Special Article

Physician self-awareness: the neglected insight

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Self-awareness is vital to a physician's development. Understanding the impact of our internal subjective world on our attitudes and values and on the fantasies we have of reality is important to us as doctors. Some of the means of acquiring this self-knowledge include accurately perceiving the reflection of one's self in patients, understanding one's learning style, studying and enjoying the humanities, expressing one's self creatively, maintaining a sense of humour and examining one's reaction to experiences. When confronted by a person who is ill the physician must take action that is constructive and affirmative and not compromised by behaviour that originates in unexamined personal issues.

Pour devenir de bons médecins connaissons-nous nous-mêmes afin de comprendre comment notre subjectivité colore nos jugements de valeur et notre perception de la réalité, et pour cela nous rendre clairement compte que nous cherchons notre propre reflet chez nos malades. Il faut savoir de quelle manière nous apprenons le mieux, cultiver avec goût les humanités, nous exprimer par la création, garder le sens de l'humour et analyser la manière dont nous réagissons dans une situation donnée. Devant son malade le médecin doit agir de façon positive et ne pas se laisser aller à des comportements dictés par ses conflits personnels non résolus.

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By walking I found out
Where I was going

By intensely hating, how to love.
By loving, whom and what to love.

By grieving, how to laugh from the belly.
Out of infirmity, I have built strength.

Out of untruth, truth.
From hypocrisy, I weaved directness.

Almost now I know who I am.
Almost I have the boldness to be that man.

Another step
And I shall be where I started from.

— Irving Layton[1]

Self-awareness is a critical prerequisite to becoming an effective healer; one's personal self is intimately connected with one's professional role as a healer. As Stein[2] wrote, "No sooner does one dissociate one's personal self from the clinical situation than one makes the patient likewise into an inanimate object." A person becomes a patient when, in that person's own perception of existence, he or she passes some point of tolerance for a symptom or a debility and seeks another person who has professed to help.[3] If that is how one becomes a patient, how might a person gain the self-knowledge to become that healer?

Not everyone can become a healer. Not all chosen can withstand the encounter with people in the extremes of their human predicament. It is a profound experience to confront, as a physician, the fears, trepidations and expectations of someone who is ill. The pain, dying, birthing, disfigurement and loneliness may at times be almost overwhelming. But I believe these emotionally charged issues

← For prescribing information see page 156

can be addressed with great sensitivity by the physician who has an accurate sense of self.

"Self" implies an intentionally active agent acting toward the world and acted upon by the environment in a continuous flow of reciprocal/dialectical moves that take place in the field of action.[4] The implication is that as doctors we are Janus-faced — both a whole and a part of a system, creatively responding to both the internal world of self and the outside world of ourselves and our patients.[5]

To be aware of self is to understand the impact of our internal subjective world on the attitudes, values, beliefs and fantasies we have of reality. This view of subjective reality may modify our behaviour, or the potential for that behaviour, toward another person. In a therapeutic relationship it is imperative that our behaviour be constructive, affirmative and honest. Anthropologists would add that this view of reality is influenced by what they call ethnocentrism — that is, the interpretation of the world through the cultural norms of society. Kleinman[6] talks of the "cultural self" and the need to acknowledge that part of us that is coloured by our cultural patterns of viewing. For instance, doctors form a distinct subculture with values such as control, precision, linear thinking, "monochronic" time (scheduled sequences) and a biologic basis to the concept of disease. These values are often at odds with those in the subculture of the patient. The physician who is aware of this cultural self is better prepared to obtain information on the meaning of symptoms, signs and behaviours[6] before acting in the learned medical manner.

Seeing through different lenses

One way to see the cultural self is to imagine looking through different lenses. Through the belief lens we see what is held to be true or factual; the attitude lens shows our preset readiness to respond in a characteristic or predictable manner; the meaning lens, an interpretive lens, measures the significance of a situation with reference to how one should respond; and the value lens acts as a gauge as to whether something is good or desirable.

A personal example illustrates the functioning of the meaning lens. In my early years in practice I was not successful in dealing with people with alcoholism. My conditioned belief was that alcoholism was not a disease and that self-control was a valued characteristic attainable by all. My role, at best, was to treat in hospital the diseases created by alcoholism (e.g., cirrhosis and delirium). My professional attitude was predictable; to me alcohol meant moderate social drinking at the right time and place and always under control. Drinking did not make one sick unless it was by choice. However, in practice I was confronted with the destruction of people by alcoholism. I responded inappropriately to the passive–aggressive personalities and to the seemingly endless noncompliance of the alcoholic patient. I was arrogant, paternalistic and intolerant. The passivity of these patients seemed to unhinge my fantasy about doctoring. I couldn't "fix" their alcoholism (it wasn't a disease anyway); I was helpless, and that made me uncomfortable and angry.

Self-awareness helps us decipher the source of our emotional response to a patient. One must acknowledge the response as developing at a personal and not a professional level. Once we have teased out that source it is then, as Keen[7] said, critical that the physician bracket, compensate for and silence the preconceived ideas and distorted emotions he or she brings to the doctor–patient relationship.

Anther example is illustrative of the meaning lens. Every time that Ralph came to my office I would become anxious and dig right into the physical manifestations of his rheumatoid arthritis. However, when he had gone I would always feel a lingering sense of incompleteness. Why? He was so like my father, who also has a major handicap. I brought the powerful feelings of my relationship with my father to the relationship between Ralph and myself. I didn't need to psychoanalyse myself and my familial roles to realize that my anxiety was interfering with my capacity to relate to Ralph. This was a typical situation of countertransference. At a later time Ralph and I were able to talk of this dilemma. The power of this disclosure became very evident as a strong sense of well-being developed in our relationship. I became a doctor to Ralph's problems, not just to his diseases.

To illustrate further, Bill, suffering from insulin-dependent diabetes mellitus and atherosclerosis, created difficulty for his physician, a family practice resident. Bill ate large numbers of chocolate bars, which resulted in weight gain and an increased blood glucose level; he refused to wear the brace for his left leg, disabled by a stroke; he rarely took his antihypertensive medications; and he was abusive to the nurses at the lodge where he lived. Bill's doctor was angry, came to dislike him and wanted to "fire him" from her practice. She somatized everything about him and offered only oblique, subversive comments to him about any substantive issues. She was, in fact, inhospitable, yet Bill kept coming back. Together she and I examined what was happening to her; we talked about aging men, loneliness, disability, impotence, loss of control and limitation. As we acknowledged the fears that surround such issues she began to experience her real compassion, and her attention focused on Bill as a person. We assume that Bill had sensed that she was capable of such compassion, which is why he kept coming back. As Nouwen[8] said, "Physician hospitality implies paying attention without intention"; it demands the creation of an "empty space" where the patient can find a certain solace.

These cases fit well with what Stein[2] eloquently wrote about the physician self: "One can truly

recognize a patient only if one is willing to recognize oneself in the patient." So, unless we permit ourselves to reclaim that part of ourselves — by reaching inward, without fearing loss of reality — the patient may not sense a connectedness in the relationship and may not risk the gesture of intimacy that is required for the relationship to become healing. The problem is that we doctors will not see in the patient what we cannot afford to see and what might threaten our defensive posture.

In his poem "Knots", Laing[9] illustrated that one can never truly know another's experience:

I feel you know what I am supposed to know
but you can't tell me what it is
because you don't know that I don't know what it is.

We know directly only what we feel. With time, the safety of a learning environment and meaningful reflection on our experiences with patients we can become increasingly attuned to the suffering of another person. We may then learn to trust intuition that at first seems irrational, illogical and dreamlike and consider that part of the patient that may be in us. We all harbour feelings, and it is the appropriate use of those feelings that makes the "wounded healer" operational.[10] For the young, developing physician the feelings of inadequacy and impotence and any threat to one's sense of wholeness and personal value may cause one to strive to fill the void with tests and objectivity.

Learning self-awareness

How, then, do we acquire the self-awareness needed to understand our emotions and behaviour? I will examine some of the methods I have found useful as a physician and a teacher of family practice residents.

The reflection of self in others

The reaction of another person is a measure of an individual's impact, as was highlighted in an encounter I had with a family practice resident. After a discussion between the resident and a simulated patient (a faculty member) the patient said that the resident had projected an air of indifference to his concerns. The patient perceived the doctor as distant, impassive and unreachable. As this feedback was discussed it became apparent that the resident had been unwilling or unable to ask for information that could be laden with uncertainty. After inquiries in the actual clinic office we learned that some of the resident's patients had indeed complained to staff that he was arrogant. The young doctor had not been aware of this perception. Over time, as this young physician began to look more closely at his patients and to be more receptive to unspoken messages, he gained self-awareness.

Understanding learning style

An understanding of one's learning style and abilities can be critical to an accurate view of self. It wasn't until age 38 that I understood that my learning was experiential and often was confirmed only after reflection. It was not concrete, observational or experimental. My inability to immediately understand something represented a need to reflect and evaluate, after which the knowledge was firmly retained.

The family practice resident referred to above had a learning style that caused some problems. He realized that his remote attitude affected his learning interactions. His style had been quiet and passive. He was always fearful of being exposed as lacking medical knowledge. Whereas his peers were willing to plead ignorance in clinical situations and thus received most of the faculty time, our resident, in the eyes of the faculty, was seen as knowledgeable even though he seemed aloof and reserved.

I had a painful experience early in my medical training. I struggled through first-year microbiology, staring down my microscope at Gram-stained rods and cocci long after my fellow students had left. Finally my professor, through exasperation, asked me to take Ishihara's test. I was found to have red-green colour blindness, which had affected my learning and my view of the world. That information has been invaluable to me.

Experiencing the humanities

Experiencing, studying and enjoying the creative world can aid self-awareness. The artist speaks of universal truths and values that are both common and unique to each person. Studying a painting, listening to a piece of music or reading a poem may reveal secrets about ourselves. We take a risk when we let go of our social and learned reflexes and confront unbounded, timeless emotions and thoughts that are unknown and may be uncontrollable. However, if we cannot experience emotion through art we will not be able to do it with people, particularly patients. A painting by Luke Fildes called "The Doctor" (1891) stirs the hidden tears and fears of attending a dying child. A teaching aid for residents, this painting is an effective vehicle for self-examination.

A further benefit accrues from studying the arts. Thomasina[10] commented that "with self-critical skills come personal development skills". Burnout is less likely if a professional realizes that there are personal dimensions of the mind and spirit that are unaddressed by his or her discipline. The humanities can provide an oasis of personal refreshment.

Creative expression

Self-awareness can also be acquired through creative, self-expressive acts, such as building fur-

niture, arranging flowers, painting, writing and cooking. The second part of this process, and maybe the most critical, is feedback. I studied photography briefly at the Banff School of Fine Arts with Paul Caponigro, a noted US photographer. We all had to show our work to the group and be critiqued by our teacher. When my work was displayed Paul commented to the group: "There are questions raised in every print of something beyond the subject. Over the mountains, behind the building, inside the child, there is always a presence." To me he said: "Take time when working, be patient with what is in you and what is out there, and focus on that 'thing beyond' the question you are asking, the mood you are experiencing." That feedback has been invaluable to my attentiveness to people with chronic pain and disability.

Humour

Humour is another route to self-awareness. The exercise of striving to maintain the serious, perfect self is in itself exhausting and may be destructive to the physician. Jim Unger, creator of the "Herman" cartoon, is a marvel at debunking the doctor. I cannot look at a plant in my office without seeing the cartoon depicting the serious-looking physician and a suffering patient seated before him. On the desk stands a potted plant, dead and denuded. The doctor says, "I always have trouble with living things."

Omniscience and omnipotence are difficult to balance with our limited expertise. Science has confused us by giving us miraculous cures. Yet we are constantly confronted with the fragile nature of these cures and the unscientific nature of humans. There is more to disease and illness than is seen in a microscope or laboratory. Each disease is so uniquely personal that every patient requires an individual approach. The uncertainty of an outcome is humbling. Hence, a humorous perspective may enable one to balance the power and the helplessness.

Experience

Experience is the critical avenue to self-awareness. Gerber,[11] in his sensitive book *Married to Their Careers*, talked with a couple in the medical profession about the death of their young son. They had been immobilized with grief over their tragedy. Over time they examined the denial of death, one of the unspoken preoccupations of modern society.[12] The experience of their son's death was something they had difficulty sharing; each partner seemed absolutely alone. Being both doctors and parents, they had denied the possibility of their own dying and death. Thus, in their practices they had difficulty empathizing with the experience of dying and death of others. With time and the opportunity for reflection the young doctors commented to Gerber, "We cannot live for someone and we cannot die for them. . . . We have to do those things ourselves."[13]

This was an agonizing, painful and tragic way to gain self-awareness. Though the denial of death is a cultural phenomenon, we as physicians must be capable of avoiding it and dealing with the emotions it may bring to our patients. Perhaps, as Needleman[14] suggested, the physician who has lived through the loneliness of another's death becomes the healer that society wants.

Doing the greatest good

The acquisition of self-awareness still leaves a question: Does it make a difference to the patient? As we understand more fully our own subjective world, does that understanding raise our communication with a patient to a higher level, one that attends to his or her unspoken needs? I believe that self-awareness builds compassion and a sense of hospitality, both of which are essential to human relationships. It does help patients. We are attending, witnessing, reaffirming and acknowledging a patient's essential value as a person. In fact, to say the word "patient" without knowing it carries with it a relationship demeans the practice of medicine.[15]

The freedom to feel and think is also the freedom to choose behaviour that best meets the demands of reality. Feelings and fantasies are not dangerous, but deeds may be.[16] It behoves physicians to acquire the broadest possible awareness of their own feelings, needs and conflicts and so bring to the healing act the greatest good.

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For prescribing information see page 167 →