice. Without enough of these, the essential elements begin to erode, often giving rise to the affliction currently termed *physician burnout*.

Depleters of the Essential Elements

What has happened to the essential elements that served to sustain many PCPs in the past? Why are so many struggling now to face themselves in the mirror every morning when they "shave"? When we consider the statistics regarding dissatisfaction among physicians reviewed earlier in this dissertation, we need to explore the themes that have contributed to the increasing erosion of these important elements over the last few decades. As this has occurred, some physicians have found it difficult, if not impossible, to continue shouldering responsibility for the health care of their fellow human beings. One participant described the toll that shouldering this responsibility had taken on themself:

> Because you have taken a burden from [them] and put it on your shoulders. And you're carrying it. So, you carried the cross with them, the Judeo-Christian view. But that's kind of what physicians can do. So, you take a very sad story, heavy burden, and you're willing. Just take a little piece of it. I'm going to carry it. Now, is that good? Is that a physically good thing? No, that's why I had a heart attack at 56. No, it wasn't good. But if I had learned how to deal with that stress better before I was 56, I would not probably have had that event. (Participant H)

Another physician detailed the impact that carrying this responsibility for patients' lives had on them through their many years of practice:

> It's like you put a backpack on and you start your job and every time you see a patient, you put a pebble in it and another pebble, another pebble. The pebbles were the responsibility that you felt for every patient. Like every time, I felt the possibility that I would be missing something. The headache that I thought did not

> require an MRI could have been due to a brain tumor that I might have missed. Or I have a patient with chest pain and decide not to send them to the ER. But there is always a small chance that I am wrong, and they have a cardiac arrest and die. Or an obese patient who smokes and drinks that I hope I can help. But it's stressful because often I can't. I feel like I should be able to help them, but I can't. And when you retire, you don't even realize the weight on your back until you take it off and then you float. And that's what I felt like. I felt I was floating without the weight on my back. (Participant J)

The rewards that physicians obtained from practicing primary care over the last few decades have slowly but consistently decreased to where the burden of this "weight" has made it too difficult to thrive. They have become more vulnerable professionally and personally. Participants described the components of this "weight" as being of two major types or themes: those within one's control, which I call *self-depleters*, and those external to one's control, which I call *external depleters*. I explore these in the subsequent subsections, dividing them into subthemes based on statements of participants that further describe these depleters.

Self-Depleters—Or Personal Diminishers of the Essential Elements

Participants described self-depleters as those feelings or perceptions that erode the rewards (the essential elements) that serve to sustain PCPs long term. When physicians ignore self-depleters, due to inadequate knowledge or lack of the tools necessary to address these feelings, these factors become significantly detrimental to both their professional satisfaction and their personal well-being.

I Must Be Perfect (or, If I'm Not God, I'm No Good)

A number of participants stated that they possessed an ever-present need to always perform at the highest possible level. Many stated that this striving for perfection began in high school, followed by college, medical school, internship, residency, and beyond. They learned there that unless they were as good as or better than those around them, they were not OK." And being "not OK" was to be endlessly vulnerable to a sense of defeat or failure when an outcome was less than perfect. This drive to always be perfect, to never be less than god-like, became deeply etched into the fiber of their being. As one physician stated, "I'm supposed to be perfect" (Participant C). Patients understandably seek this perfection when it comes to their care. Physicians understandably seek to provide this kind of care. Yet where does this leave the physician when dealing with reality? Because they are human and not god-like, they repeatedly fall short of achieving perfection and remain with the consequences of that shortfall.

The participants described this drive for perfection, often having begun early in their training, as promoting a nagging and ever-present feeling of inadequacy. It was accompanied by its frequent and equally unwelcome companion, anxiety. The belief that others must be smarter was ever-present, and the sting of falling short was always threateningly nearby. A participant described this:

> From the time I left home and went to college, and through medical school, and then fellowship and then in practice, I always felt like, "You know, I'm not quite as good as these guys." It never left. And it's sort of a frustrating sense to have. But I remember talking to [another physician]. And he said the same thing. "When I got to Harvard, I thought everyone else was better than I was." I said,

> "When I got to college, I felt the same way." [Then] in medical school . . . we had guys who'd been premeds and knew all this physiology stuff from undergraduate years. It was all review for them. And I didn't begrudge them that, but I certainly felt that I didn't know much as they did. Well, you do what you've learned to do or what you struggled with from the time you were an undergraduate. You learn to study a little bit harder. You have times when you probably should be with your family [but instead] you try to read up. (Participant C)

This ever-present need to be at the top professionally also often negatively affected participants' personal lives. It prevented them from spending time doing things that could have made their lives more satisfactory, such as spending time with family and friends or engaging in activities outside of medicine. They felt they could not stop striving, always needing to be pursuing this impossible goal. Even during times of supposed relaxation, a sense of needing to be doing something that would increase their medical knowledge would not leave them. One described this feeling:

> And I think other people do it other ways. I never got into golf, for instance, but I think some [dealt with it] by going to the golf course once a week and thinking about nothing but hitting that ball correctly or whatever. And I'm sure there are other things, like going sailing. I looked into a practice once where a lot of the doctors went sailing on their days off. Those types of things I think helped, but I never got into golf and never got into sailing. (Participant C)

Another physician lamented the significant impact perfectionism had on them:

> I mean . . . I would not want to make any mistake. I wanted everybody to say, "great doctor." [If] they just said, "Thank you, you're OK, doctor," that would not be enough. No. . . . I had to be great. So, I had to be perfect. (Participant J)

The Real (or, the Really Inadequate) Me

Many participants spoke of how perfectionism was exacerbated in them by the coexistence of IS. As one physician explained, "Perfectionism and IS were driving forces that made me work harder and harder and harder, and the anxiety builds up" (Participant J). This made some participants feel particularly vulnerable. IS results in a feeling that the true me is not the one that others see, but a lesser being who does not deserve respect. Therefore, if I don't always do better (be perfect), the real, and really flawed, me, will be discovered. I will be revealed, finally bared to the world as I truly, and inadequately, am. Those physicians who stated that they believed they had IS revealed the ongoing burden of high expectations and fear of failure that this imposed on them:

> I was a straight A student through high school and college. Two weeks into medical school . . . I was working my butt off. And I was getting C's and D's. I never got a C or D [before]. And I kept on calling on my dad saying "I don't belong here. I'm not as smart as these people." (Participant B)

A different physician described the long-term effects of this:

> I think I have IS. I mean, I was just never as good as I should be. And even though I got straight A's and got into… [an Ivy League school], I never felt like I deserved it. I remember getting the best grade several times and thinking, that must be a mistake. Or there was a nerdy guy in school . . . he was totally brilliant. And there was a test in advanced engineering or something, and I got a better grade than he

> did. I was at the top of the class, and I was thinking, there's something wrong here. That can't be. He's got to be smarter than me. There's something wrong with the test. There's something wrong with the test, or I was lucky. (Participant J)

Later in this participant's career, the impact of IS was apparent:

> [IS] made me very concerned that people are going to find out that I don't know what I'm talking about. So, [in medical practice] I had to really convince myself, as well as the patients, that I was right. . . . It was stressful. And it took more energy. I think I worked harder because of that. I never believed that I would necessarily be right. . . . It never went away; it was always with me. (Participant J)

This same physician introduced a pebble analogy that described the heavy weight that this constant striving for perfection and having a sense of being an impostor imposed on them. They recognized the need for better balance and even acknowledged the addictive nature of the need for perfection:

> You know, I think having IS, I was always waiting for me to make a mistake or to be uncovered as not knowing what I was doing or whatever. A lot of pressure. I think I would do it [medicine] again, but you know what I would do, with the insight I have now? I would like to say what I would do, not knowing if I really would, and that would be to see a therapist at the beginning and really work on the need to be special, the need to get A's and get good grades and do a great job. And then I'd have a little bit better balance in my life. Also, because I think that need is almost like an addiction, now that I think about it, and it really drives you to be driven beyond where it's healthy for you, although you don't realize it. (Participant J)

Others described ongoing self-doubt, comparison of themselves to specialists, and concerns about their knowledge gaps. They often appeared to have had an unrelenting need to continually aim for a higher level of knowledge and skills, fostering a never-ending feeling of uncertainty and worry:

> I have IS. Doesn't every doctor feel that way? I find that I don't talk about things I am uncertain about with my colleagues, . . . particularly in my practice. I think some of it is that I feel a little bit like a second-class citizen as a family medicine doc. That I didn't go into a more prestigious specialty. [And] maybe it's because I feel like, "Am I doing enough continuing medical education? Are there gaps in my knowledge?" (Participant D)

This internal struggle, of always feeling less competent or of less valuable than others, appears depleting. A participant pointed out to me a physical gesture (a form of finger-twirling) that they were "involuntarily" performing during my interview with them. They stated that they believe this was a manifestation of the unceasing anxiety that unaddressed IS has caused them. Another physician explained the impact of IS on them:

> I don't think I realized how much it [IS] impacted me until I retired, to be honest with you. I was too busy to be self-reflective and intentional about what I was doing. And I think it may have been helpful just to have had time out to do that occasionally. Like, maybe a support group amongst doctors, but I wouldn't have had time to do it, and I wouldn't have wanted to. I would have been, "I'm fine."
>
> I mean, I think there's a certain element of, like, we've made it through residency. We're tough. I can do it. You don't really allow yourself to acknowledge anything that might be thought of as needing therapy because "you

> can do it." We've learned to stay up nights. We've learned to handle the patient who is crashing. We've learned all this stuff. We're tough. We can't admit any frailty. So, I think I went through my career without acknowledging the extent of the IS. I don't think it was until after I retired really that I focused on it as having been so anxiety provoking. (Participant J)

The words of another physician describe the impact of IS on them, "[Do I know what IS is?] Oh God, yes! If they only knew what I didn't know. [I]…push it back, swallow it." (Participant G)

One participant acknowledged the usefulness of IS: "So I think there's a good that comes out of the anxiety about being discovered. You really want to do a good job and make sure that you've crossed your T's and dotted your I's" (Participant J). However, a different participant explained how their IS, which went unaddressed, negatively impacted them throughout their entire career despite their having received numerous awards for their medical practice. They felt that the rewards were never able to adequately reduce the feeling of inadequacy to a level they would have wanted:

> Since this [interview] is an anonymous thing, I would say I have it [IS] because I keep saying, "Who, me?" You look at all my awards, I have things in my den, a Top Doctor [Award] for 10 years, plaques that were given to me. . . . I have this feeling of inadequacy I guess. There was always a way to make me feel like, "Hey, I wasn't as good as that person was." (Participant G)

A Lack of Self Care (or, The Patient Comes First, Thus I Come Last)

Adding to the erosion of the essential elements required to thrive is the depleter termed *a lack of self-care*. It stresses what the physician has repeatedly been taught: that

the patient comes first, the physician comes last. During the study interviews, subthemes of this depleter emerged, including a lack of adequate sustenance, inadequate opportunities for peer interaction, an absence of mentors, a lack of use of mental health services, and a lack of skills necessary to manage a healthy work-life balance.

A Lack of Adequate Sustenance (or, No Lunch Allowed!). We can agree that doctors are taught to stress the importance of self-care to their patients. Yet when asked about the care of themselves, a surprising number of the interviewees admitted that self-care was not a topic they often considered. Many found it hard to explain why they seldom applied this concept to themselves. One seemingly small example of this that surfaced repeatedly was their inability to permit themselves a few minutes of uninterrupted time during which to feed themselves during an average workday of 8 hours or more.

The participants expressed the significance of lunchtime—or lack thereof. One physician stated, "[Being relieved of inpatient care] . . . has pushed people to the periphery. One of the joys of practicing medicine early on was lunch in the doctor's lounge" (Participant H). But that has gone by the wayside as the PCP's presence has been replaced in hospitals by the hospitalist. Following this, the act of eating lunch became uncommon among those interviewed. One physician acknowledged that "I now skipped lunch for most of the time. Only occasionally [did I eat]." Only one interviewee said they now ate lunch on a regular basis, but with this qualifier: "Well, I do eat a quick lunch, always under 15 minutes, and maybe read an article in *The Times* while I'm eating." Most, however, found it impossible to permit themselves any time for this. When I questioned one physician (Participant J) as to why this was, their response was:

Physician: I think it's terrible [to not have time for an uninterrupted lunch break], even though that's what I do.

Interviewer: If a patient described long working hours with no adequate lunch break on an ongoing basis, would you find this acceptable?

Physician: No . . . that's terrible.

Interviewer: Why do you say that?

Physician: Because you need to rejuvenate. You need to gather your wits. You need to relax.

Interviewer: So how come doctors don't do this?

Physician: I don't know.

Another physician explained how they did eat lunch but also felt compelled to work at the same time: "I ate but I would try to bring things that didn't make noise chewing, so I could make phone calls. Like a yogurt or something" (Participant E). As one physician stated, "Lunch has disappeared. It has disappeared. It's not part of the culture" (Participant H). Yet another interviewee explained that it was not always that way: "We used to meet for lunch three days a week. . . . It was quick, but it was lunch. We used my desk as our table" (Participant B). Now, it appears that lunch, and certainly lunch with peers, is no longer an acceptable practice for most. Several mentioned that denial of sustenance became ingrained during their residencies. One opined, "As a medical caregiver, you're not allowed to [have lunch]" (Participant H). One physician (Participant J) relayed a troubling interaction they had with a surgical resident who had contacted him for advice:

Resident: "Will anything happen to my kidneys if I don't drink all day long?"

Physician: “Why aren’t you drinking all day long?”

Resident: “I don’t have time. I can’t eat or drink when I’m at work because I just don’t have time.”

When I asked the above physician’s opinion of the resident’s words, they responded, “It’s terrible! But it’s so ingrained in you during training that you feel you just have to keep producing, keep producing” (Participant J).

The physician quoted earlier in this study who had a heart attack at age 56 advised:

> I should have learned earlier how to deal with stress. Making time for lunch every day. Whatever it might have been. I think all docs, if you’re going to be willing to take that burden [of the patient], that weight, then you’ve got to be able to say, “OK, that’s not my weight. I am carrying it [with you] but it’s not mine. . . .” It’s kind of symbolic. I don’t have to give my life. I’m not going to hang on the cross and die because of this. I’m not Jesus Christ. (Participant H)

Inadequate Opportunities for Peer Interaction (or, I Am a Rock, I Am an Island). When considering the words of participants regarding their lack of adequate time for sustenance, it is not surprising that in the later years of their practices, only one continued to eat lunch with colleagues (and this occurred only occasionally). Contrast this with the practice described by participants as more common a few decades ago, that of PCPs eating lunch together with peers most days of the week in the hospital or office cafeteria. Having time to talk together, whether over a meal, coffee, or a watercooler, was considered important by many. That time together strengthened relationships that PCPs cited as important. But in the later years of their practices, this came to be considered

extravagant and, ultimately, undoable. Yet in the words of one participant, “How do you . . . learn and grow from each other without colleagues to talk with?” (Participant B). This was of concern to many participants.

This lack of ability to take a pause for a communal lunch was not the sole cause of this increased isolation from peers. Other factors, including an office versus a hospital environment and the physical layout of offices, isolated PCPs from their peers and thus denied them this potential source of strength.

Some interviewees commented that the problem with social isolation was not only a lack of interaction, but also a loss of peer assistance in rendering care and easing the burdens of the immense responsibility they felt in their roles as healthcare providers. Consider the words of one pediatrician regarding the pressure their practice imposed on them:

> I had six kids who committed suicide in the course of my practice . . . six different patients. You know, here I am an expert, and I’m one of the few people trained in adolescent medicine. Sometimes I don’t pick up a teenager being depressed either. It’s very hard to know. And believe me, I’m as qualified as anyone in this world to pick up a depressed teenager. That’s in my training . . . I’ve done it my whole life. But still, I get burned. . . . (Participant A)

Without sufficient opportunity to “learn and grow” from this type of experience, damage occurred. One participant spoke of this:

> It [this interview] is totally anonymous, right? OK, then this is exactly what I want to say. Making decisions for patients and being solely responsible for

> people's lives . . . I was being burnout. . . . So, it just seemed like an opportune time to leave. That was enough . . . I had had enough. (Participant E)

Peer-to-peer interactions can do more than ease the emotional burdens of the practitioner. Training throughout medical school, internship, and residency uses peer-to-peer interaction as an instrumental tool in the doctor's education. Some participants voiced a concern that the increased isolation they experienced resulted in a decrease of their knowledge and ability. In one participant's words:

> You work in your office for 10 years and never step foot in the hospital . . . which means never going down to the radiology department, doing an X-ray with someone, never talking to a consultant in the hallway, or being in the doctors' lounge saying, "What would you do with this patient who is complicated?" I think by the end of 10 years you will be dumb . . . not as smart as you were 10 years ago. I think the negative effects of giving up the hospital are very significant. This is a very important factor in my mind. (Participant A)

Peer interactions appeared to serve as a barrier against this kind of depletion that occurs when one is removed from peers. One female PCP described how always managing on one's own became more bearable for her when she shared it with peers:

> [It was] a women physicians networking group. Several women set it up, just kind of put it out there. We always did a lot of back and forth. It's always great to see those people. We even met on Zoom during COVID, which went over very well. There were 40–50 women. Later, we even had dinner together. With new physicians, I said, "Look, come because, first of all, it'll be fun. And second of all, you can then meet doctor so-and-so. But it takes, you know, it's an

> independent initiative, it's not something that's coming from the top. (Participant D)

The burden of being alone with tremendous responsibility for the lives of others was somewhat mitigated by this PCP's decision to partake in this group. I note that this required her to use her personal time. Nonetheless, the presence of peers, their "back-and-forth," strengthened her.

An Absence of Mentors (or, Who Is Caring for Me?). Another component of self-care that served as a depleter for many participants was the lack of any mentor. Why is a mentor important? One participant opined on this:

> I think that would be a really helpful addition. I do think so. . . . I do think so. But once you're out in practice, people sort of expect, "He knows what he's doing." I'm not going to spend my time helping him, he should be taking care of patients. Earning more money for the practice. (Participant C)

When a PCP is removed from the hospital environment, as is normally the case now that hospitalists are widely used, the opportunities that existed to naturally cross paths with others who could have served as mentors have decreased markedly. Some participants commented that it would have been helpful had they sought out and found someone more experienced and willing to guide them in areas that had not been addressed in medical school. But others stated that it was sometimes difficult to ask for help, as "A lot of people were not willing to admit that they didn't know everything. They would not have been willing to reach out for help." But another noted that asking for assistance by "looking out for mentors or cultivating them, going to them and asking

for help, was important. You soon find out whether somebody is willing to give it or not."

Participants shared how they found mentors and how the mentors supported them. One physician described how they went about finding a mentor and what the mentor offered them:

> I think it's really important to have somebody that you can look to as a mentor, someone you can go to for advice. And they don't have to solve your problems, but they help direct you, help you look for where to solve your problems. The person that I asked to be my mentor was the busiest doctor, who definitely did not need a younger guy calling on him to ask what to do. But earlier, he had said to me "If I can ever do anything for you, call me." I did. But he knew the value of it. He was willing. Younger colleagues may know a whole lot more about what the literature says about something, but they didn't necessarily know how it played out in real life. (Participant H)

Another discussed the value of a mentor for them:

> I would go into his office complaining vociferously about some problem. And he would just sit there and listen and didn't say anything. And when I was done, there'd be a pause. And then the next words that came out of his mouth would get right to the heart of the problem. (Participant B)

In addition to being mentored, participants noted that serving as a mentor also was of value. One physician stated that because they had had a strong mentor, they felt motivated to become a mentor themself:

> My favorite part of the job was mentoring [others] as they came through. They told me, "I am so appreciative of the time you spent with me. . . . You were always available." And I was, . . . to my detriment, not theirs. But yeah . . . that was the part I liked most. (Participant I)

Another participant described the praise their mentee gave them multiple times: "I learned how to do medicine from school, but I learned how to be a physician from you" (Participant C).

But one physician had this caveat for mentors, "You have to be able to get something out of it as opposed to feeling that it's an imposition" (Participant F). As for the mentee, they need to be open to the concept of being mentored. One physician described the futility of attempting to develop this type of relationship with someone new to their practice who demonstrated no need to seek or accept advice, "I could never offer any advice he would take" (Participant C).

In summary, being mentored and/or serving as a mentor may serve no purpose for some. Yet for others it appears, in the words of one participant, to be a concept well-worth considering:

> I had, I won't say exactly, mentors. I went to [a medical school] and had good training there. And so, I felt like it was my job to mentor others. I tried and I did. Whenever I did teaching rounds with house staff, I would do my best to mentor them. And I think they appreciated it. And fellow colleagues, residents that I taught, it was wonderful. I kind of wish I had had that myself. (Participant G)

Low Utilization of Mental Health Services (or, Breaking News! PCPs Declared Immune to Poor Mental Health!). Discussions with participants about their

use of mental health services yielded scant information other than that most stated they had not used these types of services. Participants did not express much need for mental health care. (I did not discuss what value the physicians felt these services might offer their patients). Several expressed their opinions about different services. One physician was referred to their employee assistance program and found it to be helpful: “I think it’s a good thing that I could talk to somebody and that it was anonymous. That was important to me. I felt like they provided a good service for me” (Participant B). A different physician felt that the mental health services might be useful in the event one was sued:

> I can see how if I had been sued, I might have needed that. I really think that it would just raise the level of self-doubt to such a degree that I probably would have needed help. But I was just fortunate. I did well, I mean, the people pass away, and sometimes it’s your fault. Sometimes it’s not. I mean, I don’t feel like I ever neglected a patient. On the other hand. I think there are other times when . . . (Participant C)

Another physician noted that they did use a non-work-related therapist when they were going through a divorce and found that to be helpful. Later, the same physician found that when they would request changes or accommodations to their practice that would benefit their work-life balance, they were referred to their employee assistance program. This physician responded with the following, “I’m like, I don’t need the Calm App! I don’t need to speak with a therapist! Nope! I’m asking for a change in my schedule to make my life more reasonable, not the Calm App” (Participant I). This physician felt that being referred to this type of program was not helpful in resolving the

practice issues they believed caused this. Rather, the referral felt more like an insult to their intelligence.

A more negative impression of the overall value of mental health services came from one participant:

> I don't think much of therapists or psychiatrists. I probably shouldn't say this . . . but my personal experience, at least in medical school when I took a psychiatry rotation . . . I thought all the psychiatrists were crazy. They were nuts. They went into psychiatry because they themselves had mental health problems. I really think that one can train oneself. Maybe I'm wrong about this, and I'm willing to be educated. But if I see my problems, and I know what my problems are, I think I can solve them. I don't need somebody telling me what my problems are. You're telling me what I should do with my life? What are you doing with your life? I mean, I just think it's a sham. And I'm not saying that I'm not willing to change my mind about it. But that's kind of how I've felt over the last 50 years. Obviously, medications are necessary. Psychiatrists supposedly are experts in how to use them. Although I must say that during my interactions with psychiatrists as a practicing physician, what they kept doing is adding another medicine, adding another medicine, adding another medicine. The polypharmacy was going crazy. When people were on six medications, what's doing what after a while? So, I don't know if they really are helpful. (Participant G)

From these responses, one might conclude that few PCPs seek assistance from mental health services. Why might this be? One physician opined:

> Remember that time management is a major issue. If I went to a therapist, that would require an hour. And there is no guarantee that that hour would help, but there is a guarantee that it would be one less hour to devote to either my practice or my family. I don't have that extra hour. And, if I did, I would most probably use it, honestly, in my pursuit of "good grades" from my practice and of staying at the top of the heap there. (Participant J)

In summary, these comments give one the impression that many participants felt that mental health services could be of little use to them, designed more for those suffering from "real" mental ill health versus the stresses the PCPs were experiencing. Some felt that those in the mental health profession had little insight to offer them. Others believed that participation in these services would require too much time, which the PCPs stressed they had too little to spare.

A Lack of Skills Necessary to Maintain a Healthy Work-Life Balance (or, the Patient Comes First and I, and Those I Care About, Come Last). Most participants interviewed stated that it had been a career-long struggle of varying degrees to maintain a healthy balance between work and home. While it was acknowledged that the needs of the patient should come first, physicians complied with this concept in a variety of ways. The level of dedication to the needs of others was extreme for some, as described by one PCP married to another physician:

> We never ate dinner together. We were on different schedules. He would get up really early and get to work early. I would get up a little later. He would get all his work done and come home at 7:30 p.m. or 8:00 p.m. And I would stay in my office till about 9:00 p.m. or 10:00 p.m. doing my phone calls. And then when I

> came home, he was asleep. Monday through Thursday, we never saw each other. It was crazy. (Participant E)

More common was the practice of working a full day, coming home for a meal with the family, then either returning to work to finish the tasks of the day or completing these during "pajama time" at home. One participant depicted their routine:

> So, at six o'clock, I was home. I maybe had to be gone by seven. But at least at six o'clock I was home for dinner. If nothing else came up, [my spouse] kind of understood that at least for an hour, I was going to be here. I was grateful and fortunate to have that support at home. But the patient would always come first. That was what I had committed to. When I married, we both understood this is what we had committed to as a couple. And to be a good physician, that had to be the priority. But on a day-to-day basis, it was really what you had to do to finish the job. And you did it because otherwise, you could not have done it well. At least, I could not have done it well. I did as best I could. (Participant H)

Others commented that long work hours and lack of time for oneself were acceptable realities of not only the medical profession but also certain other professions that ranked highly in terms of financial compensation, prestige, or other areas. One physician stated:

> So, there were a lot of early mornings and there was a lot of "pajama time." I was usually at my desk at 6:30 a.m., and I really would try to get home for dinner. So that was a 12-hour day right there. And then there was the "pajama time." I mean, I just won't compromise. I try to work smarter, not harder. I just wouldn't cut

> corners where I felt like it might compromise patient care. But I don't honestly know that it's any different for many other professions. (Participant I)

Another stated that they normally worked a 60- to 80-hour week and that they and their family were comfortable with this. Other participants felt that, in retrospect, having to dedicate this number of hours each week to their patients was unhealthy and had had a negative impact on their home life. One physician, who normally put in 80 to 90 hours of work a week, credited their survival to having a spouse who handled most of the home and family. This physician explained why they had felt compelled to do this, and how they felt about it now in retrospect:

> Well, I mean obviously, home life is important. But it doesn't give you the same sense of accomplishment that you get when you're a doctor . . . I mean, the medical profession teaches you a certain way to feel good—by getting good grades, going to a good college, a good med school, doing a good job. I think being part of a family is great, it's important, but if you're trained to always excel, . . . [excelling at home] doesn't always produce the same kind of satisfaction. Being a father or husband, you don't really get graded on. It doesn't give you that same sense of accomplishment. People don't go and look at you as you're walking down the street with your kids and say, "Boy, he is rocking it as a dad." So, I guess this is my mantra, . . . [it reflects] the way I was raised. [A good homelife] was of less value than a profession—but this is dysfunctional. And I think it was not a good thing. Yes . . . it would have been better if I was not seeking that drug so much. And if I had been able to derive pleasures that were

> just pleasurable without being goal-oriented and accomplishment-oriented. Like rocking a kid on my knee . . . or having a catch with a kid. (Participant J)

Another physician described their response at the end of the day, when they were finally in bed and reading their book, and one of their children came knocking on the door: "You better be bleeding out of your eyes before you come bother me in bed with my book" (Participant I).

A different doctor commented on how their tendency toward perfectionism and/or IS made managing their time more difficult:

> I think part of what happened, having . . . IS and being somewhat of a perfectionist, I would come home, and I would call back patients. When it was all computerized, I would do chart notes at home, and I'd have to get all this done and I want to do a good job, and I want to do it right. That's where the perfectionism comes in. . . . but that's not the whole thing. I think there's competition too. You want to be the most productive doctor. (Participant G)

Many stated that the environment surrounding their education and their medical training played a significant role in promoting this sense of ongoing competition and striving. One opined:

> Well, it's a very competitive environment to get into med school, and it's very competitive in med school. And then when you're making rounds in the clinics, some attendings make it very competitive. So, when you are out in practice, it's like a dog-eat-dog type of environment to some degree. (Participant J)

The same physician described the ongoing conflict they struggled with when trying to balance good patient care with personally obtaining enough of what I have

labeled the essential element. To be adequately fed professionally, they needed to develop and maintain strong patient relationships. Yet this required adequate time to realize. This came from a finite pool, and therefore many felt there was no option for them but to take this from their personal time. One physician pondered whether there might not be a better way of managing this conflict:

> Part of the paradox to me is that the enjoyment I got out of working was due to the human interaction with the patients. But the way to be more efficient in terms of work-life balance is to cut back on that interaction. Yet you want to retain that strong patient-physician relationship. It was difficult. . . . For example, calling up and telling [the patient] the lab result takes a little bit longer than having your nurse call. But I might want to do it because it takes some discussion . . . maybe it's not just black and white, or binary, or because I know the person and feel close to them. And [someone else] answering questions might possibly be done less carefully than I would have done. "Are you sure you got it? How are the kids? Everything good?" Was it reasonable to do what I did? No . . . I think it was too much. I think I could have done better . . . yes. (Participant J)

Another physician was able to identify what helped them to manage this type of work/life balance:

> I said to the doctor who had hired me [a few years earlier], "I can't do this work alone. You have to hire someone else. I have a wife, two kids, a third on the way. I can't keep doing this." So, we hired the third person. And then a few years later, we hired the fourth. And the fifth. But the good thing about it is that when anything came up, we really were so fortunate to have a group of docs that cared

> as much about each other and our families as they did about making money. Very fortunate . . . as so many practices get dissolved [over that issue]. I never had a doc leave our practice. They just came and stayed. We fired some people. It was not a mistake. But you know what? Once you're committed to a person, it was like, maybe we can help this person become a better doctor—a better person—by embracing them and their family. (Participant H)

That same physician was able to understand what fed them early on in their practice. They were able to successfully incorporate this into their work. They explained this:

> It took me time to see people. I was more diligent, slower. Spent more time. I've had partners who could see twice as many people as I could. But that was their lifestyle. Partners who could see twice as many as I could. And be in at eight, and out at five. But when it was all said and done, we all practiced the way we felt we could practice. (Participant H)

Yet this scenario depicting this level of self-care was not a common one. Many felt that their training had never addressed productive use of time, as stated by one participant, "No one ever talked about time management." That physician felt this to be a serious deficit that adversely impacted them through their many years of practice. Yet we know that the current reality is that not all practices are willing to continue to employ a physician who sees fewer patients than the number determined to be a mandatory standard.

When asked what might be useful in improving one's work-life balance, one participant advised obtaining specific skills in time management:

> I think there are a lot of ways to do it [better]. I think mentorship would be a good idea if you had a mentor who could help with time management. I mean, the mentors and teachers that I had would talk about diagnosis, the Krebs Cycle, science pharmacology, things like that . . . but nobody talked about time management. I think if you had a time management person, that would have been very helpful. (Participant J)

This same participant warned of the consequences of not adequately addressing one's work-life balance:

> My ideal doctor growing up was this guy who was my father's age who was never home—ever. But I thought when I became a doctor and then got married that I would be different. I was—I wasn't as bad as he was. But I wasn't nearly as involved in my home life as I thought I would be. And, if I were to do it again, I would do it differently. But there was that element of forfeiting yourself for others. It's like . . . the patient comes first . . . and of course, your family comes after the patient. And you? You come last. (Participant J)

Another spoke of their difficulty focusing on something other than their patients, as there always appeared to be more to do in pursuit of good patient care:

> I suspect that if one could compartmentalize his mind appropriately, they could do it better. My problem would be that if I were sitting, watching the Super Bowl, I would feel a little bit guilty about not having spent that time doing some medical reading. Yet, on the other hand, it's part of the same syndrome. I think that while I was reading the *New England Journal*, I was thinking about my boys being downstairs watching the Super Bowl, and shouldn't I be down there with them?

> I'm not concentrating well either way. So, I think really developing that sense of compartmentalizing your mind. I think that's something that we really should teach the younger people going into medicine to do. (Participant C)

This same physician added that he did manage to enjoy the benefit of computerization when it came to writing his notes at the end of the day:

> Boy, I would come home oftentimes at night and type my notes. And that was a benefit of the computer because I could do it from home. So, I could be with the family . . . at least I'd be in the same house with my wife when I had to finish my notes. (Participant C)

Is this what we want for those who care for us? Will this feed them sufficiently for them to continue providing our care?

One participant advised: "Medicine is going to come and go in your life. It may be 40 years that you're in medicine, but it will go. Your family is always going to be there. Nurture your family" (Participant I). Another opined: "No, you don't want to be like me. Because if I had to do it all over again, I'd spend that time at home" (Participant B).

External Depleters

Unlike the self-depleters previously explored, external depleters were identified as those which affected PCP well-being but which the PCP felt they had little or no power to change or control. These external depleters include an increasingly rapid pace of change, being threatened or sued for malpractice, the pay difference between primary and specialty care, and corporatization and an increased emphasis on profitability. Each

placed PCPs in positions that increasingly threatened their levels of professional satisfaction and personal well-being.

An Increasingly Rapid Pace of Change (or, Do I Sink, or Do I Swim?)

We acknowledge that change is an inevitable part of life, and medicine's PCPs are not exempt from this. Change can bring both good and bad, depending on one's position. Many participants, however, spoke of the increasingly rapid pace of change, particularly over the last decade of their practices. This came in many forms, but the change most often cited by most participants as most difficult to adapt to was the EHR. Therefore, I will use this particular change as an example of the rapid changes required of PCPs, and I will and explore its impact on the participants.

The EHR required PCPs to end their charting of patient information on paper and instead enter this on computers. This was imposed upon most practices in what the PCPs perceived to be a very rapid manner, often described as lacking adequate consideration of their skills and/or needs. For many, it caused significant distress over extended periods time. Some did acknowledge the advantages it brought, as one participant explained:

> Access to information is so much easier now. So rapid. And technology makes it so much easier for us to keep up than before. But you must be willing to utilize the database and spend time with it, not dismissing it. I do think it's a positive change. (Participant H)

Another physician described the advantages the EHR brought to them:

> It increases the complexity but also simplifies how you handle it and gives you a lot of information at your disposal. For example, you used to have to go over everything with everybody, then make phone calls, etc. It was very much more

> labor intensive. Now the computer does everything. It just spews out a list for the doctor to look at. And you can see probably a heck of a lot more patients per unit of time than we used to be able to. (Participant J)

However, along with the positives the EHR brought to some PCPs, there were also negative reactions. Many felt that the EHR shifted the focus of a patient visit from diagnosing and treating the ailment to completing the record in a time-efficient way that would maximize revenue. Participant J summarized the impact that the EHR had on them:

> I think we're at a point in time where the technology has made things harder, at least, as of when I was retiring. More complex, much more noise. While I don't think the benefit, the increased efficiency of technology, had yet gotten to the point where it made the overall practice simpler, I think it will. It appears to have become difficult to accurately see the trees (the actual patient problem) through the forest of information required to meet insurance and other guidelines. (Participant J)

This same PCP described what this meant to their practice specifically:

> When you think about starting with the paper charts the way we did, technology has helped a heck of a lot. A heck of a lot. In terms of care. And in terms of efficiency. But it also brought a lot of inefficiencies because there was a lot more information that you were required to know. Expectations were ramped up. They expected that everybody would know everything right away. And you'd have access to everything. So, I think efficiency actually increased, but there were inherent inefficiencies because you had to look up a lot. You had to check off a lot

> of boxes. Also, there was a lot of billing stuff that at the end—you had to figure out what your billing was. That was annoying. And I did not like the checklist aspects where you had to make sure they've had this vaccine, they were wearing seat belts, etc., just to complete an exam. So, I think it did negatively impact the [patient-doctor] interaction. All these EHR chores that were not directly related to patient care or the patient interaction, they affected the interaction. (Participant J)

A troubling number of participants found the transition to EHR very difficult to adjust to. As one physician explained,

> The EHR, in some ways, made life easier as my handwriting wasn't the best so now, I didn't have to write anymore. But I never took typing in high school. I didn't grow up with a computer. I didn't grow up knowing anything about data management, or software, or even how to interact with the computer. So, I was in the generation where I had to do this but didn't know what I was doing. It wasn't in my DNA. So even simple things like sending an email, I had to learn how to do. And we had these classes that supposedly taught us what to do . . . some were taught well. Some had teachers that didn't even know what they were doing, and they were teaching us. It was kind of crazy. And some of the things I saw were just outrageous. I mean, cut and paste, for example. I mean, most physicians would take their notes, cut and paste the prior note, and put it in the current note. And they would just go down checklists, and click, click and click. So, we had men with a normal uterus, women with a normal prostate. We had men who were not pregnant. I mean, there were just crazy things in the EHR that shouldn't be there. They were time wasters—you had to ask everybody about whether they smoked or

> not, whether they were at risk of falling. They were just a lot of "busy work" type questions. And then there were the health insurance issues, getting third-party approval for things. (Participant G)

One physician describes the impact of this change on themself:

> The pace of change was huge in many ways, but particularly getting used to the computer system. It was really frustrating, as I had to learn from scratch. I think a lot of the problems were, when you had to learn a new system, you went into a room with like 30 or 60 other doctors where they instruct you didactically. I think it would have been much more helpful just to be doing it instructed by somebody over your shoulder. That's more labor intensive, but I found that to be much more helpful. Then came switching to a different system! And more classes, more learning that was not productive time where I could see patients. It was tough and it was frustrating. (Participant J)

For some, the challenge of adjusting to this new system was profound. In considering one participant's words below, one sees the significant side-effects change can cause in those who must adapt to it:

> I found and still find it very hard to adjust to new technology. I think sometimes it's there just for technology's sake. I think that the people who write software do not consider the end user most of the time. I think they make things unnecessarily complex. They don't make things intuitive where they could. And those who mandate this, they think they are giving us adequate time to learn and manage this. "Well, you don't have to see 2- patients a day for the *next week*. Only 12, because we recognize that you're going to have to spend time learning this." I

> mean, it's like telling you that you can sleep an extra half hour tomorrow if you are exhausted. One of my colleagues advised, "You know what? Don't do a good job. You should do what you have to do." Another said, "Maybe what we need to do is to not do a good job. Do what you have to do to avoid getting sued, and let it go at that." But I would be sick over that. (Participant G)

Clearly this attitude is not what those who mandated this change intended. But how did some physicians avoid this type of thinking? Some stated that they found a "work-around" method. But this was not without a sense of frustration at the seemingly wasteful information requests mandated by the EHR:

> I just would do [my records] at the end of the day. And was I good at it? No! So, I would check the boxes. To me, of all of this stuff that you do, 70% is meaningless. The only thing that is important is the assessment and plan. So, at the end of the day, for every patient, unless there was a huge physical exam finding, everything became just a checkbox. I didn't get dinged as much and I got pretty good at getting that assessment and plan in a concise manner where I could just type it in. In my reality, that's all that mattered—that somebody who would come in and have to take care of that patient if I wasn't there for them could do it. To continue with the same train of thought that I had about what might be going on. (Participant H)

Some participants sounded resentful, stating they felt forced into a corner by the expanded detail and time demands the EHR imposed on them. One stated,

> [Regarding technology and new information], you either have to keep up or leave. . . . [And in order to "keep up"] where is the time for that? Come in earlier or

> leave later? No, because that is even more time at work. So, I think what I'm wanting to say is a two-letter word. And that's NO! I mean, I have friends and relatives who complain that it takes three, four weeks or months to get an appointment now. It's like, "Well, that's the way it is." Still, the reality is that when someone wants an appointment now, they all think, "you should say NO to everyone else except me!" (Participant B)

This sense of powerlessness in the face of a mandated change did cause resentment and even anger on the part of the physicians no longer able to accommodate patients as they had in the past. One can acknowledge that this is not a healthy mindset for building and maintaining the trusting relationships necessary to provide good primary care.

This type of side effect of technology is illustrated in the following quote that describes how the essential elements are eroded when a physician is unable to develop and maintain strong person-to-person relationships with their patients when a computer takes the place of eye-to-eye contact:

> So, I wasn't really hurt as much by the medical record as [I believe] some of the younger physicians are. They are so much more attached to it. Every morning, they wake up and they're on that phone, they're on that iPad, they're on whatever. I didn't need that. My kids are very similar. They are attached to that technology from the time they wake up to the time they go to bed. So, for them, the medical record becomes all-encompassing. They have to be doing that because that's, I feel, a part of who they have become. The young physicians are so attached to this technology that they can't break away from it. I look at them on the computers. They can't break away. They can't break away from their phone when they're at a

> meeting. So, they begin to lose this eye-to-eye contact. They lose the ability to just become a part of their patient's life in a meaningful way. And that creates a void of despondency for the physician. That void, that despondency, creeps in. That frustration that I'm giving, giving, giving, and I'm not getting anything back. I just never ever experienced. I never felt it. (Participant H)

We can thus see, when that void occurs, how the physician is unable to care for the patient as they believe they should. The patient suffers. Additionally, unable to adequately obtain the degree of satisfaction that the physician previously would have gotten from the close relationship with the patient, the physician also suffers. They lack the sustenance necessary to thrive well long term when they know that the care they are rendering serves neither themself nor their patients as well as it should. One elaborated:

> With the computer, learning how to dictate notes, learning how to chart your notes, crossing all the T's, dotting all the I's. Sometimes I felt that it was more important to dot all the I's and cross all the T's than it was to really look your patient in the eye and have a conversation with them, because that wasn't a measurable parameter. But whether they smoked or not, that was measurable. (Participant G)

One can see that an awareness of the impact of rapid change is important in being able to cope with it, although this does not always make coping possible:

> Medicine is constantly evolving. It's not a defined science. So, what we learned last year is not necessarily what's right this year. I used to read the journals, and when [new information] went online, keeping up was easier. And I taught, because the best way to learn is to teach. Well, because they ask you questions,

> and you may not know the answer. So . . . you learn. And you had to keep up, otherwise you were going to drown. The computerization of medicine was, in some ways, a boom for us but also an albatross. I adapted to it fine. It was just an added burden. But once we started becoming part of larger systems and we got involvement in the insurance companies, everybody wanted more information. And then they said, "It's one or two more clicks." It ends up being a lot. It adds up to a lot of time. And with such a click, it's really having to think about what you're going to click. And getting the information that's needed behind that click. Yeah. And so, that became the real burden. And that was one of the things that really led to me deciding to retire. (Participant F)

Being Threatened With or Sued for Malpractice (or, My World Just Fell Apart)

Of all the topics discussed with participants, that of malpractice received the most comments and revealed the greatest level of distress. Most had been threatened with or served with lawsuits. Some felt they had made a mistake and therefore deserved to be sued. Others felt that a suit was inappropriate because they had believed they had rendered an adequate standard of care. Still others spoke of the gray area in between these two positions. Many spoke of the deeply negative and long-lasting emotional impact that either the threat, or the act, of being sued had on them. It included guilt, sorrow for the people involved, helplessness, dread, anxiety, fear, and resignation. When one considers the words that participants used to describe their reactions, this becomes more apparent:

> "Terrible . . . hard to work, hard to function, hard to sleep."
>
> "It's a terrible thing. I messed up. I'm angry at myself, not the patient or the lawyer. I'm responsible. I failed as a doctor. I've done a terrible thing."

"It was very, very difficult. Very difficult."

"[It] took a couple of years of my life."

"There's no logic for any of this."

"You can't sleep at night. It's a huge issue."

"I yelled at my wife over those two years. I didn't hit anyone or scream, but I was tense with stuff."

"Very stressful . . . absolutely."

"Terribly stressful for me. It was just a very difficult time."

"God, what did I do?"

"No one helps the doctors. No one is on your side. It [makes one] . . . feel very vulnerable. So, that's one of the issues that made me retire a year or two early. I could have worked another couple of years if I hadn't had those."

In some cases, physicians felt they had neglected to render the optimal care that they should have. Thus, they felt that they deserved to be brought to task. In one such case, the physician had a patient that they were managing post-operatively. The patient subsequently died, and the physician was left feeling that they had not provided optimal treatment advice that could possibly have prevented the patient's death. The physician stated:

> And I felt terrible, just terrible. I think if I had done some things differently, she may have survived. I felt really terrible. I didn't end up seeing a therapist or I didn't take any drugs myself or get drunk or anything like that. It was hard, though. It was hard to go to work. It was hard to function. It was hard to sleep. (Participant J)

That physician was later sued for this. Being sued appeared to release some of the burden of guilt this incident had caused them:

> I was sued after that. And it was almost a relief. I mean, as much as I hated it, getting sued . . . I think I could have done better. And that was the worst part—knowing that I could have done better and not doing better and that she maybe lost her life because of me. I could have . . . ugh . . . it is a terrible thing. (Participant J)

The same physician then went through some of the required legal steps:

> I went through hoops . . . the insurance company . . . a lawyer. Then, it turns out that the plaintiff's expert witness was totally off. What they said was just wrong. And I had proof that what they said was wrong. But I did not want to go to court because knew I could have done better. And so, we settled, and I felt better for having settled. I felt that at least the family got something. (Participant J)

This physician opined about the difference in the personal response one might experience when they are sued for an outcome they believe resulted from their own medical error versus one where they believed they had caused no harm or provided no substandard care. The participant stated that, when a suit is based on your medical error: "That's the hardest. It's really hard . . . because I do deserve it. I mean . . . I messed up."

In contrast to this sentiment, when one is accused of substandard care when they believe they rendered the standard of care, participants described feelings of anger, helplessness, frustration, and a sense of self-doubt. These responses did not appear to be short-lived, but rather caused significant stress to physicians over lengthy periods of time. In one physician's words:

> Yes, I've been sued—three times. All found favorable for me. Terribly draining. And I think for me as a person, I'm a crowd pleaser, I want to make somebody feel better. I want to go out of my way. So, when something happens where my image, in a narcissistic way, my image is going to be tarnished or is damaged? That is hard. That's hard. It was very, very difficult. Very difficult. (Participant H)

Another stressed that again, unlike being sued for an event you believed you should have addressed more appropriately, being sued for one you feel unjustly blamed for doesn't come without cost to the physician, as described here:

> I was sued several times, I think unjustly. And once it took two years, but the plaintiff's attorney finally realized I was totally not culpable. I won't say I had saved [the patient's] life, but I made a good diagnosis which led to a surgery that he needed. But I had to go through two years of a lawsuit because I wrote a prescription for a medication which the pharmacy misinterpreted, gave him the wrong medication. But the point is that I totally was not responsible for what happened to him, but I was sued along with multiple other people, two pharmacies, nurses, etc. That took a couple of years of my life. (Participant G)

Another case involving this same physician impacted them not only emotionally, but also in ways that had a long-term impact on their career. One can sense from these words the feelings of frustration and helplessness that this type of suit resulted in for this physician:

> Even worse, I took care of a young man for maybe five years. He had his physical, was feeling fine. Then one day, he came to me with shoulder pain. I did a full workup. I knew a close relative [of his had] died at a young age of a heart attack. I did an EKG just to make sure it wasn't cardiac. I said, "Well, I'm not

> sure what's going on, but come back." Two weeks later, he came back, and he looked terrible. He was losing weight. He had no appetite. He clearly was ill. I sent him to a colleague who tested him for everything in the world. His blood cultures came back positive. We put him in the hospital right away, started treating him. He ultimately went on to need heart surgery. But what bugged me about this whole experience was that he blamed me for not making this diagnosis two weeks before I did. He sued me for this. And meanwhile, the cardiologist who was taking care of him was watching his heart deteriorate for two years, and never, never did much about it until he had this crisis. [The patient felt that] . . . if I had made this diagnosis two weeks before, maybe this wouldn't have happened. And it was at a time when the administrator of my medical group had decided he wasn't going to pay for malpractice insurance anymore; he'd just let us "fly free" (self-insure). So, when it came down to a potential trial, my lawyer said, "Well, I don't think we should go to court because if this goes the wrong way, you could really be in trouble. Let's just settle it for malpractice." So, I had to settle it. I mean, that was a stain on my record for the rest of my career. And that goes into something called the National Practitioner Data Bank. So, if I were applying for a job today . . . they would pull that up and they'd say, "Hey, wait a minute, do we want this guy?" (Participant G)

Another physician described similar reactions to this type of suit where they felt they had done no wrong:

> One experience I had was terrible. Just terribly emotionally upsetting. I saw a baby who was very sick, high fever. Couldn't determine why, which is not

uncommon. So, I admitted the baby to the hospital. It turned out that this baby had a certain disease which I treated it appropriately for. However, this disease can cause a complication, not from the treatment but from the illness which this child developed.

Two years later, I was sued for medical negligence by the family for this reason. I had done nothing wrong. I've made plenty of mistakes in my 45 years of practice. But I did nothing wrong in this case. But it takes hours and hours over two years of interrogatories and depositions. Two years. Then, I spend the 13 days in court—Monday to Friday, Monday to Friday, and Monday to Wednesday. And no one is paid for this except the lawyers. Three-quarters of the way into the trial, my lawyers came to me and said, "We'd like to offer a settlement, but you have to authorize a settlement." They felt that because this child was now 3 years old and with a significant disability, this had sympathy value with a jury. The lawyers suggested I settle. I said, "No, I don't want to settle. I did nothing wrong. I used the standard medicine, standard treatments, and standard evaluation." They said, "Well, fine, it's up to you, of course, but do you have [sufficient] insurance if they give the child *x* millions of dollars?" They gave me a pretty strong arm-twist, so we offered *X* [a substantial amount of money]. And the family turned it down. They turned down that amount of money.

So, the trial continued until the last day, when the judge gives a charge to the jury. Is Dr. *X* negligent and, if so, what amount of award should be given to the child? The jury came back in a couple of hours. They said I was in no way guilty. They said there was no negligence, no guilt. So, I'm thinking . . . there's

> no logic for any of this. You think you're being sued, malpractice . . . you can't sleep at night. It's a huge issue. I yelled at my wife over those two years. I didn't hit anyone or scream, but I was tense with stuff. Very stressful . . . absolutely. (Participant A)

Clearly this case caused great distress to this physician. Yet we acknowledge that patients who have been unjustly harmed by physicians deserve to be compensated in some way. However, the case above illustrates that there are times when it appears the physician is unjustly harmed by the patient. Another participant described being sued by a patient the physician had been treating for many years. The patient underwent a treatment in that physician's office that resulted in an infection that later required plastic surgery on her arm. The physician explained:

> Then she sued us. I contacted her, asking, "[Patient's first name], what is going on?" "Oh, Dr. *X*, well, you have insurance. Just get it out of insurance. It's like home insurance . . . if something goes wrong, they will pay you." My response was, "Yes, they will cover me. I'm not going to lose. But you're telling me we did something wrong."
>
> The malpractice company wanted us to settle for *X* thousands of dollars. No, I'm not going to give her anything. We did nothing wrong. So, we ended up going to court with this. It gets thrown out, dismissed. And then the patient came back to me and said, "Well, Dr. *X*, I'm sorry. But will you still take care of me?" I said, "[Patient's first name], I'm not going to take care of you anymore. This a breach in our trust. If you really felt so bad about it, you should have come to me." (Participant H)

This same physician told of a similar incident. It illustrated the sense of bafflement and helplessness when a physician is accused of wrongdoing and expected to compensate a patient when the physician believes no malpractice occurred. This physician describes how they handled the self-doubt that what is referred to as a "frivolous" lawsuit imposed:

> The worst [suit] involved a patient of mine that was dying of cancer. It was Thanksgiving evening, and I decided to make a house call, something I did a lot of then. I felt good about it [that visit] . . . felt it was a good thing.
>
> The patient died a few months later, and a few months after that I got a call from the Medical Society: "This woman [the spouse of the gentleman who passed away] has filed a complaint against you for your behavior." And for the life of me, I'm thinking . . . what did I do? She was . . . whatever? Grief? Sadness? I understand a lot of things can happen, [but] I never knew anybody who reacted this way.
>
> So, their board looked at that. She had her day, I had my day. And the board responded, "There is nothing here. You were in this family's house for an hour on Thanksgiving Day, helping." [I felt] . . . there was a disconnect in this woman's mind. Terribly sad for her, but terribly stressful for me at the same time. It was just a very difficult time. The process always looked at it in a bad way if people were critical. So, I would think "God, what did I do?" If people were critical, I always would, instead of fighting, say, "OK, what can I do to change, to make myself maybe better, so that doesn't happen again?" I kind of wished, many times, that I just would say, "Well, fuck you. I'm not going to take any crap here." But that just wasn't who I was or even who I am. I know who I am, and those

> who matter to me know who I am. What other people think of me is not what matters. That is probably how I was able to go through these episodes.
>
> After this happened, I actually ended up writing this woman a letter saying, “This was a terribly stressful occurrence for me, but it probably was so much worse for you because you have lost your husband. But if there’s anything I can do. . . .” Anyway, a year later, I get a note from her saying, “I’m sorry.”
>
> I just always thought “We can't change everybody, but we can change the small group of people that we are surrounded by.” And all I can think of is that if I can keep just kind of doing the best I can, people around me will recognize that’s who I am. I’m not what accusations or letters or whatever might come to public light is. And I can’t do anything about that. All I can do is a small circle. And the circle gets bigger and bigger as you grow and live. But it’s still a small circle. And those are the only people I worry about. (Participant H)

When viewed from a physician’s perspective, one would hope that suits resulting from causes for which the physician is not responsible should optimally be dismissed as timely and accurately as possible. Failure to do so can cause unintended and unjust consequences that can bring harm, such as that described by another participant:

> Another time, I was called in to treat a badly injured six-week-old baby. There is a note from another hospital that this baby had been brought in two weeks earlier for another injury. So, I asked the mother how this injury had occurred. I get one of these stories [a classical excuse for an injury caused by child abuse] that I then report as possible child abuse.

I was trained for this . . . it was in my wheelhouse to take care of this baby. But I know that this baby is, frankly, going to die from this injury. Very serious sick baby . . . he dies from infection. Two years go by, and I get a note that I am being sued for medical malpractice. I mean the surgeon, the hematologist, the infectious disease person, every single doctor [involved] is being sued. I do what I'm supposed to do for the insurance company, who then calls me. "Dr. *X*, we had our experts look at your records. Your medical care is excellent. We'll defend you. But," they said, "There's one problem. You're also being sued for punitive damages."

I said, "Punitive damages, what does that mean?" He said, "You reported there was potential child abuse. And when the baby died, they went ahead and arrested the mother and put her in jail for four days." I didn't know this had happened. She was never convicted of child abuse. I'm not sure whether she was the abuser or someone else was, I have no idea. It could've been a relative, a friend or who knows. "But she's suing you for the insult of being incarcerated for four days—that's the punitive damages aspect. You reported the suspected child abuse."

I said, "What does that mean?" He said, "Well, your medical malpractice policy doesn't cover punitive damages. You should hire your own attorney to go through covering the punitive damages." And right now [2023], this morning, [medical malpractice policies] . . . still don't cover punitive damages. I said to these guys, "I feel there's got to be a way [out of this]." I called the state Division of Youth and Family Services. They told me it's a felony not to report suspected

> child abuse, but added, "But we will not defend you for it." So, I had to hire my own lawyer. It was finally dropped as the [other side] did not prepare a strong case. But I had to spend time and money on this. (Participant A)

This case had put the physician in a position of vulnerability. They were required by law to report this incident to the Division of Youth and Family Services, but then left alone to defend themself for having done so. Being placed in this no-win position had serious repercussions for them, including a deep sense of isolation caused by a world unwilling to support them in complying with a law that society has deemed necessary. In this participant's words:

> I can say, no one is on your side in your practice. People don't realize that. The board is not on your side, and even the hospital is not on your side anymore. You have no buddies in the system. There's collegiality among the doctors, and everyone is a nice person. They are all the nice guys themselves, and the hospital administrators are nice people and they're OK to play tennis and golf with. But these companies, they have lawyers to represent them and work for them. No one helps the doctors. No one is on your side. It [makes one] . . . feel very vulnerable. So, that's one of the issues that made me retire a year or two early. I could have worked another couple of years if I hadn't had those.
>
> Sure, I've made plenty mistakes in life. Those are not the ones that I got sued for. And there was never a suit against me that was successful in terms of people getting money for it. But it's very aggravating, nevertheless . . . very aggravating. You have to be really aggressive in that defending yourself. And, again, you have no friends in the system. (Participant A)

Unfortunately, as one participant noted, there appear to be many situations where it is difficult to determine exactly who is to blame for a poor outcome. This appears to explain one reason why coming to a swift and accurate conclusion about who is to blame is not always a simple task. One physician described this, saying that there are

> a lot of gray areas. A lot. Sometimes it's not your fault, so it would be terrible to be sued for a bad outcome then. You'd get really annoyed and angry at the lawyers and the person that's suing you. Why are they suing you when you didn't do anything? But a lot of times, there are gray areas. (Participant J)

Another participant related that they had managed to survive an entire career without being sued. They acknowledged their good fortune in doing so, but they admitted that it was by chance that they were able to avoid this:

> Never once [was I sued]. And I think that is a real blessing. I mean, I think it would have been shattering to have had it happen. You would always ask, "Could I have done better?" Well, if you'd stayed a few hours more with this patient the night before she died, she might have done better. And you sort of say to yourself, "Yeah, maybe that's right." Fortunately, I was never sued. I just look upon myself as having been extraordinarily fortunate, not because I was better than anyone else.
>
> I was good friends with a pediatrician. Two years after he retired, his group was sued because of a tragic episode with an infant who died. He was ultimately exonerated. But he was describing how upsetting being sued was and the self-doubt that came from it. Even though he was completely cleared. But it still leads to enormous doubt about oneself. [We ask ourselves:] "Could I have

> done better?" The answer is, "Yes, we all could have done better." Because if you step into the ring, you're going to get hit on the chin. (Participant C)

The Pay Difference Between Primary Care Physicians and Specialists (or, Why Would Anyone Ever Choose Primary Care Over a Specialty?)

One issue discussed in interviews that served to both baffle and annoy many PCPs was the pay difference between them and those in specialties involving procedures, especially surgical procedures. A few PCPs stated that there had been some improvement in this discrepancy toward the end of their practices, but the discrepancy still rankled them. One described this feeling:

> I think it's indecent. I don't think that the difference in pay is fair. We do a lot of groundwork and stuff that's hard. Yeah, they get the glamour. But we do a lot, especially now in primary care, that is based on value-based pay systems. All the business stuff that we're doing, or organizing, and putting into the computer. I don't think that primary care is rewarded as much as it should be for that. I think it's a lot better than it was. But I still don't think . . . [specialties like] ENT and orthopedists should be making seven figures when we're barely making six. (Participant F)

This same physician shared their sense of helplessness caused by their perceived inability to change this balance: "It's hard to say if it will change, because those guys have always been the ones in control, making the decisions, because they are the big moneymakers. They will continue to be the ones making those decisions" (Participant F).

Another physician described their reaction to the pay difference:

> For the first decade or two when I was in practice, it bothered me a lot. What was discouraging is that I was working extremely hard to the extent that it adversely affected my home life. I would refer patients to a specialist, for example a gastroenterologist, for symptoms. The consultant would do an EGD [upper endoscopy] and colonoscopy and return the patient without a diagnosis or treatment, but with normal test results. I felt like the consultant would make as much in doing those two procedures as I would make in a week. I was left addressing the patient's problems and getting home late while the gastroenterologist would be on the golf course. (Participant J)

An interesting reality is that those PCPs who chose to care for children rather than adults generally had the lowest income of all physicians. This speaks poorly of the value our society places on the health of our children. This study will not address that issue, but it does appear to be an area worthy of further exploration. One physician spoke to this issue:

> But I always felt jealous. I felt that pediatricians are clearly the underpaid part of the profession. Pediatricians get paid even less than interns. Also, family practitioners and even primary care doctors. I thought that was inappropriate. I didn't like that at all. (Participant A)

Regarding the low reimbursement received by those who care for children, this same physician also commented on the reimbursement physicians received for treating adolescents:

> I do like pediatrics, and I also was trained in adolescent medicine. I enjoyed that part of the practice, too. But to see an adolescent always takes a lot of time that

> you were never reimbursed for. Nobody ever . . . [treated] a 15- or 17-year-old with a problem in the office and was reimbursed enough for the time you spent with them. You got reimbursed very little. I always felt that we were underpaid for that. (Participant A)

In addition to this reality, PCPs depicted scenarios from the past where they rendered care that was later duplicated (in part) by a different type of physician or a specialist who went on to bill at a rate that far exceeded what one would suppose appropriate, given the amount of time and energy expended by each:

> So, I'll give you an example. Early in practice, before there were pediatric emergency doctors in the hospital, [a] patient of mine had some head trauma, and was taken to the hospital. I went in at midnight, examined the patient neurologically, looked at the skull X-rays (what we had at the time), and decided it wasn't a fracture. I give them some instructions, sent parents and the youngster home and did the follow up. I billed X amount of dollars at the time.
>
> About two months later, the mother came to me and said, "Remember when you saw my youngster? You billed very reasonably. But I've gotten the bill now from the radiologist who came in the next morning. His bill was bigger than yours." I went in at midnight, examined the youngster, looked at the X-rays, made a clinical decision, instructed the patient, and did a follow up. Yet he charged more and only read the X-rays. It makes me feel like an idiot! I thought I was underpaid for worrying about people's problems. If I had to do it again, I might pick a subspecialty because they are reimbursed better. (Participant A)

That same physician noted that care that involves "more physical than mental effort," such as that required to perform procedures and surgeries, is generally much more highly reimbursed. Another example Participant A depicts this:

> And you were overpaid for surgical things. For example, I used to get paid more for circumcisions than taking care of babies. So, I would take care of a newborn baby for two or three days. Yes, I would examine the baby, make sure they had no heart disease, no eye disease. No complications, newborn syphilis or jaundice, etc. I'd take care of newborn babies and examine them completely. And talk to mother about that baby. Maybe on day two, maybe on day three, discharge mother with advice about feeding or breast feeding the baby. And I would get a fee for that. But maybe on day two, I'd do a circumcision on that baby, which took me 90 seconds. I'd get paid more for the 90-second procedure than the three days of care for the baby. I always noticed that. I used to make a lot of money doing circumcisions compared to taking care of babies. That's no logic. It's a crazy system. (Participant A)

Another participant described their appreciation for the work surgeons do, but not without voicing frustration when comparing the benefits surgeons often had in comparison to the PCPs:

> Surgeons work hard and have to come in for emergencies, and their jobs are very stressful. They are often at risk for having sudden emergencies and disasters. However, in general, they work fewer hours. They have much more time to develop relationships with other doctors, nurses, and techs while waiting for OR time. I had no time for this. Again, they made much more money than we primary

> care providers did and were often able to just focus on the specific problem. That is, as a primary care doctor, I felt responsible to address *all* the patient's complaints. Let's say a patient had leg pain. I would send him to a neurologist who would conclude the pain was not due to nerve inflammation or damage. Then I would send the patient to a vascular surgeon who would conclude the pain was not due to a blood clot or ischemia. In all these examples, the high earning subspecialist could focus only on their area and if they could not explain the symptoms, then they were done with the patient. (Participant J)

This same physician described in more detail the frustration caused by being reimbursed substantially less while having more responsibility for the well-being of the patient:

> I was making rounds and saw a urologist who was a friend of mine. He was always hanging out in the doctors' lounge and wanting to chit-chat. I never had time to chit-chat. He had time to hang out. One time, he operated on a patient of mine. The patient asked me a lot of surgical questions. I asked him what the urologist had said to him. He told me he hadn't asked the urologist questions because he felt the urologist was too busy to address his questions. In my experience, this was not uncommon. I often found surgeons to be binary—should I do this surgery or shouldn't I? And then they were done. I felt like I had to address all the patient's concerns, whereas the surgeon would be in and out.
>
> So, yes, I was resentful of high earners, as they made a lot more money and worked fewer hours and were able to pass on difficult problems and focus on their money-generating procedures or surgeries. (Participant J)

In time, this physician did find peace with these emotions, crediting it to the reward of having sufficiently fulfilling relationships with their patients: “Eventually I got over the resentment and realized that it was not helpful to compare myself with others. I had relationships with people (patients) that were very rewarding, so I was content with the pay, responsibilities, and hours” (Participant J).

Another physician dealt with this reality in a different way. They decided early on to maximize revenue by practicing not as an employee of an organization but as the employer of other pediatricians. In this way, that physician not only earned income from the patients they themself saw, but also from the earnings of those they employed. The physician explained:

> I always made a good living . . . [because] I always made extra money from people working for me. I had a business. I made a certain amount myself. And I also made part of what the people working for me earned in the years they worked to become my partners. So economically I never missed any meals. (Participant A)

At this time, fewer and fewer small practices remain, and thus the type of practice just described becomes more difficult to establish or maintain. Yet without other potential sources of income, the financial strain of medical education and training may require some to consider areas other than primary care despite believing this would be the best match:

> Oh, yeah . . . you come out of medical school with $300,000 in debt because of college and medical school training . . . and then you do a couple years of residency, which you get paid just enough to have a family. Then you do a

> fellowship. You know what you're going to do. You go into something that's going to try and recoup your money back.
>
> Unless you're lucky to be someone like me whose parents were able to cover your expenses. And so, you come out without debt, then you have a better choice of what you want to do, as opposed to what you think you have to do. (Participant F)

Corporatization and the Increased Emphasis on Profitability (or, the Patient No Longer Comes First!)

Many PCPs, who traditionally possessed significant autonomy, have been thrust into positions where this has been relatively diminished. This has occurred with increasing frequency during the last few decades as most physician practices have transitioned from being physician managed and owned to having undergone what is known as *corporatization*: a consolidation of practices into ownership by a central corporate force that guides and supersedes local autonomy. Thus, physicians become employees of large entities such as hospital systems or practices owned by private equity firms. While physicians are still held responsible for the health of their patients, they now have decreased ability to control how they can achieve this within their new confines.

This dissertation does not address the numerous and wide-reaching consequences of this change to corporatization, but instead uses as examples two consequences to PCPs due to corporatization of their practices. These created a sense of victimhood and powerlessness in many participants, conflicting with their goal of good patient care.

Mandated Patient Visit Length (or, Who Pulled the Rug Out From Under Me?). One aspect of corporatization that affected participants was being required to

maintain a mandated average length of time for patient visits. Traditionally, physicians generally determined the length of time they would allocate for these. One physician described their method of interacting with patients, enabled by having control over the length of their encounters:

> So, one of the compliments that I receive most from my patients is that I speak to them in a way that they understand. That I am speaking to them non-clinically, without using excessive clinical or medical terminology. But always without being dismissive, always with respect, always with a desire to understand, to make sure that I'm really getting down to the root of their concern, their fears, their questions. That I'm not hurried. (Participant I)

As control of practice was increasingly placed in the hands of larger organizations, their goals did not always align with those of the physicians. Many physicians found it a challenge to adhere to these mandates while continuing to provide good patient care. One participant described the impact of this: "Our appointments were 15 minutes. Sometimes I spent more, and it would take away from the next patient. And I always was behind at the end of the day" (Participant F). Another stated how this dilemma affected them:

> There were some doctors, when the 15 minutes was up and the patient says, "Well, I also want you to take a look at something else," the doctor would say, "Well, you'll have to come back for that. That's a separate problem." I could never do that. I mean, if there were people that really need a lot of time, I would say, "You know, I think it's better for you to come back so we could talk about this in more detail." But if it was something I could do with an extra minute or

> two, I would do it. But most of the time, I was running late and stressed by that. (Participant J)

A number of physicians found they could only adapt to these visit mandates and continue to adequately care for patients by adding additional hours to their workdays. This time, frequently in the form of "pajama time," was added to allow physicians to spend their allotted visit minutes interacting with the patient versus preparing for that interaction. One participant described this, *"*[I did] . . . a lot of work on the back end. I would come in an hour or two before my office hours would start and prepare for my day (same-day visits notwithstanding). I never, never walked into a room cold" (Participant I). Another physician detailed the additional time commitment this required:

> They were strict. You got 15 minutes for follow-up visit, and you got 20 or 25 minutes for a new patient. I mean, you are running. If you work for a commercial organization like I did towards the end, they wanted you to see anywhere from 20 to 30 patients a day, which is a lot of patients. So, I used to spend a good deal of time at home going through the patient's chart and typing out everything, the set review of systems and so forth. And the focused history the night before, because otherwise, I'd spend all my time with the patient with me typing away and trying to catch up. This way, I had it all down there. And I could look the patient in the eye and say, "How are you, Mrs. Jones? Or how is your family?" and such. (Participant C)

One cannot help but wonder what personal cost this additional work resulted in for this physician. Prior to these types of mandates, the physician's "pajama time" was less. It appears that even if the total number of patients seen remained the same, the time

required for the physician to complete their tasks (due to the relatively new requirements of the EHR) was significantly increased.

Other related mandates, designed to maximize the number of patient encounters each physician had, have been introduced. For example, one physician stated that their practice no longer permitted them to keep a few appointments open each day for patients who require a same-day visit. Previously, the practice of leaving several slots open for same-day appointments had worked to the advantage of both physician and the patient, although it did not always result in maximizing the number of patients being seen each day. But it did appear to provide some reduction in stress for both physician and patient, as well as possible improved treatment for the patient:

> But I understand part of this is to increase billing by having every minute of your schedule filled. Which is also why, at the end of my practice, keeping spaces open for same-day visits was not permitted. Before, I did this for the convenience of my patients and to give myself some flexibility to expand visit length if need be. Now those patients had to see someone else, which neither I nor the patient were always happy about.
>
> If it was a patient that I know that I want to see and wants to see me and has an intricate history, I really, really need to be there. Sure, there are some problems that anybody could take care of like, "I've got an earache or a headache," or "it's sinus congestion." But there are other problems that you really need to know the person to figure out, you need to know their stress level, their history. I mean, a whole bunch of stuff that I think you're much better able to help

> with when you know the patient. If not, it's terrible. So, I think you really need to leave openings for those people. (Participant J)

Another physician confirmed this advantage that decent knowledge of a patient provides, allowing optimal diagnosis and treatment:

> It helps to know the patient. Let's say the patient is talking about their stomach pain. Well, if I knew they had a developmentally delayed daughter at home, I'd say, "What's going on with her?" I could shortcut things, because I knew them. A lot of the time the physical complaint was just a manifestation of an emotional issue. With a shortened visit time, you can't always get to this and take good care of the patient. I hear that *X* [a medical group] is making longer visits. It doesn't sound like much, but now some of the visits are 20 minutes instead of 15. Now physicals are 40 minutes, instead of half an hour. And those extra minutes can be a real game changer. (Participant B)

When I was questioning one participant about how they would define good care, they described their method of assessing the strength of a practice:

> I just talked to the residents I was teaching about this. They asked me how to judge how good a pediatric practice is, how competent the doctors there are and whether you should use that practice for your child. I told them to find out how many patients physicians in that practice see in an average work hour. I'm in charge of our [pediatric] practice, and I try to keep our practice going with four patients per hour per doctor. Obviously, some patients, like those with a painful ear, take less time. Those with emotional issues, for example, are going to take more. So, I try to keep it balanced. But I know a lot of practices see six and seven

> patients an hour. But you can make a living seeing the number of patients we did. From a business point of view, you will produce more income with more patients. But if you see so many patients, you shortchange the patient. (Participant A)

This shortchanging of the patient because of mandated visit length is apparent in participants' comments. There is no denying that a PCP seeing more patients each workday produces more revenue. The important question, though, is: What unintended consequences does this produce in PCPs?

Decreased Control Over Staffing (or, Who's in Charge Here?). When participants initially practiced medicine, many had small offices with only a few staff members. As corporatization increased, control over one's staff decreased. When one reviews the words of physicians who practiced in a small group for decades, one can see how they had a degree of control that is no longer easy or even possible to obtain in a larger group. That strong level of control appeared to enable them to intentionally develop a practice model that promoted the thriving of all stakeholders:

> People would come into the office, right? They have a problem . . . meet the people at the front desk . . . meet our staff . . . meet the nurses taking their blood pressure, drawing their blood. They come into my office . . . see me. Then they walk out of the office, "Dr. X, I feel so much better." And you just told them they probably will be dead within a year, but they walked out and said, "I feel so much better." That patient began to feel better just because of the person that first said hello to them. Brought them to the back room, took their blood pressure, chit-chatted. It was about the physicians who were in the practice setting examples. It kind of came down from the top.

> We were all really good people. Yeah, we all had our quirks. But we were good people. We cared as much about each other as we did our patients. It was very important to take care of each other. If something was happening [to one of us], someone would sit with him. Here, I'll take care of that one. Just take a week off, then come back, or vice versa. So, we did care about each other. And we cared about the people working for us. They stayed . . .and the docs stayed. (Participant H)

Another physician spoke of the importance of the atmosphere set by the staff in their office. There appeared to be an appreciation of all staff members by the physicians, an ongoing respect for what they did and how they did it. In return, the staff appeared to be willing to go the extra mile for the physicians to keep them and their patients well:

> Oh, my God. Some of my staff have worked for us for over 20 years. We're a very collegial social group. They had a retirement event for me and three or four other people who are about to retire. I said to the coordinator, "Can I ask how many people I'm allowed to invite? She said, "Well, how many people are you thinking of?" I said, "I'd like my entire staff to come." And all of the support staff, the RNs and the front desk staff came. They were like, "This is great!" because they like being around each other. [Some have been pulled out to work in other health offices at our center] . . . and the work ethic is different in some of these offices. They're a lot more isolated, and it's kind of siloed. There's not as much camaraderie.
>
> Yesterday, one of my nurses arranged for lunch to be delivered, because we get a stipend every month that we can use however we want. And she said,

> "We haven't used it. Let me order lunch from the Mexican place." So, we all socialized a little bit around that. So yeah, there's definitely a culture like that. And I think they respect the medicine that's being practiced. And we give them a lot of responsibility because they're worthy of it. So, they feel valued. And then they get a lot of positive feedback from our patients. I walked out of my last patient last night, and my staff member who was supposed to leave at 6:00 was still there at 6:30. I said, "What are you doing here?" [She was with L.] . . . a long-term patient that I had just seen. She said, "L. wanted to chat. So, I just talked to her for a little bit." We cultivated that. (Participant D)

One can acknowledge the value of a staff well familiar with both the patients and the working style of the physician. While developing and maintaining such a staff is neither simple nor rapidly accomplished, participants stressed its importance. An informed and dedicated staff appeared to result in many positive outcomes for all, as depicted by one participant:

> I think it's extremely important for the staff to know the patients. I think that really helps. For example, I have a cancellation. If somebody calls up—a healthy 30-year-old who I saw last year for a physical—has a sinus infection, I think that person should be triaged to the nurse practitioner, or somebody else if I'm busy. I want to keep that open, for example, for somebody with a bad cardiomyopathy who feels a little bit more short of breath and has a low-grade fever. So, I think that the staff should know the patients enough to be able to do a bit of triage that way.

> Also, when you get phone calls . . . there are some people that you need to be able to interpret, is this serious enough to bother the doctor and get them out of the room, or is this a call back today, or can I handle the call? I think it's really important to have a staff that knows the doctor and knows the patients. (Participant J)

As many practices have changed in size from small to large, physicians have had to adjust to the lessening, or even loss, of the authority they traditionally held over non-physician members of their group. With this decrease in authority, there was also a concomitant decrease in control over how one's practice is staffed. One physician described the impact of this:

> There was a point before I left practice *X* where, oh my gosh, it was months, it was from November until June, where I didn't have a regular medical assistant. I was working with a different person every day, and often multiple people over the course of one day. My long-term medical assistant, who was on surgical leave, used to finish each other's sentences. When she was gone, it was good for nobody. The stress and strain of trying to work like that was enormous—I never knew what I was going to walk into. But if you aren't the one in charge of it, you don't have the capacity to fix it. (Participant I)

Other participants stressed the importance of the physician standing up for the staff as they cared for patients. I wonder if this level of support is now possible given the loss of control in larger organizations. One physician described how they went about supporting the staff:

> When I first started practicing, I thought the patient was always right. As I gained more experience, I became more supportive of my staff. For example, when a mother complained about how my nurse administered a tetanus shot to her 3-year-old daughter, in the past I would have said, "I'll talk to the nurse about it." But then I went a management course that taught me something valuable. That is, the best way of marketing your practice is through your staff. So, if I were to have this encounter with this mother now, I would say, "That nurse . . . knows how to give a tetanus injection. Believe me, she knows what she is doing." I am more supportive now of my staff. I grew up believing that the consumer was always right. Now it's more important to me that my staff is happy rather than the patient. It was not an easy thing for my head initially, but it's logical now. (Participant A)

The "firing" of patients was not something that all participants had practiced. Yet several felt this taking this type of action was important, particularly in situations involving abuse. One illustrates how they went about this:

> I fired one guy because he was verbally abusive in an interaction with my partner. He was in the hospital, a foul-mouthed guy, very opinionated. And he dropped the F-bomb on one of my partners. I told him, "You're going to get fired from the practice if you keep up that behavior." I'm often not that direct. But he did it again and I called his wife and said, "That's like one strike and you're out." She said, "I knew this was coming. I understand completely." She was embarrassed. So yeah, I fired him.
>
> At this point in my career, I know who the troublesome people are. And I talk to [them] . . . because what happens is, if I don't, they will be problematic

> with the staff and not with me. One of the benefits of being this far along in my career is that I'm not getting new patients. So, the people that are troublesome are people that I know. I'll try to say, "Look, I know you had difficulty getting an appointment or I see there was a miscommunication. You're not doing yourself any favors by berating my staff or getting into arguments with them. They are the people who are working for me and what you do to them, you do to me. I don't want you to be that way." (Participant I)

One can see that having authority to control staff can make an important difference to all stakeholders. One hopes that as practices continue to grow, consideration will be given to the importance of physician input into staffing. Without that, the powerlessness to effect change may have consequences, such as in this situation depicted by a participant:

> Yeah, it's unfortunate, because I feel like there's this messaging, "If we give you a little bit of wiggle room, you're going to take advantage of it." And I think that industrial studies have really shown the opposite. People are a little more loyal or willing to do what's right because they are being treated like adults. (Participant D)

The words of another participant may be worth considering:

> A good staff is so important. I really think that's underrated . . . underrated. More effort needs to be put into appreciating and training all the staff in the office to really make things efficient, for them as well, but also for the doctors who are forced to see patients so quickly. (Participant C)

Conclusion

This chapter discussed the findings of this research study, including the essential elements, self-depleters, and external depleters. The essential elements are required for PCPs' professional satisfaction and personal well-being. These include development and maintenance of long-term personal relationships with patients and those who care for them, personal growth achieved via physician/patient interactions, having a positive impact on the lives of patients, and maintaining a sense of self-respect. The essential elements become diminished by certain forces divided into the themes of self-depleters and external depleters. Self-depleters are divided into subthemes of perfectionism, imposter syndrome, and lack of self-care. Lack of self-care is further divided into lack of adequate sustenance, absence of mentors, low utilization of mental health services, and lack of skills necessary for a healthy work-life balance. External depleters are divided into subthemes including the impact of rapid change, being threatened with or sued for malpractice, the pay difference between primary care physicians and specialists, and corporatization and the increased emphasis on profitability. The latter includes two results of this, decreased control over one's staff and mandated patient visit length. Chapter 5 will discuss the implications of these findings.

Chapter 5

DISCUSSION

Data obtained in this study describe participants' experiences that caused a decrease in the PCPs' professional satisfaction and personal well-being. They stated that, over their many decades of practice, it became increasingly difficult to satisfy their patients, colleagues, and society, placing the PCPs in increasingly vulnerable positions. This caused harm or suffering to many, mirroring what was previously described in this paper as physician burnout, an affliction currently affecting a troubling number of PCPs in the United States. My study's purpose is not to find correlations or explanations, but to seek deeper understanding of participant experiences and their resultant practical wisdom—or phronesis. This information can be useful to current and future PCPs to more accurately recognize vulnerabilities that exist especially in those who practice primary care.

Using the participant narratives that capture and describe these vulnerabilities, I visually depicted their practical wisdom in a set of challenge cards. These invite PCPs into a space where they can more easily recognize their vulnerabilities and explore them with deeper and more compassionate inquiry. Rather than advocating for the elimination of their vulnerabilities, my study explores how PCPs can proactively address them. Recognizing that vulnerability is an inherent aspect of the human condition, even for health care professionals, this study seeks to honor this reality by producing strategies for productive exploration of these vulnerabilities. Enlightened by the wisdom of those who have "walked this walk" before them, PCPs can better equip themselves to navigate the road that lies ahead.

This chapter critically examines the study's findings, integrating them with existing knowledge of PCPs' experiences navigating practices while acknowledging and responding to their vulnerabilities. Building upon the theoretical framework outlined in Chapter 1, I will explore how these findings contribute to our understanding of the topic.

The Essential Elements for Primary Care Physicians

Participants began their interviews by sharing their descriptions of practice components most important to their professional satisfaction and personal well-being. These included the development and maintenance of long-term personal relationships in the workplace, the achievement of personal growth through patient interactions, the knowledge that the PCP has had a positive impact on patients' lives, and the maintenance of a sense of self-respect from knowing one has done well in serving one's patients. Together, these formed the essential elements, deemed indispensable for a PCP to thrive.

Other resources have reported that PCPs are finding it increasingly challenging in the current practice environment to obtain the essential elements in amounts sufficient to sustain themselves. For example, a recent *New England Journal of Medicine* article, entitled "The Plight of Primary Care, Part 1", shares a PCP's description of this environment:

> It's turned us into a widget factory of just throughput, getting people transferred onto money-making specialties without really addressing their health care needs. And it's demoralizing, and it's not good care. . . . The hospital company that took over the practice wanted things done a certain way, and there was really no room for . . . personalization of the experience between doctor and patient. Lost . . . was the chance to really

> talk, and to have time to talk. . . . So, a lot became impossible overnight. . . . What was quickly missing, the key thing we go into medicine for, we want to help people. And the way we can help people, yes, it's based on our knowledge, but knowledge is not nearly enough. It's got to be the relationship. (Gotbaum, 2023)

Non-scholarly resources confirm this, offering different descriptions of the reality PCPs often encounter while providing primary care. For example, this online advertisement for a physician-run company called TheHappyMD.com quoted a physician's response when asked for a description of their typical day seeing patients:

> A non-medical friend recently asked me to describe a clinic. I told her to imagine you have 20 meetings in a day, half of them new clients with urgent needs. Each requires your best self. You are late for at least ten of them. You must prepare a report and deliverables for each one. (Drummond, 2024)

Online comments on this description by other physicians added to this scenario:

> In 90% of those meetings, there is 100% uncertainty, and in over 50% you have no control in any action steps. Most, or all, of the meetings require multiple items on the agenda, and most of your clients are irritable and not at their best. The rules for each meeting are different. If you make a mistake, someone could die. And you could harm or kill the person if you don't pay attention to details, or you rush through your assessment of the situation! And after that you can get sued, lose your license, and therefore your job and your only way of income. 20 [patients] is a modest number, many physicians see 30, 40 or more. (Drummond, 2024)

This description aids in understanding why the essential elements, so critical to PCPs' thriving, are no longer accessible to many. This lack then causes a decrease in personal well-being and professional satisfaction. These can lead to greater levels of burnout and its unwelcome consequences, resulting in suffering or harm to them.

Some hope that PCPs will somehow manage to adapt to this unhealthy environment and still manage to provide a reasonable level of care for both them and their patients. Others argue that we cannot afford to continue to ignore this. They conclude that this is perilous not only for patients, but also for the PCPs who provide their care. In a recently issued Milbank Foundation report *The Health of Primary Care: 2024 Scorecard Report*, the answer to this affordability question is apparent. It states:

> Despite overwhelming evidence that access to primary care improves population health, reduces health disparities, and saves health care dollars, support for primary care continues to dwindle. . . . As a result, the average life expectancy in the U.S. continues to stagnate, and health disparities in preventive and other basic primary care services persist, accounting for 60,000 excessive deaths each year (Jabbarpour et al., 2024)

This report concludes that the systemic lack of support for primary care is "harming people's health and weakening the entire U.S. health system." This is cause for concern not only for PCPs, but for all of society.

One must acknowledge that PCPs serve as the patient's entry point into the health care system. Their gatekeeper-type role grants access to patients and subsequently feeds the entire system. To weaken this function appears unwise.

Gatekeepers who cannot maintain a reasonable flow of entrants into the system can cause the entire system to malfunction. Add to the gatekeeper function that of "ongoing coordinator of the patient's use of the entire system" (aafp.org website). One sees that the PCP has a tremendous impact on physicians in other specialties, many of whom are the main income producers for the system. Because PCPs hold the keys to both the entry into and the ongoing use of the entire health care system, should we not provide them with what they need to do this efficiently and effectively? There are a variety of responses by a variety of organizations to this question, but until it is better addressed, PCPs would be wise to consider what they personally can do to improve their own lot in this dilemma.

I acknowledge that the individual PCP plays but a small part in causing this current crisis, but I also believe that the PCP needs to acknowledge and claim their role in this. They must seek and acquire the mandatory basics that they require (the essential elements) to thrive. While our government, professional associations, medical schools, and health care organizations should be better at providing these, other priorities currently supersede much of this, preventing solutions needed at this time. (Shanafelt et al., 2019, and Gotbaum, 2023). In the meantime, PCPs do have some degree of control over their acquisition of the essential elements. If they don't acquire adequate levels of the essential elements for themselves and demand adequate levels of support those they work for, they will likely find themselves increasingly depleted.

It may be useful to follow the ancient advice of a proverb existing in the Bible, "Physician, heal thyself" (Luke 4:23). This counsels physicians to

adequately care for themselves to adequately care for others. It reminds one of the more current airline caveats to don your oxygen mask before you attempt to assist others who require care. PCPs, like most doctors, were unfortunately taught that care for themselves was not a priority—that it was even a selfish act. This is a difficult, normalized, and cultural practice for many doctors, difficult to change without tremendous effort.

Physician author Gabor Mate (2022), in *The Myth of Normal*, cautioned physicians that self-examination or a willingness to question these kinds of "truths" is not automatic or something that one learns in medical school. Rather, G. Mate stressed, one needs to learn this despite one's education. G. Mate suggested physicians ponder the words of Socrates, "An unexamined life is not worth living." G. Mate concluded that "if one does not examine oneself, one is completely subject to whatever one is wired to do. But once you become aware that you have choices, you can exercise those choices" (p. 35).

Physicians need to intentionally seek and discover what is important to their own health, not just that of the patient. Another physician author, Rachel Nemen (2006), supported this, counseling that medical training "changes the way you see things . . . the way you think. . . . After a time, I forgot many important things" (p. XXXV). These "important things" resulted in that physician's denial of the needs of their body, their need for sleep, for comfort, and even food. "No one complained," Nemen stated. "It was just the way we all lived" (p. XXXIV). Is this reasonable? Many physicians think not, as this lack of self-care increasingly results

in the “progressive loss of idealism, energy, and purpose experienced by people in the helping professions” (Sanchez-Reilly et al., 2013).

This study proposes that PCPs reposition themselves to where they are no longer selfless. Rather, they acknowledge that they also require care if they are to continue to care for others. How might they accomplish this? This study proposes that PCPs explore the issues identified by the study’s participants that depleted them of the essential elements. These include a variety of occupational hazards (related to the personal characteristics of PCPs) and external depleters (environmental factors impacting PCP practices). Each causes suffering, but each contains some aspects under the control of the PCP that they can use to improve their professional and personal well-being. Strengthened by improved understanding of the necessity for self-care, they can move forth more successfully in their chosen work of caring for others.

Occupational Hazards

Physicians were shaped during the early years prior to their medical training by a variety of environments (familial, educational, cultural, and societal). They were then further shaped by the medical profession’s environment, whose norms and values they absorbed. This created persons imbued with a set of absolutes that worked well to serve that profession. Statements from participants demonstrated how fervently many believed these were absolutes. Participants also spoke of how these beliefs often resulted in their carrying themselves to extremes, resulting in harm or suffering to them while at the same time providing them with guidance.

A Need to Re-Envision Competence

Perfectionism

The goal of physicians is to heal their patients. To achieve this, according to many of the study's participants, a PCP must be perfect. Absolute perfection is the ideal in medicine, they reported, especially because errors in this realm can have serious, if not deadly, consequences. It is impossible for us humans to achieve this, as the PCPs of my study knew on some level. Yet, some had come to believe that they must be above this, always demonstrating perfection. This type of perfection is demonstrated in the words of Dr. Anthony Fauci (2024), American public servant, in his autobiography *On Call*. He modeled this behavior, describing how he treated every patient:

> I cannot explain this except to say it comes naturally . . . a nonpathological form of obsessive-compulsive behavior when it comes to making sure that every aspect of my patients' care is attended to. This played out late at night before I captured the couple of hours of sleep when I was on call, where before I went off to the on-call room, I checked the settings on every ventilator, made sure every IV was open and dripping, looked at every indwelling catheter to make sure that it was performing properly, and stopped at the bedside of every one of my patients, regardless of the severity of their illness. (p. 340).

This degree of perfection must be wonderful for those under the care of a physician who can practice in this manner. Yet one participant in this study described the toll this type of behavior took on them. They recounted feeling perpetually stressed and drained, haunted by self-doubt, driven by an unattainable ideal of perfection. Simple

affirmations of gratitude and acceptance were insufficient; instead, they felt compelled to always excel.

Unfortunately, perfectionism must be viewed as a double-edged sword. It can result in physicians providing the best care that they are capable of. But it also can result in ongoing feelings of inadequacy, shame, or despair when reasonable limitations are not set. These results can occur even when the physician has provided the best level of care they can possibly render, as the physician is human and therefore imperfect. But not sufficiently grasping this reality in one's practice of medicine can have a negative impact on one's mental health, as shown in a recent study conducted by Martin et al. (2022), which concluded that "high self-critical perfectionism uniquely predicted both high emotional exhaustion burnout and depersonalization (detachment from peers and patients) burnout in physicians." A different study further illustrates the never-ending sense of inadequacy that perfectionism can cause:

> All doctors have some degree of perfectionism; after all, meticulous attention to detail and the wish to get things done right are desired characteristics. Healthy perfectionists set high standards for themselves but drop these when required. . . . [Those with an unhealthy level of perfectionism] develop a cognitive triad of doubt, guilt and an exaggerated sense of responsibility. . . . [which causes one] to work harder, achieve more, give more to our patients and deny our own needs. . . . It can lead to never feeling good enough, being overly self-critical, and placing impossible demands on ourselves [causing] . . . a cycle of failure, procrastination, and reassurance seeking as we blame

> ourselves for the losses and failures that are inevitable in medicine. (Gerada, 2019)

This same type of outcome was described by many of this study's PCPs. Feeling that their best effort was never adequate set them up to always feel lacking. *The Book of Joy* by the Dalai Lama, Desmond Tutu, and Douglas Carlton Abrams (2016) reinforces this concept that perfectionism prevents self-compassion:

> Modern culture makes it hard for us to have compassion for ourselves. We spend so much of our time climbing a pyramid of achievement where we are constantly being evaluated and judged and often found to be not making the grade. We internalize the voices of parents, teachers and society at large. As a result, people are not very compassionate with themselves. They don't rest when they are tired, and neglect their basic needs for sleep, food, and exercise. . . . Even when they are successful and grab all the brass rings, they often feel like failures or frauds, just waiting to fall off the merry-go-round. (p. 260)

Thus, the need to be perfect comes at significant cost, recently linked to an assortment of negative mental health outcomes (Martin et al., 2022). These can lead to anxiety, depression, and suicidal ideation, as physicians find it difficult to be satisfied with what others may see as their successes (Canadian Medical Association, 2021). Furthermore, a recent study published in the *Harvard Business Review* on perfectionism (in the general population as opposed to physician population) demonstrated that it leads to more "detrimental" work and non-work outcomes, reinforcing the case for better management of perfectionism (Swider et al., 2018). The aforementioned conclusions add more reason

for PCPs to consider what degree of perfectionism they might personally wish to maintain.

One approach that may assist a PCP in evaluating their level of perfectionism is to observe the degree of thoroughness in their individual chart notes. Notes can range from bare-bones minimum to extremely lengthy and detailed. One cannot help but wonder what cost the latter requires in terms of time and effort by the writer. Is this level of perfectionism necessary? Why? And what is the opportunity cost of this practice in terms of taking time away from other activities that the PCP values? If one accepts that this may be a predictor of the level of perfectionism a PCP has, might it not be used as a tool to evaluate one's level of perfectionism?

Failure to address a continual striving for perfection leaves little for the PCP. Dr. Kimball, CEO and president of Harvard Medical Faculty Physicians, noted that physicians typically enter medical school only after enduring a number of highly competitive processes that often serve to increase their sense of perfectionism and related traits (Berg, 2021). Yet while perfectionism's role in medical profession wellness has been raised by several investigators, it is still considered understudied (Martin et al., 2022). Until this reality improves, PCPs may be best served by knowing that while they are often expected by the outside world to "have all the answers," the prevalence of high perfectionism in their profession may be a liability for them personally. Kimball advised

> [developing] self-awareness and recognizing it in yourself so that you can actually process how you want to think about it. The key thing is giving yourself permission and forgiveness. . . . also reframe what's important and

> what's not important. . . . You just have to let some stuff go because this is not the way we're used to living life or taking care of patients. . . . you may have to give yourself permission to not do some things . . . [find] personal strategies that embrace imperfection, reframe challenges as opportunities, focus on process rather than product, and seek self-acceptance with perceived shortcomings. . . . [make] efforts to restore conversations among physicians . . . to share challenges, questions and provide support to colleagues. (qtd. in Berg, 2021)

With improved responses to perfectionism via practices such as less critical assessment of one's level of performance, more certainty about the quality of one's practice, and less expectation that others demand perfection, the PCP may experience fewer feelings of distress and shame (Martin et al., 2022). PCPs do not practice in a perfect world, and because they cannot control many factors in their environments such as time, resources, and outcomes, they will never achieve perfection. They may achieve excellence, but never perfection. Through increased self-awareness, they may instead achieve more self-compassion, more self-care. And by acknowledging that perfection is not always the best goal, they may actually find themselves not only suffering less but also becoming better providers of care to their patients.

A Sense of Inadequacy That Requires Masking of the Real Self

Residing close to perfectionism is IS. Participants' words illustrated the ongoing and significant impact that IS had on some of them. Practicing medicine under this type of pressure, this fear of being unmasked as someone other than who you truly are, may result in better provision of care because of the endless striving it

causes. But it also comes with side effects similar to those of perfectionism, such as the ever-present questioning of one's ability to perform adequately. IS has the additional burden of endless fear that the real (and really inadequate) self will be exposed to the eyes of others, exposing the person as a fraud. This possibility appeared to be especially troubling to some of this study's participants.

IS is not exclusive to physicians. Many other accomplished and confident-appearing people admit to suffering from this syndrome, including Mahatma Gandhi, Maya Angelou, Denzel Washington, and Tina Fey (Cuddy, 2015, p. 96). A public figure who is probably even less suspected of suffering from such an affliction is Lady Gaga. Yet she stated,

> I still sometimes feel like a loser kid in high school, and I just have to pick myself up and tell myself that I'm a superstar every morning so that I can get through this day and be for my fans what they need for me to be. (Lady Gaga, 2011)

Need life be so difficult? Apparently so, especially for some who begin their professional training at medical school. Medical school is considered a "breeding ground for Imposter Syndrome . . . [consisting of] unrealistic, unsustainable expectations of what it means to be competent" (Khan, 2021). Incidentally, IS is even more pronounced in women and international medical students (Corkindale, 2008). Medical schools, along with other factors, ultimately result in physicians being at a troubling 30% increased risk of suffering from IS compared to non-physicians (Shanafelt, 2022). Shanafelt et al. (2022) reminded us that "nearly 1 in 4 physicians had frequent or intense IS experiences . . . and that is strongly correlated with both the

emotional exhaustion and depersonalization domains of burnout and inversely correlated with professional fulfillment."

When one acknowledges what a PCP is tasked with on an average day, one can see the unnecessary and depleting toll IS can take as the PCP strives to provide quality care to their patient population. When this task is affected by reawakened feelings of fear and/or inadequacy from the past, it becomes even more difficult to accomplish one's work. Is operating with IS constantly looming wise? Some say not. The first step to overcoming IS is to normalize it (Khan, 2021). Social psychologist and author Amy Cuddy (2015) in *Presence: Bringing Your Boldest Self to Your Biggest Challenges*, counseled, "The more we are aware of our anxieties, the more we communicate about them, and the smarter we are about how they operate, the easier they'll be to shrug off the next time they pop up" (p. 109).

In addressing IS, PCPs may finally be able to shed the uncomfortable mask they have been wearing to obscure their chronic self-doubt. They have been wearing that mask in the mistaken belief that it will protect them from the harm of another's critical gaze. In the popular book *Outlive*, physician author Peter Attia (2023) addressed long-term health and quoted the words of novelist Paul Coehlo to advise those afflicted with this ailment, "Maybe the journey is not so much about becoming anything. Maybe it's about unbecoming everything that isn't really you, so you can be who you were meant to be in the first place" (p. 408). As a result of this mask-shedding, the "really adequate me" will then be allowed to come forth, unburdened by the heavy weight that IS has imposed on them. The PCP can then increasingly experience deserved feelings of competence and success.

A Need for More Compassionate Self-Care

Many words participants spoke depicted their fervent belief that the patient always comes first. And while one might agree that this is a sensible goal for the rendering of patient care, one might also acknowledge that an excess of this practice might result in the PCP being unable to adequately care for themself. Neglect of one's own care can diminish the health of the PCP physically, mentally, and/or socially, causing serious consequences for the PCP, their patients, and their loved ones. In this study, I focus primarily on the health of the PCP.

Who is responsible for overseeing the health of the PCP? Certainly, the PCP has, or should have, the predominant role in seeking and acquiring adequate care for themself. Self-care is defined as a "cadre of activities performed independently by an individual to promote and maintain personal well-being throughout life" (Sanchez-Reilly, 2013). Yet these types of activities appear difficult for many PCPs to engage in. Physician training and the culture surrounding medicine are often blamed for this. Some feel these have led doctors to believe that they are so godlike that they are immune to the consequences of poor self-care. Others place blame for this lack of physician self-care on traits such as IS. This manifested itself in some of the participants demonstrating that they felt undeserving of the level of self-care that they strove to instill in their patients. Yet we know that, as human beings, none of us is granted immunity from the consequences of poor self-care. PCPs require what the rest of humanity requires.

The following aspects of self-care appeared to affect the well-being of participants: a lack of adequate sustenance, inadequate opportunities for peer interaction, a lack of mentors and opportunities to mentor others, a lack of use of mental health

services, and a lack of skills necessary to maintain a healthy work-life balance. A closer examination of these seemingly small components that contribute to one's level of wellness is called for.

Deprivation of Adequate Sustenance. Participant responses pointed to a culture that placed them in a superhuman category requiring no replenishment during their working hours. I ask if the PCP is truly so godlike, so immune to the ill-effects of poor nourishment, that they don't require what the rest of humanity needs. Or does the PCP feel entirely undeserving of receiving the same level of self-care that they recommend for their patients? This includes a pause every few hours to obtain sufficient nourishment, use the restroom, and prepare themselves for the next few hours of work.

A 2023 study shows that the average physician works 50.8 hours a week, with 40% of physicians working more than 55 hours a week. It also states that WHO and International Labor Organization systematic reviews have shown that working 55 or more hours a week may lead to increased risk of morbidity and mortality related to ischemic heart disease and stroke (Shanafelt et al., 2023). Shanafelt et al. (2023) reported that other studies have shown that chronically working 52 or more hours a week, which a substantial proportion of physicians do, is associated with adverse personal health outcomes of elevated risk of cardiovascular disease, stroke, cancer and poor self-reported general health. Most of my study's participants stated that they often worked weeks that exceeded 50 hours. Many far exceeded eight hours in their typical workdays.

The U.S. Department of Labor informed us about "meal periods":

> Bona fide meal periods do not include coffee breaks or time for snacks. These are rest periods. The employee must be completely relieved from duty for the purposes of eating regular meals. Ordinarily 30 minutes or more is long enough for a bona fide meal period. A shorter period may be long enough under special conditions. The employee is not relieved if he is required to perform any duties, whether active or inactive, while eating. (Meal Periods)

While the PCP is not "required" to perform any duties while they are eating, many participants felt "required" by their belief that "the patient comes first" to literally place the patients' needs before their own. Thus, they were not able to relieve themselves of any (work) duties during their "meal period" so that they could have a reasonable period within which to replenish themselves. While one can see that meal periods for physicians might necessarily come in a variety of forms, consistent denial of a meal period while PCPs are working many hours a day appears worthy of their reconsideration.

One quote from a participant that described choosing yogurt as their necessary lunch of choice was particularly unsettling to me. The PCP felt that yogurt was specifically appropriate for their lunch because it enabled the PCP to multitask several chores at once. They could make patient callbacks while they fed themself and reviewed information on their desk or computer. They did not feel they could take time out to do this in a less hidden or rapid manner as this was not adhering to "the patient comes first" goal or to the aim of maximizing the number of patients seen in a day.

Consider the words attributed to Greek physician Claudius Galenus (200), who warned us, "That physician will hardly be thought very careful of the health of others

who neglects his own". Replenishment for workers during their workday is a given, even a mandate, in many present-day workplaces in the United States. Why do some PCPs continue to feel that they are exempt from this human requirement? This appears a topic not addressed in the literature but worthy of further exploration. I believe it to be a symbol of the unhealthy attitudes held by some PCPs and those who employ them that serve to work to the detriment of both. It is worth considering the wisdom of the guardians of our health whose experiences warn against continuing to ignore the same advice they often give to their patients.

Inadequate Opportunities for Peer Interaction. We recall that the participants were fed by the essential elements, which are composed of long-term personal relationships, personal growth through interactions, having an impact on others, and a sense of self-respect. We can acknowledge that some aspects of the elements often came not just from patients but also from peers. Yet, if it is no longer possible to connect with peers due to current realities such as lack of break time and/or lack of a common space within which to interact, this replenishment does not happen. The PCP can be increasingly forced into living by the lyrics of songwriter Paul Simon (1965): "I am a rock, I am an island . . . I touch no one and no one touches me." This position of extreme detachment is not a position society wants these providers of care to be in. Yet somehow most of my study's participants felt that they were put into steadily increasing positions of unwanted isolation in their last few decades of practice. And one can reasonably predict that this will only be exacerbated by the recent increase throughout the workforce of working remotely.

In addition to the lack of a pause for sustenance as described above, the reduction or elimination of time that PCPs spend in the hospital has caused many to feel they no longer have sufficient opportunities to interact with peers. Prior to PCPs' removal from inpatient care, they had frequent opportunities to connect in areas such as the doctors lounge, cafeteria, or elsewhere in the hospital. Removing PCPs from hospitals appears to have increased their sense of alienation from other physicians. They report a sense of being siloed or isolated from those who previously provided a sense of camaraderie and support (Frey, 2018). While participants acknowledged the many advantages that the relatively new use of hospitalists had provided for both patients and themselves, they repeatedly lamented the increasing lack of options available to them to connect with peers. They reported that this was detrimental both intellectually and socially. They also reported that because of current practice of mandating PCPs to serve a certain number of patients per time period, it became even more difficult to permit themselves time for the privilege of peer interactions. How does this impact physicians? Frey (2018) elaborated,

> A profession is a culture, a way of seeing and acting in the world in which we live. A profession is learned from teachers, colleagues, and examples, both bad and good. We also learn from unstructured conversations and learn trust through the kindness and understanding of others who share our struggles. [Not allowing this] . . . leads to a soulless efficiency and professional isolation that drains physicians of our ability to help ourselves, help each other, and help patients.

An Absence of Mentors. One tool that did serve to keep participants less isolated from those who could support them was the practice of being mentored. A few

participants felt fortunate enough to have been assigned a significant mentor early in their practice or to have successfully found a mentor for themselves. Most, however, had never had a mentor nor served as one. Yet the ancient words of Hippocrates caution current PCPs: "Foolish the doctor who despises the knowledge acquired by the ancients." Why not use this powerful (and free for the asking) tool that is available from others? Participants who had had strong mentors spoke of the sense of support and comfort those doctors provided for them as they accessed and then used the wisdom of those who had come before them.

Interestingly, those who had been well-mentored often made the decision to become mentors themselves, having understood the value that this practice had not only for the mentee but also for the mentor who had chosen to give of themself. Industry acknowledges that building community and teams of workers has many benefits (Kroll, 2014). Yet Kroll (2014) also stated, "Today, physicians practice in silos, hardly having time to talk to colleagues much less having lunch together or joining specialty societies." Why do individual physicians not seek out others that they can learn from? Why do they not realize the value they can impart to less experienced peers and to themselves from this practice?

Murthy (2020) recently declared that Americans are suffering from an "epidemic of loneliness" (p. 10). Awareness of the factors that promote this situation appears important to ponder, particularly among PCPs. Because of the importance of relationships to them, recognition of factors that impede these is needed. Consider the findings of the famous Harvard Study of Adult Development, one of the longest studies of adult life. Robert Waldinger, director of the study, stated:

> The surprising finding is that our relationships and how happy we are in our relationships has a powerful influence on our health. . . . Taking care of your body is important, but tending to your relationships is a form of self-care, too. Close relationships . . . protect people from life's discontents, help to delay mental and physical decline, and are better predictors of long and happy lives than social class, IQ, or even genes. (qtd. in Mineo, 2017)

Further, Waldinger advised, "Loneliness kills. It's as powerful as smoking or alcoholism. . . . When the study began, nobody cared about empathy or attachment. But the key to healthy aging is relationships, relationships, relationships" (qtd. in Mineo, 2017). Observing that this study's participants rated relationships as critically important to their personal well-being, one asks why it has become acceptable to significantly diminish those of the PCP.

The PCP is a human being who requires nourishment physically, mentally, and socially. So, why might they permit their increased isolation from peers and those who have served in medical positions before them? Depriving the PCPs of their knowledge and the experience these others can provide can result in detachment and disconnection that seems unnecessary and even harmful. The words of author Nora Ephron (1966) may be useful here, "Above all, be the heroine of your life, not the victim."

Low Use of Mental Health Services. If one were a patient in a depleted position, a PCP might recommend that the patient contact a mental health provider. Perhaps a depleted PCP would benefit from this same treatment. Dr. William Osler (1968), who was instrumental many years ago in developing our clinical medical education system, advised "A physician who treats himself has a fool for a patient."

This echoes an even older proverb that advises, “He who physics [treats] himself poisons a fool.” Some of my study’s participants did not appear to seriously consider this advice when it came to their mental health, essentially avoiding those services that may have been useful at various times during their practices.

The one participant who stated they were referred to mental health services by their organization responded with anger about and resentment of this, as they believed their problem stemmed not from themself but from the organization. That PCP felt that the organization was attempting to mask the real issues of the PCP’s discontent (organizational disrespect of the PCP) under the guise of the PCP having personal issues. One wonders if this is a common response, and if the response may not sometimes be valid.

Yet when one considers the struggles that many PCPS are currently dealing with, one cannot help but question why those who render care for a profession seem reluctant to seek the care of these other health care professionals. There was a general sense from participants that mental health services are appropriate for patients but not for themselves. We recall one participant’s words: “If I see my problems, and I know what my problems are, I think I can solve them. I don’t need somebody telling me what my problems are. . . . I mean, I just think it’s a sham” (Participant G). While this response was not reflective of all participants’ experiences, it was concerning. One may want to consider American novelist Flannery O’Connor’s (1988) words: “Doctors always think anybody doing something they aren’t a quack.” Participants attributed their lack of use of mental health services to several things: they felt that mental health care providers possessed no knowledge that the PCP did not have; that there would be a stigma, at times

career-altering, attached to seeing a mental health provider; and/or that the PCP lacked sufficient time to meet with a provider. Because the PCPs often believed that mental health care was not useful and/or readily available to them, the PCPs continued to suffer. Again, the PCP is a human being who requires nourishment physically, mentally, and socially. An acknowledgement that mental health care providers might possess useful knowledge may assist the PCP to better thrive. Untapped, this resource remains useless to them.

A Lack of Skills Necessary to Maintain a Healthy Work-Life Balance. Dr. Tait Shanafelt, chief wellness officer at Stanford Medicine and author of many studies about physician well-being, reminded us that the concept of "the patient comes first" has been deeply implanted in physicians via medical training and culture (qtd. in Shanafelt et al., 2019). This concept was also acknowledged in many of the comments from participants noted in Chapter 4. Some opined that their rigid practice of prioritizing patient care over their own worked to the detriment of their own well-being and relationships. This pattern of behavior, characterized by long working hours and neglect of personal life, was common among participants. To PCPs without a healthy work-life balance, the demands of practice resulted in a sense of being continually inundated by a firehose of demands and expectations.

This balance dilemma is not new to our time. Robert Louis Stevenson (1905) warned, "Perpetual devotion to what a man calls his business is only to be sustained by perpetual neglect of many other things." A few decades ago, American anthropologist Edward Hall (1973) described time, in the modern world, as feeling like an unstoppable conveyor belt, bringing new tasks as soon as we can dispatch the old ones.

In *Four Thousand Weeks: Time Management for Mortals*, Oliver Burkeman (2021) reflected on Hall's words and stressed that these new tasks require us to become ever more productive, resulting in the conveyor belt speeding up. This then forces us to let slip away the most meaningful parts of life (p. 9).

This sensation of the ephemerality of life's most significant elements was echoed in the words of many participants, whose personal lives seemed to have become increasingly diminished under the weight of their practice demands. Many voiced a wish that they had managed this better, but they also stated that they found improved management of their personal life beyond their abilities at the time they were practicing. With the skills they possessed, it felt impossible to simultaneously well-serve patients, themselves, and those they cared about. Participants showed some acceptance of this, but often not without an acknowledgement of the harm it had caused to both them and to their loved ones. Some felt a sense of resignation because they believed a high level of self-sacrifice was necessary to maintain the standard of care that they believed they were required to provide. Many had hoped to address this "one day," but that day forever lay beyond their horizons. For some, this resulted in feelings of regret and sadness.

It has been demonstrated that medical training and culture have been so successful at putting physician needs beneath those of the patient that physicians often have great difficulty honoring the importance of their personal lives (Melnick et al., 2023). Shanafelt et al. (2019) explained,

> The high level of occupational distress among clinicians and its impact . . . is well-defined. . . . [Yet] there is minimal evidence regarding effective

> interventions to drive progress. . . . [resulting in increased incidence of] . . . broken relationships, problematic alcohol and substance abuse, depression, abandonment of the profession, and suicide.

Because it sometimes seems that no one else is adequately "minding the store," PCPs might use the experiences of participants to evaluate the long-term consequences of their current work-life balance on themselves and on the relationships important to them. Author Matthew Kelly (2015), in *Getting Beyond the Work-Life Balance Myth to Personal and Professional Satisfaction*, advised that "Work-life balance . . . is not an entitlement or benefit. Your company cannot give it to you. You have to create it for yourself. You are personally responsible for living the best life you can" (p. 35).

Summary of Occupational Hazards

If PCPs continue to permit themselves to be deprived of components of the essential elements by remaining vulnerable to the above-noted occupational hazards, this bodes poorly for them. Many PCPs appear to have "drunk the Kool-Aid," believing that the needs of their patients or their organization must always precede their own. Many organizations appear to have increasingly embraced this also, understanding that this improves their efficacy and thus their profits, at least short-term.

As PCPs become more aware that the hazards discussed in this study are not due to weaknesses within themselves but instead are both common to their profession and a result of the environment in which they practice, PCPs can more readily acknowledge these hazards' existence within themselves. This may reduce the feelings of inadequacy and self-blame that many participants manifested. This may enable them to take a more active role in acquiring the essential elements, enhancing their self-care so that they

may better manage the dilemmas that modern-day practice confronts them with. We can hope that this will prevent more unnecessary damage to the PCP, those they serve, and those they hold dear.

External Depleters of the Essential Elements

Improving the lives of others, which is why physicians often choose to practice medicine, is becoming increasingly difficult for many to accomplish. Heavy workloads; administrative burdens; and the profit motives of insurance, pharmaceutical companies, and health care systems have proved “intractable barriers” to this goal for many (Guile & Sen, 2024). Participants identified the major factors they felt were outside of their control and had caused them significant stress. These included the increasingly rapid pace of change, the effects of malpractice claims, pay differences among physicians, and the impact of increasing corporatization of medical practices. Participants shared how these realities made them increasingly vulnerable to diminished personal well-being and professional satisfaction.

The Impact of Rapid Change

Over the last few decades, the field of medicine and those it served have benefited from many significant changes. This is particularly apparent in the areas of imaging, information access and retrieval (both patient specific and general), information communication (both with patients and with other providers), and testing (in addition to imaging) in such forms as blood tests for genetic mapping and antibody measurements. Treatments also have been positively affected, such as targeted radiation therapy, targeted chemotherapy, immunotherapy, and CRISPR. The study participants acknowledged and applauded the many positive impacts these have had.

As a society, we welcome many aspects of change, particularly those that might improve our health. In the words of John F. Kennedy (1963), "Change is the law of life. And those who look only to the past or the present are certain to miss the future." However, change does not occur without consequences, particularly for those currently practicing medicine. The rapid advancements in this field over the last few decades have confronted those physicians with "an exponential growth of medical knowledge, increased complexity of medical practice, and greater medical specialization" (Laiteerapong & Huang, 2015). These realities require PCPs to understand that they must nurture their ability to acknowledge and adapt to change in a timely manner if they are to thrive.

In my study, I used the change to the EHR as an example of the difficulties of adapting to rapid change. For most participants, the EHR seriously impacted their later years of practice. Many participants and those mandating the change neither adequately anticipated nor well understood the impact that this change would have on medical practices. Many participants felt it extremely difficult to be forced to learn and use the computer in the way the EHR demanded. They found that adapting to it was time consuming and frustrating. Many stated that their organizations had not given them sufficient instruction or time to absorb it while at the same time requiring them to maintain a normal pace of patient care. For many, adapting took months, in some cases even years, to adequately come up to speed on patient records. Some felt that even after that time period, the EHR continued to seriously detract from their goal of good patient care. This was especially troubling when they realized that use of the EHR lessened face-

to-face contact (or literally, the eye-to-eye contact) that participants deemed important in establishing strong personal connections with patients.

For future changes, the words of participants may be useful. They ask that serious exploration and consideration of the needs of users be undertaken. If retention of the people impacted by the change is not important, perhaps this is not necessary. But if retention is important, their voices should be considered more seriously. It appears that some of the suffering PCPs experienced during this change to the EHR could have been avoided had there been a better understanding and acknowledgement of PCPs' needs, skills, and values. More appropriate training would also have been of value, as would have well-designed ongoing assistance available for those struggling with the change. It also appears valuable to not undertake revisions to changes at a pace where practitioners are unable to maintain their normal output levels at the same time. Resentment and anger often come with change, but determining accurate reasons for these responses, and then addressing them, may alleviate some of the negativity change can produce. Given the damage that changes like the EHR can result in, an earlier and more appropriate effort to make the adaptation easier for those charged with this task may result in fewer negative consequences long term.

In addition to organizations better preparing for change, the PCP has a responsibility to acknowledge the need for themself to address and prepare for rapid change. This can be done in a variety of ways, but unfortunately these generally involve the PCP spending time away from actual patient care to absorb information and undergo training for the change. The words of the participants demonstrated that taking adequate

time away from their normal patient care schedule was necessary for them to be able to adapt to many changes and maintain the essential elements necessary for their well-being.

A PCP must acknowledge that the rate of change, particularly in the field of medicine, will likely accelerate. Interestingly, in 1930, Charles H. Mayo, medical practitioner and one of the founders of the Mayo Clinic, stated that: "Probably the most interesting period of medicine has been that of the last few decades. So rapid has been this advance, as new knowledge developed, that the truth of each year was necessarily modified by new evidence, making the truth an ever-changing factor." Now, almost 100 years later, this remains not only true but even more concerning. Today, significant developments such as telemedicine and artificial intelligence are waiting on the doorstep of every medical practice. These and other new developments will have profound impacts on those who practice primary care. Applying lessons learned from the transition to EHR may help PCPs to better prepare for the demands required of themselves. Ignoring these lessons as they navigate these uncharted waters may be at their peril.

Malpractice Claims

A very fortunate PCP might avoid being accused of malpractice over the course of their entire career. However, because all physicians are human and thus flawed, most will probably render less than standard care at some point during their years of practice. Gawande (2008) weighed in with these words, "Are doctors who make mistakes villains? No, because then we all are" (p. 106). A study participant echoed this sentiment after many years of practice by asking, "Couldn't I have done better? Yes, we all could have done better."

We agree that no PCP is exempt from making errors. It behooves them to understand that regardless of whether they are actually responsible for a medical error, nearly half will be sued if they practice for several decades (O'Reilly, 2018). Assuming that most PCPs are motivated to care for each patient as best as they can, one can see where the need to be perfect (or godlike) can take hold of PCPs. Over time, this can cause them to come to believe that they may be exempt from making mistakes or from the consequences of doing so. If they are fortunate, they will not be sued for the times when they could have rendered better care. If they are unfortunate, they will be sued. And, at other times when they believe they have rendered care that meets the standard, they may be sued anyway for a variety of other reasons. But judging from the words of participants, it can help them to more clearly understand this reality at the beginning of their practice to better prevent and/or deal with the suffering that normally confronts a PCP accused of malpractice.

Regardless of the veracity of the malpractice claim against a participant, the act of being accused came with significant consequences. Many participants described the suffering these caused both them and those important to them. I would describe these as often *derailing* the self-respect of the participant, defined by Merriam-Webster as "disrupting the process of." Participants described this kind of reaction as often lasting for months and or even years. Some experienced this even years after the case had been resolved. Given this, one cannot deny that aggrieved patients were not always the only victims in malpractice claims. Physicians have even been identified as "second victims" of claims because of the damage done to them as a result of being accused of wrongdoing (Gomez-Duran et al., 2018). Considering Mahatma Gandhi's words, "I cannot conceive

of a greater loss than the loss of one's self-respect" (qtd. in Smith, 1997), we can see the depth of suffering an accusation of malpractice might bring to one who requires the essential elements to thrive.

A review of the literature regarding physician responses to accusations of malpractice echoes the comments of participants in their experiences of grief and stress. While I cannot comment on whether a patient is justified in accusing their physician of malpractice, it is apparent that this accusation often significantly impacts the PCP, regardless of whether the PCP believes they are to blame. I believe that PCPs unnecessarily experienced some of this pain because they either believed that a malpractice claim could never happen to them or because they had little accurate understanding of the degree of impact a claim would have on them.

Most physicians are not familiar with our legal system. In most cases, they have not been educated well about the language and the process in a malpractice claim. Their identity is as a physician, not a defendant in a lawsuit. They cherish strong personal relationships, not adversarial ones. The latter are undesirable and detrimental to many. Improved preparation of PCPs appears to be necessary to help them better understand the prevalence of claims and to avoid the diminishment of their well-being that claims commonly cause. This does not lessen a PCP's responsibility to always render the standard of care to each patient, but instead introduces them to a different perspective they might use to continue to be a thriving but imperfect human being. It might include components such as statistics about the prevalence of claims,
reasons for filing claims, strategies to avoid being sued, defining the process of being sued, a description of the normal time frame involved, common emotional reactions to

claims, recognizing destructive/defensive reactions to claims, consequences of suppressing emotional reactions to claims, acknowledging the sense of exile a claim produces and the subsequent need for help to counter it, accessing legal assistance, reducing the sensation of being exiled via acquisition of appropriate support (peers, mentors, medical societies, support groups), and career impact.

Gawande (2007) affirmed that physicians must acknowledge both the reality of the current malpractice system and their role in it. They are not without the power to better manage their position when faced with a malpractice claim:

> I think we are faced in medicine with the reality that we have to be willing to talk about our failures and think hard about them, even despite the malpractice system. I mean, there are things that we can do to make that system better. Until we humans become gods, this is the reality we must deal with.

Generally, when a patient files a malpractice claim, the essential elements that sustained their doctor are seriously damaged because the relationship of trust that they had with the patient has been broken. The PCP no longer trusts the patient, and the patient no longer trusts the PCP. This trust-based relationship, once critical to the well-being of both, is fractured. In some cases, this can be remedied by a wise (and fortunate) PCP prior to a malpractice claim. However, if the PCP has sought legal advice, they are commonly instructed to refrain from acknowledging to the patient that they have made a mistake. As the participants demonstrated, a PCP allowing themself to become exiled from those relationships may find them replaced by the PCP's own suffering. A process of humiliation and shame begins for the PCP. The lawyers also then commonly ask the PCPs to refrain from discussing their case with anyone other than their legal team, further

isolating the PCP from those relationships that served to support them. To better combat this response of abandonment and despair, a PCP more educated about, and thus better prepared for, malpractice accusations may prove more resilient. They might better sustain themselves through these challenging events by believing that no human is without fault. And if they can treat themselves with the compassion that one hopes all doctors treat their suffering patients with, perhaps less harm will result for all.

Pay Difference

The extreme pay discrepancy between different kinds of physicians appeared baffling and, at times, troubling to participants. Currently, it seems that society more dearly values those who literally enter a patient's body in their attempts to heal it. Orthopedists, plastic surgeons, cardiologists, and urologists all occupy the top positions on the physician compensation ladder (Kane, 2023). Those who attempt to heal patients in a non-invasive fashion, especially PCPs, occupy the bottom rungs (Kane, 2023).

Interestingly, those within primary care who specialize in pediatrics are at the very bottom of even the PCP pay scale (Kane, 2023). This position of those treating our babies, children, and adolescents is particularly troubling. Why are the physicians who choose to care for the most vulnerable among us rewarded less than those who care for adults? Given that the adults of our society are the ones responsible for determining the compensation levels of physicians, this does not reflect well on the value they place on the health of those other than themselves, i.e., our children. We might consider the words of Nelson Mandela (1995) here: "There can be no keener

revelation of a society's soul than the way in which it treats its children." I will not address this aspect further, but it does appear worthy of further exploration.

Returning to the issue of why one type of medical practice is more highly compensated than the other, I ask why physicians who most often literally enter the patient body versus the patient mind are most highly rewarded financially. The results of these invasive acts are certainly more dramatic, more immediate, in terms of appearing to resolve suffering. But they also come with more risk than the exchanges of ideas and information that are conducted between patients and doctors to promote improved health. Are we paying more highly for the drama these invasive acts produce? Are we paying more because we value the speed with which these acts can heal us? Perhaps. But one also must consider the value of the healing and/or curing that occurs when a PCP enters the mind and body of a patient in a non-invasive manner. The skills that a PCP brings are not as apparent as those of surgical and procedure-oriented specialists. The fact that PCP reimbursement is much lower suggests that the PCP's skills are not as valuable to society. However, in my opinion, the skills that the participants possessed were extremely important to good patient care. These included the willingness and ability to listen, empathize, be compassionate, and communicate effectively. Together, these often combined to form wisdom, a much-valued asset in healing. Consider the words of Plato (380 B.C.E./2000), spoken long ago but still applicable today:

> As you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul; and this is the reason why the cure of many diseases is unknown to the physicians . . .

> because they are ignorant of the whole, which ought to be studied also; for the part can never be well unless the whole is well.

It was impossible for most participants to understand why their skills, which aim to cure by using both the soul and the body, are not as valuable to society as those that aim to do this by altering the body. For some, it was difficult to accept their position at the low end of the pay scale, which resulted from this skewed set of values. Their self-esteem suffered to varying degrees because of the low esteem in which their skills were held. It is difficult to believe that this did not have some impact on the care they rendered.

Medical students choosing their future area of practice normally consider what they will need to thrive. If they are the type of people that most highly value the essential elements, as the participants in this study were, they will need those elements to sustain themselves in practice long term. But if society deems primary care skills to be of relatively low value compared to those of other physician skills, our future doctors may understandably choose to avoid primary care. One hopes that our current compensation system will not force too many to do so solely because of its lower level of financial reimbursement. In *The Health of US Primary Care: 2024 Scorecard Report—No One Can See You Now*, we find that "The primary care workforce is not growing fast enough to meet population needs . . . and the number of trainees who enter and stay on the professional pathway to primary care is too low" (Jabbarpour et al., 2024). Granted, physicians require different levels of training based on what they will practice. Still, this does not appear to be an adequate explanation as to why a discrepancy this large continues to exist. I could find no answer to this quandary. Society's need for PCPs will most probably not decrease in the near future. Given this, it would be a disservice to our

future physicians and a loss to all of society if those most well suited to a non-invasive practice of medicine find they must go elsewhere to thrive. This calls for a reconsideration of how the pot of money available to compensate all physicians is best allocated. Perhaps the words of Shakespeare (1608/2004) might be considered useful here by our society that continues to require primary care: "So distribution should undo excess, and each man have enough."

The Corporatization of Primary Care

Corporatization of health care has increased dramatically over the last decade, leaving many unanswered questions regarding its impact on physician well-being, the quality of care delivered, and health care expenditures. Nolte et al. (2022) stated that the high number of opinion papers in the literature on this topic emphasizes the need for more empirical research. This dissertation does not attempt to opine on this important and controversial topic. Rather, it provides examples of its unintended consequences that impacted participants and diminished their ability to obtain the essential elements that they required to thrive.

The two areas resulting from corporatization that participants most frequently mentioned as having affected their practices were a mandated average patient visit length and a lack of control over staffing. While these certainly are not all-encompassing of the many changes corporatization has imposed on many PCPs, I use them to demonstrate how some seemingly insignificant changes, apparently designed to ultimately maximize profit, can have serious and harmful unforeseen consequences on those impacted by them and those they serve.

Mandated Average Patient Visit Length

Participants experienced the relatively recent change brought about by increasing corporatization of medical practices only at the end of their practice. However, all participants identified the mandate requiring an average length of time for patient visits as detrimental to both themselves and their patients.

Holding a PCP to a mandated average patient visit length may appear to those with a profit orientation as a logical practice. Certainly, if patients were uniform widgets, this would be a productive way of producing revenue. Participants, however, felt that they were dealing not with widgets, but with unique human beings as varied as one's fingerprints. One size did not fit all. When a participant did not have adequate input into determining a reasonable visit length and control over the scheduling of patient visits, they were deprived of the ability to practice in a way that met their and their patient's needs. An overseeing body had tossed aside their training, knowledge, and judgment in its pursuit of profit. The participant was prevented, in varying degrees, from developing and maintaining adequate relationships with patients, literally being prevented from doing what they knew was best for both. This eroded the essential elements that fed them, depriving them of what they needed to sustain themselves in their practices. Thus, both physician and patient suffered and, ultimately, it is not unreasonable to predict that in the long term, the corporate body overseeing this will suffer as well.

Lack of Control Over Staffing

Participants described the consequences of having an oversight body increasingly exercise control over the staffing of their practices. They stated that this was clearly done to increase revenue, but it unfortunately often resulted in a staff that no longer was able to

serve a particular set of patients well. Rather, a generic set of patients was assumed, again in hopes that one size would fit all and result in a reduced cost of staffing and, ultimately, increased revenue.

Participants described how having a staff insufficiently familiar with the physician and/or the patient was particularly disturbing. Consequences included less probability of a practice accurately responding to the patient's needs as well as significant increases in the amount of physician time and effort it took to accurately evaluate and treat a patient. These illuminate the increasing stress placed on the participants by their lack of control under corporatization.

It is not difficult to imagine a business where one's assistants continually rotate to make staffing "more efficient." In some circumstances, this is appropriate. But place this model onto primary care, where relationship is of the ultimate importance, and one can see that this may not fit. It is important to acknowledge the depth of harm that this maladaptation can impose on the patient. But in the context of this study, it is more important to acknowledge the harm that this can cause the PCP, trained to care for patients, not profits. In the corporate setting, these participants felt that they were often "going to a job" instead of answering their calling, which was to care for patients.

Summary of External Depleters

These depleters imposed on participants resulted in serious barriers to their provision of care. This did not come without consequences to the participants' well-being. Rapid change often resulted in their inability to provide the level of care that they could and should provide. For some, this produced deep feelings of frustration, shame, and anger. Trying to cope with this appeared a relentless and haunting stressor, as they

felt they were unable to effect change. With little preparation for or understanding of the legal system and its impacts, claims of malpractice also left participants feeling helpless to help themselves, residing in a limbo-like state of suffering. This could take many forms, but often involved a sense of betrayal, shame, anger, and isolation. Pay differences impacted participants to varying degrees. To some, it was puzzling but not of high importance. To others, it gnawed at their sense of self-respect and caused ongoing resentment. Acknowledging and addressing all of these depleters as significant is important if we want to maintain an appropriately sized cadre of PCPs.

At least as important, if not more so, than the depleters just noted is the issue of corporatization of medical care, increasing rapidly in its relevance at this time. Its long-term consequences are unknown, but attention to the words of physicians should be heeded now. A recent article entitled "Beyond Moral Injury—Can We Reclaim Agency, Belief, and Joy in Medicine?" reinforces the belief that physicians are suffering because of corporatization. Its author stated that physicians believe that "there is something sacred in the possibility of making other people's lives a little better" (Rosenbaum, 2024) But when this mission is

> corrupted by corporate ones . . . work thus becomes more transactional, increasing ennui, and many clinicians want to do even less of it . . . [the corporatization] makes it feel like a job, where, if everyone else is going to not do their best for this patient, it's probably easier for me to also just disassociate and not be so invested, because it's eating me up. And the system clearly doesn't want to help me, so I'm just going to clock out and go home. (Rosenbaum, 2024)

This same author applies the term ‘moral injury’ to physicians impacted by corporatization, “encapsulating the distress physicians feel when they can’t give patients needed care. . . . How, then, can we recognize the system’s failure without becoming its victim?” This is not an easy task for physicians to accomplish. In another article, entitled “The Moral Crisis of America’s Doctors,” Press (2023) agreed that medicine’s corporatization places physicians in moral binds and depletes their well-being:

> Doctors on the front lines of America’s profit-driven health care system were also susceptible to such wounds . . . as the demands of administrators, hospital executives and insurers forced them to stray from the ethical principles that were supposed to govern their profession. The pull of these forces left many doctors anguished and distraught, caught between the Hippocratic oath and “the realities of making a profit from people at their sickest and most vulnerable.”

Conclusion

Do we, as a society, wish to keep our PCPs in positions vulnerable to distress? Participants have informed us that they need the following components of the essential elements: development and maintenance of long-term personal relationships, achievement of personal growth through patient interactions, knowledge that they have had a positive impact on patients’ lives, and a maintained sense of self-respect from knowing that one has done well in serving one’s patients. We would be wise to listen to their voices should we want to remain well as a society. We need these providers of our primary care. The following poem, “When You Come Into My Room” (Schmidt, 2000) may help us to better understand why we need to support our PCPs:

> . . . . Sit at my “mourning bench” if you are my physician

Listen to me, talk truthfully to me

You need to know all this if you want to heal me

And bear my rage about my disease

That I will never be cured

That my daughter has Crohn's disease and is only 33 years old

That she too has had her first surgery and lives with many of my feelings

And I am angry and sad

And support my hope

That tomorrow there may be new medicines

That today you care deeply

That you will do your best

When you come into my hospital room, promise me presence

Promise me a healing partnership

Keep hope alive

It is all I have. (p. 293)

Given that the hope a PCP can give to patients is what many are seeking, it would be wise to remember that the PCP cannot endlessly bestow this unless they themselves are fed. And they have clearly stated that they are fed, first and foremost, by the essential elements. Without this, they cannot continue to reduce patient suffering without suffering themselves. We, as a society, cannot afford to continue to deprive them, in ways that

appear to be steadily increasing, of what they need. And they, as individual PCPs, should heed the words of those who have walked this path before them. These instruct them to explore, seek, and demand what is necessary to acquire and maintain the essential elements.

Chapter 6

CHALLENGE CARDS

The Need for New Tools

I used the collected wisdom of participants to produce challenge cards, a series of visual prompts for use by PCPs. Participants in this study spoke of the situations that caused them suffering during their years of practice. Many didn't appear to seek solutions because they had come to believe that they should be above this human dilemma, residing in an omnipotent position where a sense of vulnerability was not acceptable. When they did seek solutions, they often were familiar only with biomedical ones that came from their training. However, these did not always provide the relief they sought. While some had been exposed during training to other tools that are sometimes referred to as "soft skills," these were often considered "less-than" skills. These were regarded by some as tools to be utilized either at a "later date" (which often meant "never"), or by someone less able than they were.

For some PCPs, there appeared no end in sight to a diminishment of their professional satisfaction and personal well-being. This was often exacerbated by a troubling sense of shame or despair for feeling vulnerable. In hearing about their dilemmas, it appeared that the traditional textbook methods of educating these PCPs had proved inadequate. In seeking alternative methods, I turned to the relatively new approach of arts-based research (ABR), which integrates artistic methods—including visual arts—into medical training and practice. Why might art be a useful tool here? In Winner's (2018) *A Psychological Exploration: How Art Works*, she quoted anthropologist Claude Levi-Strauss, who placed art above science, describing the work of

the painter, poet, and composer, as well as the myths and symbols of primitive humans, as

> if not a superior form of knowledge, at any rate as the most fundamental form of knowledge, and the only one that we all have in common: knowledge in the scientific sense is merely the sharpened edge of this other knowledge. (p. 3)

Winner added the words of another philosopher, Alva Noe, defining the purpose of art:

> Art aims to disclose us to ourselves and expose us to what we did not know about ourselves. Because it has no practical function, it forces us to ask "what is this thing that I see in front of me"? If we ask this, we extend our minds and have experiences we would not otherwise have. (p.11)

Winner herself supported these statements, opining that "Art exposes us to ourselves, more like going to a psychiatrist; challenging us and forcing us to introspect (p. 12).

Because my primary learning style is visual, and because I have experience and education as both a professional artist and an administrator in diverse areas of health care, ABR, particularly utilizing the visual arts, was the optimal choice for my addressing physician vulnerability. A systemic review of visual arts-based training in undergraduate medical education (Alkhaifi et al., 2021) reveals that it holds "promise to enhance important competencies in medical education, particularly empathy." The need for non-traditional medical education tools such as ABR has been recognized by many medical education sites across the United States who have, over the last few years, established programs such as University of Virginia's School of Medicine "Clinician's Eye" and "Storying Illness" programs, Yale University's Program for Humanities in Medicine, the University of Michigan's Medical Arts Program, and Columbia University's Narrative

Medicine Program. While longitudinal studies about the effectiveness of ABR remain to be conducted, the need for enhanced humanistic, emotional, and ethical competencies, which is what ABR has demonstrated in the short term, appears to continue (Alkhaifi et al., 2021).

To date, much of ABR appears designed to improve care that physicians render to their patients. The challenge cards that I introduce here are designed instead to improve PCPs' care of themselves via lowering their levels of identified vulnerabilities. Certainly, this should result in improved care to patients long-term, but the emphasis here is on improving self-care of the PCP now via use of these challenge cards.

Challenge Cards?

Challenge cards are a set of simple black-and-white drawings developed from the wisdom of the PCPs I interviewed. Their purpose is, quoting from philosopher Schoepenauer's description of art, to serve as a device which "plucks the object of contemplation from the stream of the world course, and holds it isolated before it" (Winner, 2018, p.13). The cards aim to stimulate PCPs to more deeply explore and improve management of issues which have caused them harm. Each depicts a scenario described by participants as having made them vulnerable to decreased professional satisfaction or personal well-being. I believe these depictions allow PCPs to place themselves in the environments displayed on the cards and to explore how they felt at that time. There are no solutions suggested in these images, only tools to transport PCPs back to their own experiences to seek relief via improved understanding. The cards permit time for self-reflection, pondering, exploring, figuring out issues that made the PCP curious or puzzled. For a variety of reasons, every card will not speak to every PCP,

for they are designed to promote reactions to the major vulnerabilities individual PCPs may face. They are, as shown in Figures 1 through 12:

1. The Perfectionist (or, If I'm Not God, I'm No Good)
2. The Real (or, Really Inadequate) Me
3. A Lack of Adequate Sustenance (or, No Lunch Allowed)
4. Inadequate Opportunities for Peer Interaction (or, I Am a Rock, I Am an Island)
5. An Absence of Mentors (or, Who Is Caring for Me?)
6. A Lack of Utilization of Mental Health Services (or, Breaking News! PCPs Declared Immune to Poor Mental Health!)
7. A Lack of Skills Necessary to Maintain a Healthy Work-Life Balance (or, The Patient Comes First and I, and Those I Care About, Come Last)
8. An Increasingly Rapid Pace of Change (or, Do I Sink, or Do I Swim?)
9. Being Threatened with or Sued for Malpractice (or, My World Just Fell Apart)
10. The Pay Difference Between Primary Care Physicians and Specialists (or, Why Would Anyone Ever Choose Primary Care Over a Specialty?)
11. Mandated Patient Visit Length (or, Who Pulled the Rug Out From Under Me?)
12. Decreased Control Over Staffing (or, Who's Running This Show?)

Figure 1

The Perfectionist (or, If I'm Not God, I'm No Good)

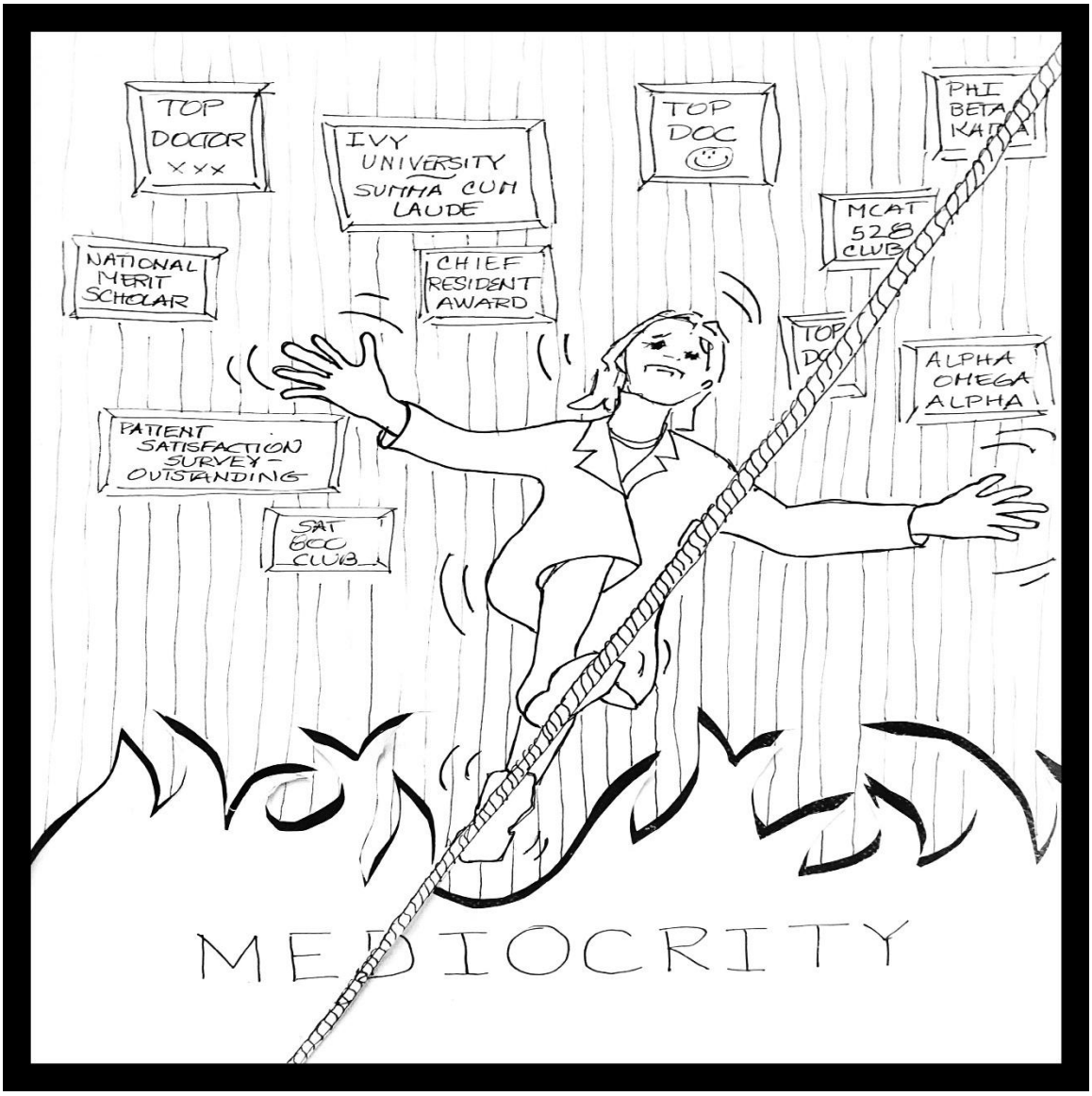

Figure 2

The Real (or, Really Inadequate) Me

Figure 3

A Lack of Adequate Sustenance (or, No Lunch Allowed)

Figure 4

Inadequate Opportunities for Peer Interaction (or, I Am a Rock, I Am an Island)

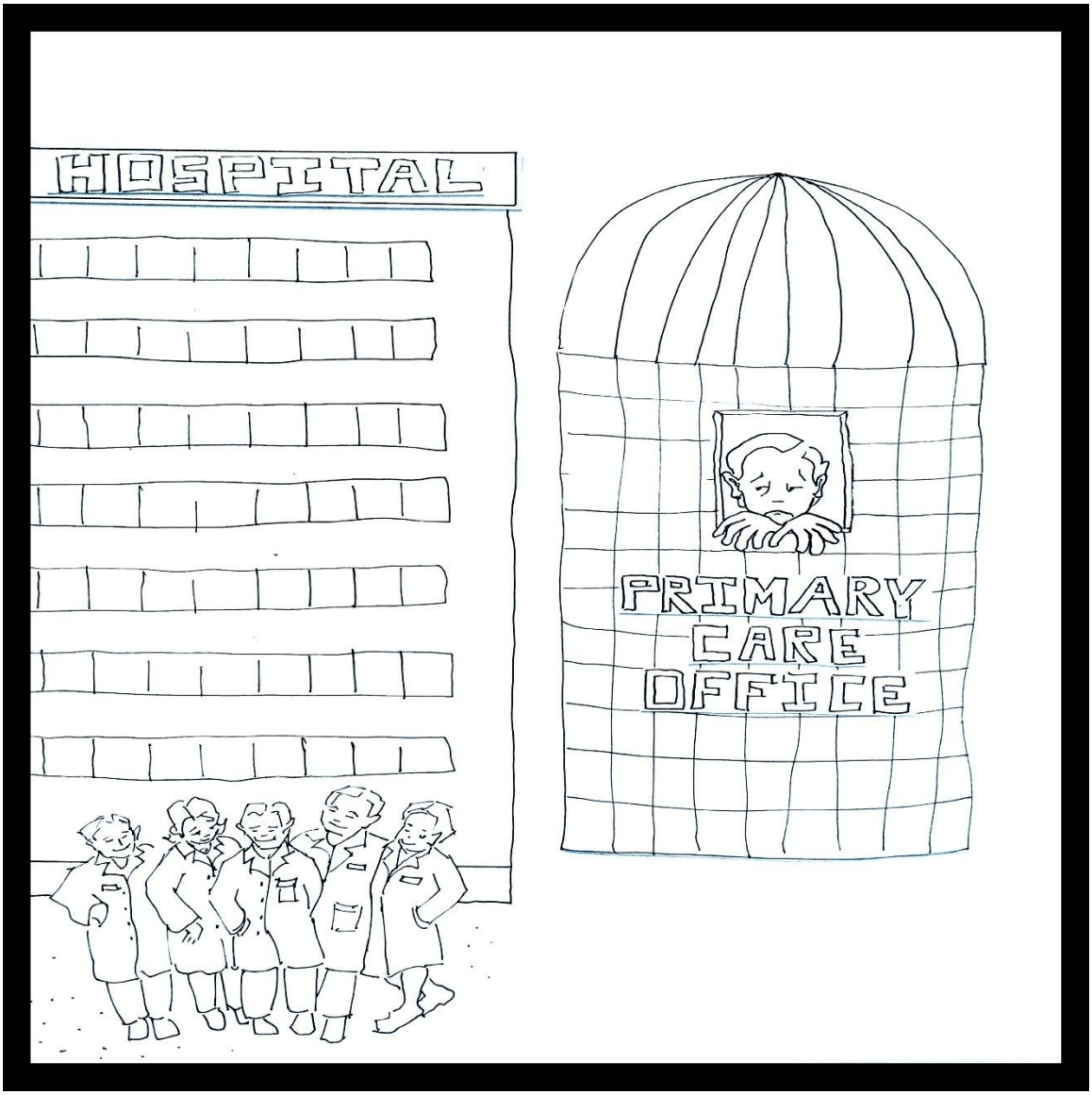

Figure 5

An Absence of Mentors (or, Who Is Caring for Me?)

Figure 6

A Lack of Utilization of Mental Health Services (or, Breaking News! PCPs Declared Immune to Poor Mental Health!)

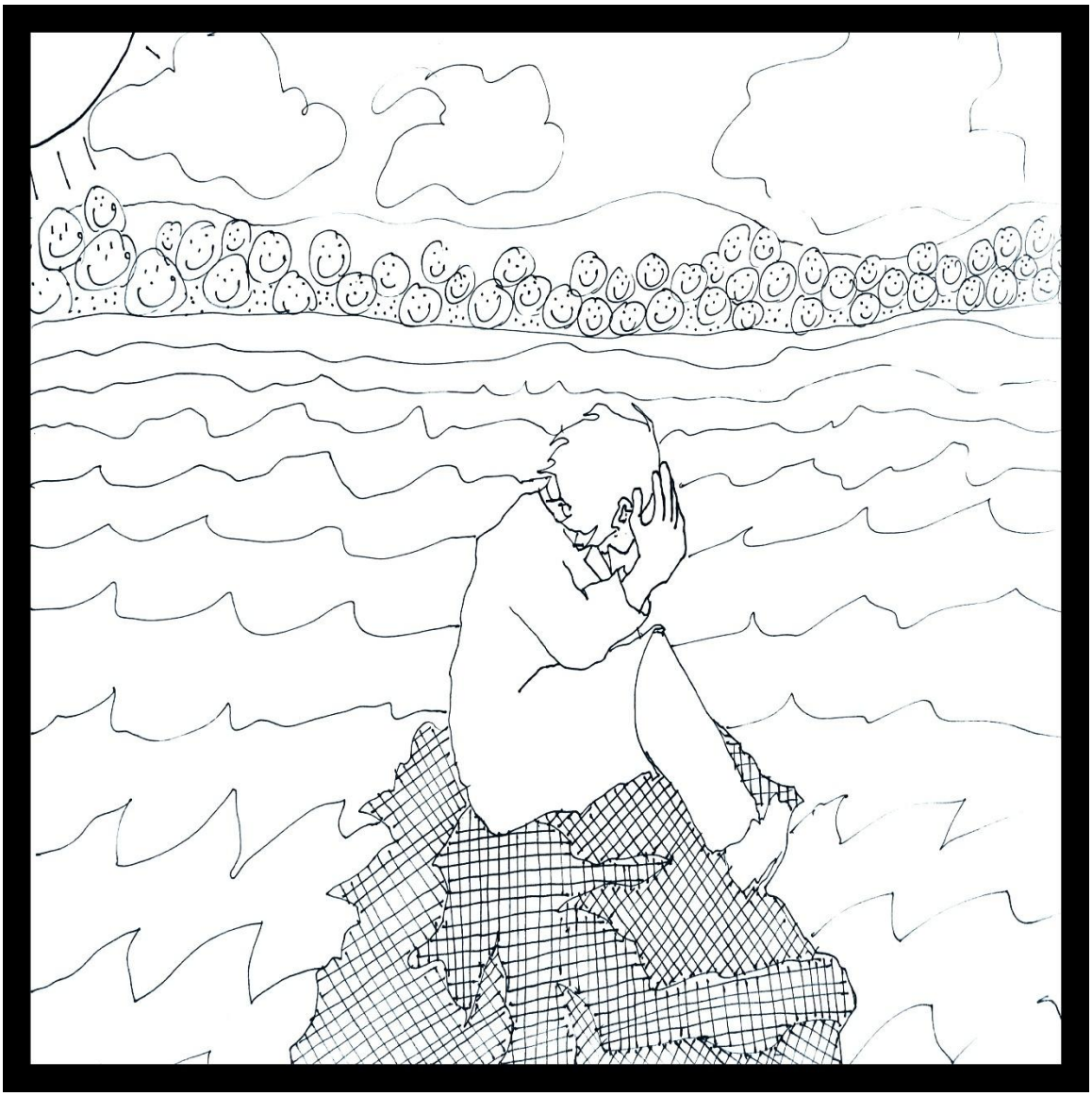

Figure 7

A Lack of Skills Necessary to Maintain a Healthy Work-Life Balance (or, the Patient Comes First and I, and Those I Care About, Come Last)

Figure 8

An Increasingly Rapid Pace of Change (or, Do I Sink, or Do I Swim?)

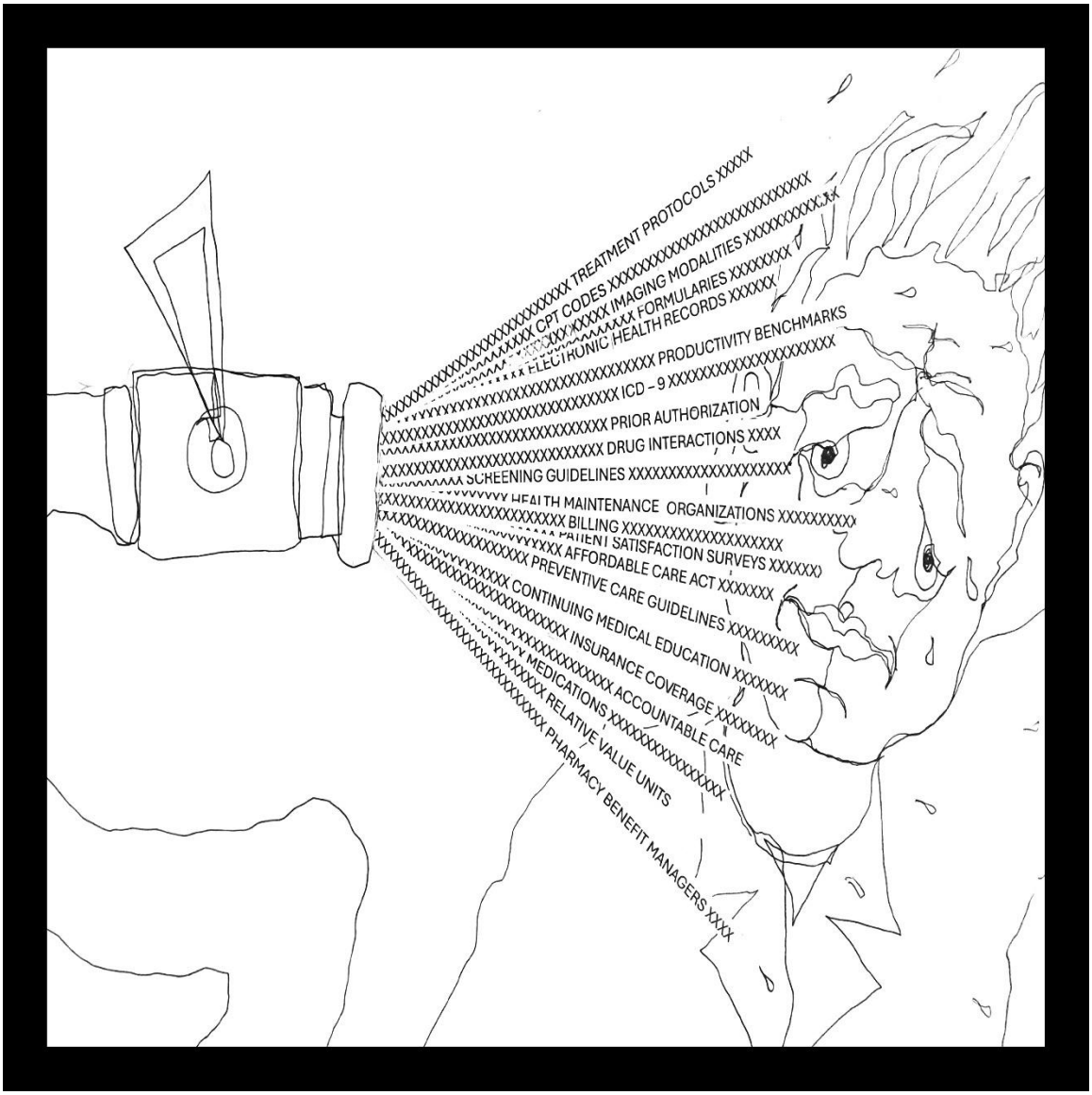

Figure 9

Being Threatened with or Sued for Malpractice (or, My World Just Fell Apart)

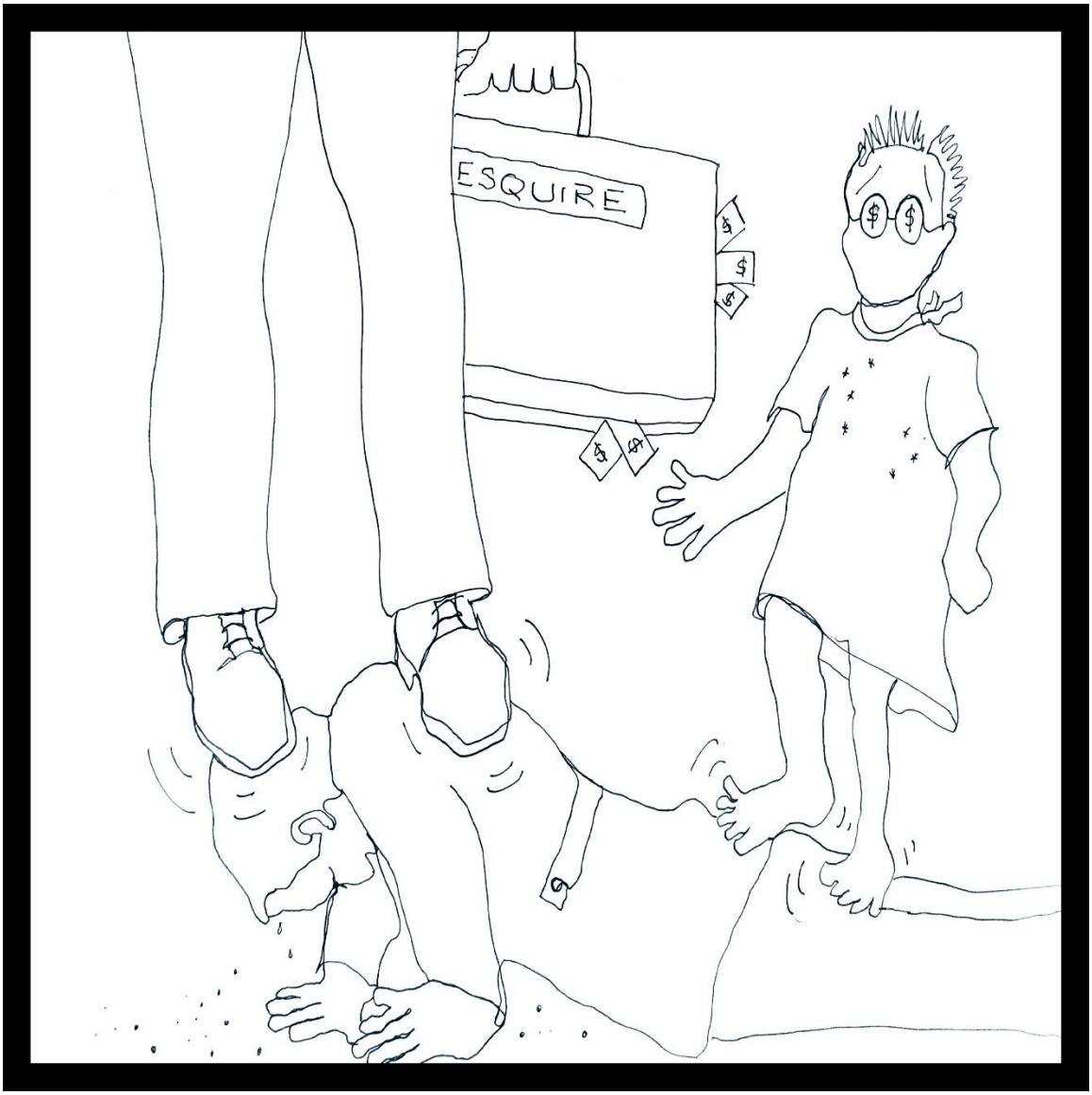

Figure 10

The Pay Difference Between Primary Care Physicians and Specialists (or, Why Would Anyone Ever Choose Primary Care Over a Specialty?)

Figure 11

Mandated Patient Visit Length (or, Who Pulled the Rug Out From Under Me?)

Figure 12

Decreased Control Over Staffing (or, Who's Running This Show?)

How to Use Challenge Cards

Ideally, cards should be used prior to the beginning of a PCP's practice to better prepare them for issues now known to exacerbate vulnerabilities. The cards may also prove useful at other points during their careers when PCPs find themselves struggling under the realities of their current-day practices.

The cards are designed to be used by an individual PCP or by a PCP with a facilitator. However, the.ideal scenario is to use the cards in a group of PCPs along with a facilitator to enable a wider sharing of lived experience. There are a variety of approaches to viewing these types of visual images, such as Harvard Graduate School of Education's Project Zero, which focuses on understanding learning in and through the arts. It has developed numerous tools, such as "Looking Ten Times Two" and "Creative Questions," designed to deepen the observations one makes when viewing visual images. Another approach is "The Ultimate Cheatsheet for Critical Thinking," designed by the Global Digital Citizen Foundation. This includes a series of questions designed to discover or discuss who, what, where, when, why, and how. In my opinion, however, the most appropriate tool for exploring these cards is Yenawine's (2014) Visual Thinking Strategy (VTS; p. 23). Because the ideal scenario for utilizing the challenge cards is in a group of PCPs along with a facilitator to enable a wider sharing, VTS makes for a good fit. VTS has been shown to be useful in medical education, specifically in improving clinical competency in better observing patients (Cerqueira et al., 2023). Its potential to develop better competency in physicians attempting to better understand themselves has not yet been assessed. Nonetheless, I believe VTS to be most appropriate for use here.

Yenawine's (2014) strategy begins with silent observation of an individual card, with no information about it shared. Participants "look deeply for an extended time and think . . . about what they saw . . . and become curious" (p. 23). Then the facilitator asks the following questions:

1. What is going on in this picture?
2. What do you see that makes you say that?

3. What **more** can you find? (ask this again, and again, and use the word "more," not "else")

Yenawine claimed that this is similar to "how a scientist studies climate and a historian pieces together the past" (p. 13). It bestows upon the PCP a "permission to wonder," using their eyes, memories, openness, time, and encouragement to engage in a "mind-stretching exploration." Then, like in scientific exploration, collaboration begins: conversing, bouncing ideas off each other, grounding opinions in evidence, considering options, and building on the knowledge and ideas of others in order to achieve more than any individual could alone (p. 35). As vehicles for self-exploration, for wandering and wondering, the cards produce expanded personal or group conversations, deepened understanding of the issue, and more possibilities for its management. The cards serve as bridges between participants, normalizing their experiences by revealing the commonality of their concerns, hopes, and fears. The increased verbalization and subsequent sharing of ideas and knowledge with others can achieve more than any PCP could do on their own. The facilitator links agreements and disagreements as early thoughts are probed, elaborated on, and reconsidered. The facilitator serves as the paraphraser of the participants' voices and refrains from adding comments or from correcting or directing participants. New details and shades of meaning are added, building on the observations and knowledge of others. There are many ways to "think about most phenomena, and there are usually multiple solutions to problems" (p. 31). Yenawine suggested that closure is not important here. The facilitator is not aiming to teach a particular thing here; rather, the facilitator is aiming to have some people gather information about themselves and from others to better address issues that are troubling

to them. Exploration is what is happening. And sometimes, explorations are made into an individual's or group's opinions, and the information this brings forth can even serve to change minds.

Conclusion

In summary, challenge cards strive to stretch the minds of both the user and the group, enabling new and more effective responses to the vulnerabilities that caused earlier PCPs to suffer. The cards aim to aid our incoming PCPs in achieving more satisfactory professional and personal lives. As noted earlier, the PCPs interviewed often felt that vulnerability in themselves was unacceptable. If a tool such as the challenge cards had been available to them, perhaps, they could have better acknowledged their own vulnerabilities by understanding that doctors are not immune. The vulnerabilities cannot be addressed unless they are acknowledged. The well-being of PCPs is important to their continuing ability to provide good care for all. If we continue to ignore PCP suffering, the well-being of both the PCP and the patient will continue to decline.

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APPENDIX A

Interview Questions

Name

Type of practice setting

Years in Practice

At what age did you retire? Why?

What was the most meaningful part of your practice?

What was the most meaningful patient experience that you can recount? What happened? Why did this feel rewarding to you?

What was most rewarding about your work? Can you give examples of situations where you experienced this?

What other aspects of your work gave you the most satisfaction? Examples, anecdotes?

What was the least satisfactory or most difficult part of your practice?

What was your most difficult type of patient and why? What happened in that situation?

Most difficult patient experience and why?

Did you ever "fire" patients? How?

What aspects of practice made it less satisfactory than you would have liked? Why?

What happened when you went from the top of the heap (college or medical school)

and then transitioned to a practice?

Did you feel you were in a satisfactory practice? What made it satisfactory?

Did you have a sense of working as a team? How? Was it a plus or minus?

How did you deal with significant changes forced on you such as the Electronic Medical Record?

How did/would you deal with the following:

- A poor outcome or mistake of your own or of a partner/colleague
- Witnessing other physicians or your partners render less than adequate care
- Lack of sense of common goals/community among partners
- Awareness of other physicians 'up-billing'
- Being sued

Give examples of these situations, including who, what, where, etc.)

Who, if anyone, did you go to for advice on these issues (colleague, spouse, etc.)?

What, if anything, did you find helped you at these times?

Did you ever utilize mental health/well-being services provided? Were they useful?

What could have made you more content at work?

Were you as effective of a physician as you had hoped for?

What were the barriers to getting your work done the way you wanted to?

Did you ever feel you suffered from burnout?

Are you familiar with impostor syndrome and its frequency among physicians?

Did you feel you suffered from impostor syndrome?

If so, how did it impact your work?

How was your relationship with your partners?

Were you part of a team? What parts of it were useful to you?

Were you a leader in your practice?

If not, did you have someone who served as the leader? Effective?

Are you concerned about the increase in physician suicides? Why do you think this is happening? What do you feel can be done about this?

What education in addition to that you received would have made you a better doctor?

Would more education about how to better thrive as a physician have been appealing to you?

What do you wish you had learned more about when you were beginning your practice?

Was time management at work an issue for you? Could/did you do anything about this?

How much did you spend on administrative tasks? Were they a problem for you?

Were you able to delegate work as much as you would have liked?

Did you use physician extenders or scribes in your work?

Was your work-life balance where you wanted it?

How many hours a week did you average at work (including “pajama time” at home)?

How much call did you take? Was this ever a problem for you?

Did being a doctor positively or negatively affect your relationship with your spouse or partner?

Would you have liked this to be different than it was?

If you had to decide whether to be a physician again or not, would you do it?

Why or why not?

In the same or a different specialty?

Does the pay difference between medical and surgical specialties seem reasonable to you? Do you believe this should be changed to be more equal?

Knowing what you know now about pay and/or time commitment, would you have been more satisfied by having chosen a different specialty?

Do you think medicine, as practiced today, is as satisfying to practice as when you began?

Would you encourage your child to become a doctor?

APPENDIX B

Consent Form for Participation in Study

1. SUMMARY AND KEY INFORMATION

You are invited to participate in a research study of twenty retired physicians. Your participation is voluntary. You were selected as a possible participant because you are a physician who has retired after many years of practice. The purpose of the study is to collect the wisdom of retired physicians in exit interviews to improve the professional satisfaction and personal well-being of incoming physicians. The study will last for twelve months. As part of the study, you will be asked a series of questions regarding your practice as a physician. This data will be collected and summarized to guide incoming physicians in addressing issues that they might face. The benefits of your participation are that you can contribute to the well-being of other physicians and ultimately to the well-being of patients' that physicians serve. The study is being conducted by Rosemarie Gelber, a doctoral student at Drew University in the Department of Medical and Health Humanities.

2. BACKGROUND

The purpose of this study is to employ exit interviews to gain information from physicians who have been practicing medicine for decades. This information will be used to provide specific knowledge that visually depicts themes and issues useful to incoming physicians by enabling them to increase their professional satisfaction and personal well-being.

3. DURATION

The length of time that you will be involved with the study, via an interview, is approximately one hour.

4. PROCEDURES

If you agree to be in this study, you will be asked to meet with researcher at a time and place of your convenience. You will be asked certain open-ended questions related to patient care and self-care. Your voice will be recorded. Not all questions must be answered, and you may end your participation at any time without consequence or penalty.

5. RISKS/BENEFITS

This study has the following risks:

While it is anticipated that the study has minimal risk because it is about your personal experiences, discussion of your past may cause a negative reaction or some emotional distress when recalling certain memories. Your further participation is completely voluntary; thus, you may stop the interview process at any time.

The benefits of participation are:

Improving the professional satisfaction and personal well-being of incoming physicians, and ultimately improving patient care because of this.

6. CONFIDENTIALITY

The records of this study will be kept private. In any sort of report that is published or presentation that is given, the researcher will not include any information that will make it possible to identify a participant. In addition, all source data will be coded, compiled without names, locked in a secure cabinet (no one else can have access but the principal researcher), and destroyed after the conclusion of the study. To the point of confidentiality, the details of the data will be summarized according to themes, therefore making it virtually impossible to identify individuals.

All participants will be anonymous when the information is published. Copies of the dissertation will be available to the participants at its completion if requested.

7. VOLUNTARY NATURE OF THE STUDY

Your decision to participate will not affect your current or future relations with the principal researcher, Drew University, any health care facility, any mutual association in the field of concentration for this study, or any employer. If you decide to participate in this study, you are free to withdraw from the study at any time without affecting those relationships and without penalty.

8. **COMPENSATION** Not applicable

9. CONTACTS AND QUESTIONS

The researcher conducting this study is Rosemarie Gelber. You may ask her any questions you have right now. If you have questions later, you may contact the researcher at [redacted] or [redacted].

If you have questions or concerns regarding this study and would like to speak with someone other than the researcher, you may contact the Chair of the Drew University Institutional Review Board or Dr. Visse, Director Medical and Health Humanities, [redacted].

10. STATEMENT OF CONSENT

Please verify the following:

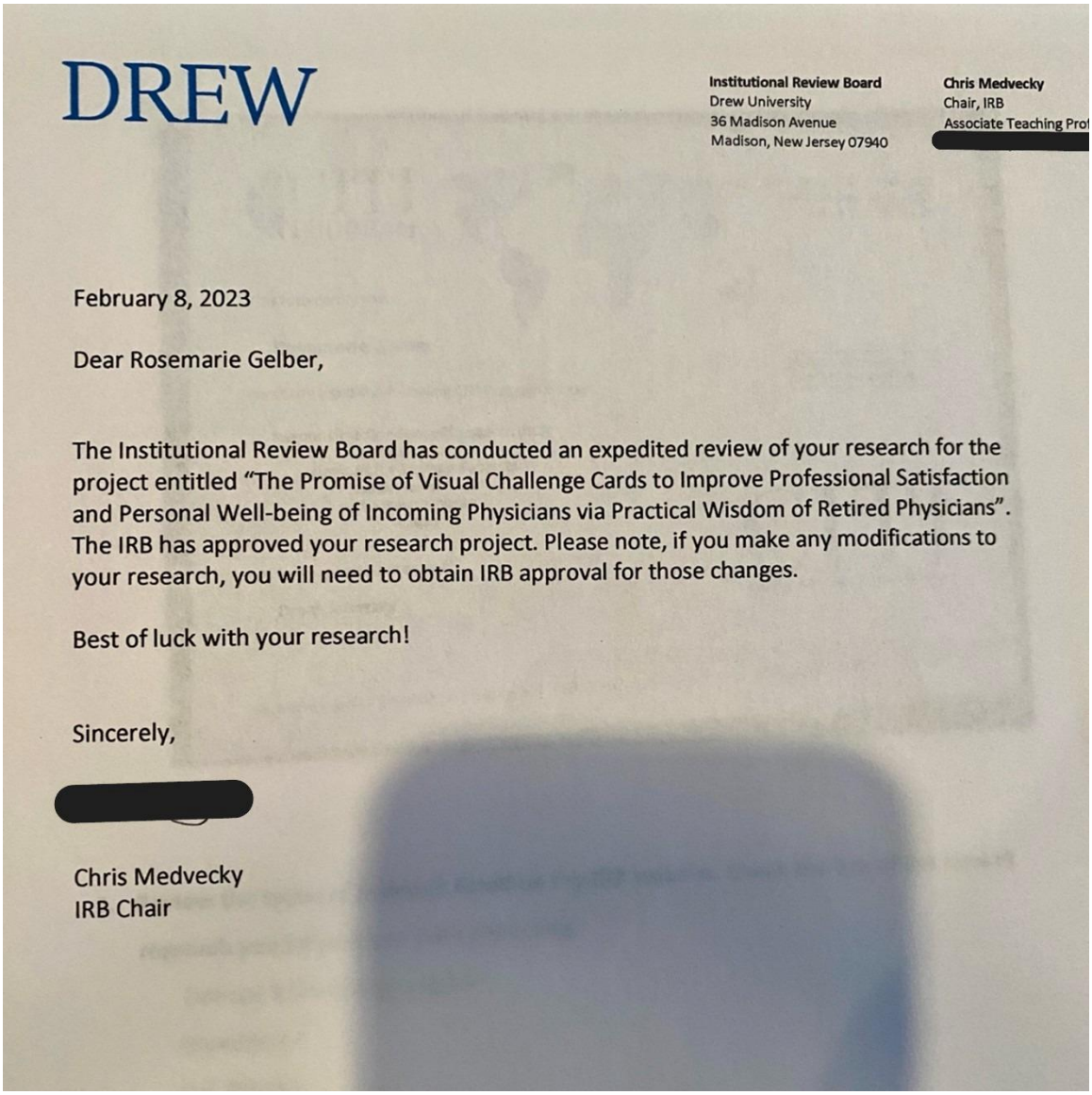
The procedures of this study have been explained to me and my questions have been addressed. I understand that my participation is voluntary and that I may withdraw at any time without penalty. If I have concerns about my experience in this study (e.g., that I was treated unfairly or felt unnecessarily threatened), I may contact the Chair of the Drew University Institutional Review Board regarding my concerns.

PARTICIPANT NAME: _____DATE: _____

PARTICIPANT SIGNATURE: _____

APPENDIX C

Institutional Review Board Approval



DREW

Institutional Review Board
Drew University
36 Madison Avenue
Madison, New Jersey 07940

Chris Medvecky
Chair, IRB
Associate Teaching Prof
[redacted]

February 8, 2023

Dear Rosemarie Gelber,

The Institutional Review Board has conducted an expedited review of your research for the project entitled "The Promise of Visual Challenge Cards to Improve Professional Satisfaction and Personal Well-being of Incoming Physicians via Practical Wisdom of Retired Physicians". The IRB has approved your research project. Please note, if you make any modifications to your research, you will need to obtain IRB approval for those changes.

Best of luck with your research!

Sincerely,

[redacted]

Chris Medvecky
IRB Chair

APPENDIX D

Human Participants Research Review Form

1. Project Title:

The Promise of Visual Challenge Cards to Improve Professional Satisfaction and Personal Well-Being of Incoming Physicians via Practical Wisdom of Retired Physicians

2. **Principal Investigator**:

Rosemarie Gelber

3. If student research, name of faculty advisor:

Dr. Meryl Visse and Dr. Liana Piehler

4. Name of anyone else involved in the study administration/data collection:

-

5. Email Address:

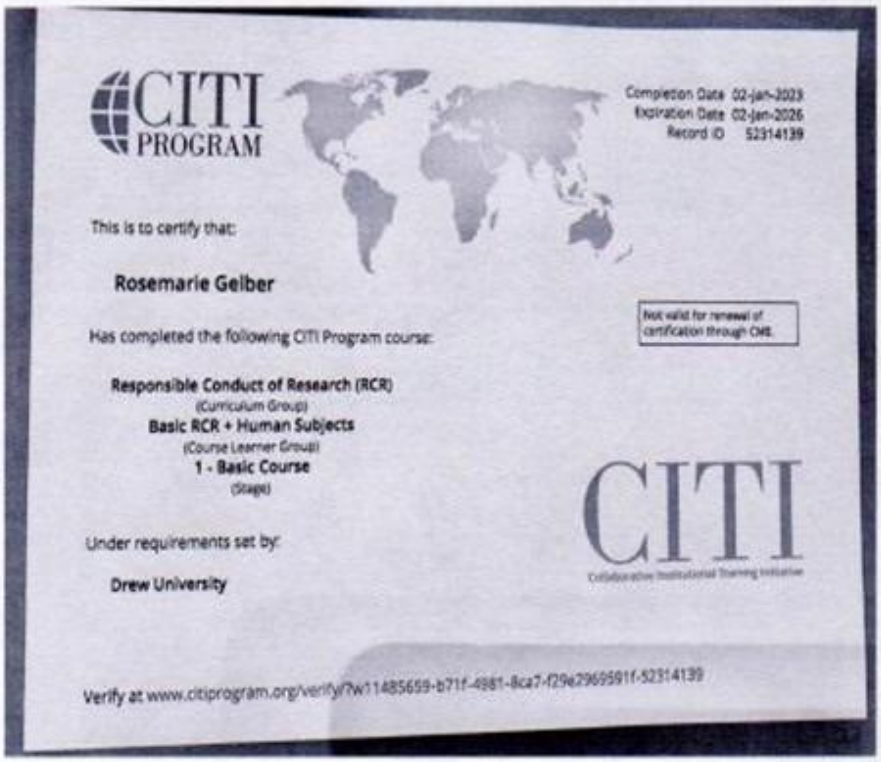
[redacted]

6. Duration of the Project (approximate starting date and completion date of data collection):

January 2023–December 2023

7. Describe how the requirement to obtain training in the responsible conduct of research involving human subjects was met:

Completed course entitled Basic RCR and Human Subjects - Basic Course on CitiProgram.org on January 2, 2023 (certificate attached).



CITI PROGRAM

Completion Date 02-Jan-2023
Expiration Date 02-Jan-2026
Record ID 52314139

This is to certify that:

Rosemarie Gelber

Not valid for renewal of certification through CME.

Has completed the following CITI Program course:

Responsible Conduct of Research (RCR)
(Curriculum Group)
Basic RCR + Human Subjects
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Drew University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w11485659-b71f-4981-8ca7-f29e2969591f-52314139

8. **Review the types of research listed on the IRB website. Check the box of the type of research you believe you are conducting.**

   Exempt from further review

   Expedited-X

   Full Review

9. **Electronic Signature(s):**

   Principal Investigator: [redacted] Date: 01/21/2023

   Faculty Supervisor: [redacted] Date: 21/1/23

10. **Provide a brief description of the purpose and goals of the proposed research, including what form the research is potentially to be published (e.g., thesis, dissertation, article, book.**

    The purpose is to better explore with incoming physicians with the potential causes of professional and personal dissatisfaction that they may encounter in their practice of medicine. Methods include reviewing literature on causes and management of physician

and business burnout, collecting narratives regarding this from retired physicians, and utilizing their narratives to create visual images (challenge cards) of emergent themes. The cards aim to foster deeper exploration and understanding of these themes, assisting physicians to identify and manage potential causes of dissatisfaction earlier and more effectively in their practices.

This shall be done in the form of a dissertation. Additionally, I would like to publish the cards to educate physicians before or as they begin their practices.

11. Participants:

A maximum of 15 retired physicians from the greater Newark, New Jersey area will be interviewed. Both male and female physicians will be recruited from a mix of specialties, primarily those who are gatekeepers to medical care (emergency room/family medicine/primary care/pediatrics/internal medicine physicians). None will be minors nor will they be recruited from other protected populations.

12. Method of Recruitment:

Participants will be recruited via personal contacts made via telephone calls, emails, or texts. Participants will not be compensated. The option to not participate will be explained in the initial contact with each person.

13. Consent:

Consent will be obtained, prior to the interview, via the ‘Consent Form for Participation in Study’ (Appendix B) prepared by the principal investigator.

14. Study’s procedures and activities participants will be asked to perform:

Participants will be asked a series of open-ended questions (Appendix A) during interviews of approximately one-hour in length.

15. Where will the research be conducted?

In the participant's home or other location of their choosing

16. Are any aspects of your research kept secret from participants?

No

17. Describe any potential benefits to participants and/or society?

Decreasing the level of incoming physician burnout by increasing their levels of professional satisfaction and personal well-being.

18. Consider the risks that your study may pose to participants, including physical, psychological, social, economic, or other types of risks or harms. Explain those risks even if minimal or routine to daily life.

It is anticipated that the study has minimal risks because it is about the physicians' personal experience. If participants experience triggers, contact numbers for immediate help if needed, will be provided.

19. If applicable, explain the procedures you will utilize to minimize the risks to participants that you identified in your answer to question 18.

If discussion of a physician's past experiences causes a negative reaction or emotional distress when recalling memories, the interview can be terminated by the interviewee at any time. This has been stated in the Consent Form for Participation in Study that the interviewee signed prior to the interview. Additionally, I feel familiar enough with the physician population to be sufficiently attentive to this occurring.

20. Discuss the procedures you will utilize to protect the anonymity or confidentiality of your participants and your data.

The records of this study will be kept in private. In any sort of report that is published or presentation that is given, the researcher will not include any information that will make it possible to identify a participant. In addition, all source data will be coded, compiled without names, locked in a secure cabinet (no one else can have access but the principal researcher), and destroyed after the conclusion of the study. To the point of confidentiality, the details of the data will be summarized according to themes, therefore making it virtually impossible to identify individuals. All individuals will be anonymous when the information is published and the visual Cards are created. Copies of the dissertation will be available to the participants at the completion of the dissertation if requested.

21. For the majority of research projects, participants should be provided with a debriefing

form that contains further information about the study and contact information for the principal investigator. Will you provide a debriefing form? If not, indicate why?

Yes, I will provide a debriefing form (Appendix E).

APPENDIX E

Debriefing Form

1. PURPOSE OF THE STUDY

The study in which you just participated was designed to collect the wisdom of retired physicians. It aims to improve the professional satisfaction and personal well-being of incoming physicians. It is well-known that dissatisfaction among physicians has increased significantly in the past few years. This has contributed to a variety of issues that threaten to decrease their well-being as well as that of all of us. Proposed solutions have yet to significantly reverse this trend. This study is an attempt to contribute to solutions that will assist in this goal.

2. METHODOLOGY

In this study you were asked to participate in an interview of approximately one hour.

From the information that you share, visual images will be created to depict different scenarios that contribute to burnout. These images are designed to be shared with incoming physicians to stimulate discussion about strategies used to successfully deal with these issues.

3. CONTACT INFORMATION

If you are interested in learning more about the research being conducted, or the results of the research of which you were a part, please do not hesitate to contact Rosemarie Gelber, principal investigator, at [redacted] or [redacted].

Thank you for your help and participation in this study. It is very appreciated.

APPENDIX F

Artistic Awards/Exhibits—Rosemarie Gelber

New Jersey Emerging Artist Series - Solo Exhibition 2022

Monmouth Museum, Lincroft, New Jersey

National Juried Competition and Exhibition 2020

Galex 54, Galeburg, Illinois

33rd Annual Women's Work Exhibition 2020

Woodstock, Illinois

Persistence II: A National All Women's Exhibition 2020

D'Art Center, Norfolk, Virginia

The Art of the Photo 2020 2020

Prairie Village Art Center, Prairie Village, Kansas

Best in Show 2006

American Society of Media Photographers N.J. Juried Exhibit

New Jersey Fine Arts Annual 2003

Morris Museum, Morristown, New Jersey

National Prize Show 2003

Cambridge Art Association, Cambridge, Massachusetts

H. Juergen Theick Memorial Award 2002

New Jersey Center for Visual Arts, Summit, New Jersey

Triamericas Exhibition 2002

Cork Gallery, Lincoln Center, New York, New York

VITA

Name: Rosemarie Taylor Gelber

Birthdate: October 14, 1950

Parents' names: Rosemarie W. Taylor and Dr. Wilber F. Taylor

Educational Institutions:

School	Degree	Place	Date
Secondary:			
Glen Ridge High School	High School Diploma	Glen Ridge, New Jersey	June 1968
Collegiate:			
Syracuse University	Bachelor of Arts Art History	Syracuse, New York	June 1972
Graduate:			
George Washington University	Master of Hospital Administration	Washington, D.C.	1978
Drew University	Doctor of Medical and Health Humanities	Madison, New Jersey	2025