

Self-Awareness among Doctors: The Importance of Reflecting on Medical Practice

Self-Awareness nos Médicos: A Importância da Reflexão na Prática Médica

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Resumo

A prática da Medicina actual está carregada de múltiplos factores geradores de stress no médico. Esta temática torna-se ainda mais evidente nos médicos internos, por inerência da sua condição, levando frequentemente a situações de *burnout*. Surge por isso o imperativo de realizar práticas de *self-awareness*, isto é, reflexão sobre em que medida as sensações, a vida emocional, pensamentos, crenças, atitudes e valores que o médico vivência influenciam a sua experiência de vida, incluindo a sua interacção com os doentes, famílias e outros profissionais. Neste artigo, os autores pretendem alertar para alguns dos factores que influenciam a atitude do médico com o doente no exercício da sua profissão e desenvolver estratégias de gestão dos mesmos, nomeadamente práticas reflexivas.

Palavras-chave: Autoavaliação; Conscientização; Educação Médica; Esgotamento Profissional; Relações Médico-Doente.

Introduction

"The problem is that the brain may be the most crowded and noisy place. It is not easy to get people away from the brain."¹

In current medical practice we are subjected to various pressures and demands which often generate stress and tension. This stress is felt differently by each individual, who experiences multiple emotions, more or less intensely, such as frustration, sadness, feelings of failure and impotence. This issue is even more relevant when it comes to medical residents because, in addition to existing pressures, there are other contributing factors: in particular a lack of experience and knowledge, a lack of training in communication and the demands and pressures to assist during residence.²⁻⁴ It is essential to recognize that doctors experience emotions with their clinical practice and instead of denying them we should know how to deal with them in order to improve our primary

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Abstract

The practice of Medicine today is weighed down by multiple factors that generate stress in the doctor. This issue becomes even more evident in resident physicians because of their particular circumstances, which often leads to burnout. It is, therefore, imperative to perform self-awareness exercises, that is, to reflect on the extent to which the experiences, emotional life, thoughts, beliefs, attitudes and values that the doctor experiences influence his or her life experience, including interaction with patients, families and other professionals. In this article, the authors wish to draw attention to some of the factors that influence the attitude of the physician towards the patient while exercising his or her profession and to develop reflexive practices to manage this.

Keywords: Awareness; Burnout, Professional; Education, Medical; Physician-Patient Relations; Self-Assessment.

mission – to take care of others.

There is clear evidence that doctors experience high levels of burnout that can compromise their clinical work⁵ and, in order to combat and prevent it, doctors and especially residents should develop their personal awareness and self-care ability through reflective practice. From a personal perspective and without preconceptions, it is our goal to draw attention to some of the factors that influence the attitude of the doctor towards the patient during the exercise of the profession. It is also our objective to develop reflective practices for dealing with these factors.

The concept

Real everyday situations such as caring for a patient with a chronic disease and on the verge of death, dealing with, often unrealistic, family expectations, or dealing with repeated emergency situations pose a challenge to the doctor and require courage and specific skills. Over time, these, in turn, require personal awareness and self-care strategies; otherwise the doctor may suffer a process of depersonalization or burnout.

Personal awareness, described by Novack at the end of the 1970s, is defined as a reflection on the extent to which sen-

sations, emotional life, thoughts, beliefs, attitudes and values influence our experience of life, including our interactions with patients, families and other professionals.⁶ This personal awareness can further be divided into three dimensions: self-awareness, awareness of others and awareness of the environment around us.⁷ Self-awareness refers to the sensations, emotions, beliefs and values that one holds. We should know how to spot when a patient or a particular situation causes us grief, conflict, doubt or affection. This recognition is fundamental in the process of building self-awareness because it is the starting point for the next phase – the questioning. At the same time, awareness of others (the patient) refers to the sensations, emotions, beliefs and values of others. We cannot dissociate our conduct from the principle of the therapeutic relationship we wish to strengthen, and so an understanding and a contextualization of the patient's experience, as represented by the acronym FIFE, is necessary⁸:

- F, "feelings" where fear and hope predominate. The physician should be aware of them, and explore them.
- I, "ideas". We should openly ask ourselves what the patient knows, how he/she represents what he/she is going through and what meaning he/she attributes to it.
- F, "function". It is important to understand what impact the disease/condition has on the patient's ability to function.
- E, "expectation". The doctor should assess and manage the expectations of the patient, the family, the caregivers, other physicians and, finally, his/her own expectations.
- Awareness of the environment refers to all those external factors that, implicitly or explicitly, influence the activity of doctors. It facilitates a better understanding of what is the end result of their care. Examples of these factors include: the availability of human and technological resources (ratio of professionals per patient, existence of the correct therapy, etc.), the critical and supportive attitudes of peers, and the standard demanded.

The problem

There is evidence that not developing personal awareness strategies affects the doctor or care of the patient,⁹ with repercussions in clinical practice and in the management of health services. In the first case, it can lead to a loss of clinical judgment, depersonalization, burnout, frustration, dehumanization (failure to see the patient as a human being), loss of sense of being appreciated in the profession and even depression. In the second and third cases, it can lead to unrealistic treatment goals, inappropriate use of technological and therapeutic resources, the breakdown or distancing of the doctor-patient¹⁰ and doctor-family relationship, culminating in poor patient care and increased inefficiency.

There is, therefore, a need to recognize the risk factors that influence the doctor's attitude while providing care to the patient. For example:

1. Doctor's Factors

- a. Identification factors: age, appearance, character; or similarity of the patient (or his/her condition) to the doctor's family member or friend

- b. Reflection on feelings/desires expressed by the patient or family
- c. Fear of error and uncertainty
- d. Confrontation with death and "mortality" (includes spiritual factors)

2. Patient's Factors

- a. Feelings of the patient and/or family (depression, sadness, anger, disagreement over the clinical decision)
- b. Patient is a health professional; recognized in society
- c. Patient with a dysfunctional family
- d. Uncertainty over the prognosis

3. External factors

- a. Economic
- b. Time restrictions
- c. Prolonged hospitalization (and consequent close doctor-patient relationship)
- d. Medical literature explosion in recent decades
- e. Conditions in Emergency Services

Central to the argument is the concept of "overload" or "over-stimulation" which, although it is not itself a risk factor, often triggers the process that influences negatively the care of the patient. "Overload" refers to the situation in which demands on the doctor (whether personal or professional) exceed his/her ability to respond to them. As a result, there is stress along with greater vulnerability to the risk factors described above. "Overload" is the result of pressures of time, responsibilities and excessive demands, lack of support and the doctor's own excessive expectations of him/herself and of others. It often triggers depression and the depressive symptoms that have an estimated prevalence of 28.8% in resident doctors.¹¹ National data report 21.6-47.8% prevalence.¹²

It is not always easy to recognize risk factors,¹³ and they are so familiar and frequent that they can easily go unnoticed. However, if they are not recognized, the process of personal awareness (the reflection on why these risk factors in some way influence the conduct of the doctor) does not take place, and warning signs and symptoms appear in the doctor-patient relationship. In this context, we often think "I'm tired of this patient" or "I cannot stand this family."

The rejection of the patient or family or feelings of anger towards them are just some examples of the warning signs and symptoms⁹:

1. Signs

- a. Rejection of the patient and family (and stress in their presence)
- b. Failure to communicate with other professionals about the patient
- c. Failure to treat the details of patient care seriously
- d. Requests for additional diagnostic means and excessive or futile therapies (defensive medicine)

2. Symptoms

- a. Anger with the patient and/or family
- b. Intrusive thoughts/judgements about the patient and/or family
- c. Feelings of guilt, failure, victimization, contempt, obligation to save the patient

d. Feelings that the patient's complaints may be manipulative attention-seeking actions.

There is, however, sparse literature on the strategies doctors use to identify extreme situations and risk factors that influence their practice negatively and, in the last analysis, strategies which give meaning to their practice to carry it out competently and continue to get enjoyment out of it.

The solution

We recently had the opportunity to ask Prof. Robert Twycross, a pioneer in palliative care in Great Britain, what strategies he used to deal with this burden. With the humility that defines the great, he was the first to recognize that he had experienced burnout several times in the 1980s. Being introspective and afraid to speak openly of this suffering, he took refuge in coping strategies like gardening or spending time with his family. There is no shame in recognizing this human weakness, but rather the courage in recognizing that it is necessary to take care of yourself in order to take care of others.

The practice of a reflective medicine is an essential step towards the resolution of conflicts, pressures and demands that the responsibility of being a doctor entails.¹³ It is common sense that the individual learns and becomes richer with experience. However, a doctor cannot develop personally and professionally, and generate consistent self-awareness without reflecting on his/her actions. This is something which is learned and practiced and should be encouraged throughout the period of medical residence.

Reflective cycle of Gibbs, first described in 1988,¹⁴ it is consensually considered a useful tool which makes it possible to assess the experience and learn through reflecting on it.¹⁵ In its original version it comprises six stages: description, feelings, evaluation, analysis, conclusions and action. From a mentoring perspective, this exercise should be taken into account by the tutors, and reflection should be encouraged and developed jointly with the resident.

- Phase 1. Description: The doctor should make a detailed summary of the experience. The intention is not to understand at this stage but merely to describe what has happened (when, where, how, with whom, what was the outcome)
- Phase 2. Feelings: the doctor should be encouraged to talk about how he/she felt and thought during the experience (which feelings preceded it, how he/she felt when it happened, what he/she thinks others thought, how he/she felt after, and how he/she looks back on the situation). From the point of view of supervised medicine, at this stage the tutor should avoid commenting on these emotions and adopt an empathetic attitude (empathetic listening) since many residents may find it difficult to talk honestly about feelings with someone who represents an example, for reasons of intellectual inferiority or personal detachment.
- Phase 3. Assessment: there should be a reflection on what went well and what went wrong, and why. At this stage it is important to identify the risk factors described above, as

well as "overload". In the case of supervised medicine, the tutor can encourage the resident to look objectively at what went wrong and examine the choices made.

- Phase 4. Analysis: After assessing the positive and negative points and why they happened, the next step is to analyze what could have been done differently. From the point of view of personal growth, it is important to compare previous similar situations and analyze what the reaction was at that time.
- Stage 5. Conclusion: After dissecting the whole situation, the doctor will be encouraged to draw conclusions from what happened – what has been learnt, what positive points emerge and, once identified, what are the plans to work on the negatives. Again, from the perspective of the residents, the tutor must be a link, for two reasons. First, the tutor has probably also been faced with the same situations in the past. Second, because the tutor knows the tools that can help the resident to improve.
- Stage 6. Action: This phase involves assuming a commitment to work the negative aspects, mapping out a plan and scheduling a date to review whether that objective has been achieved.

Nevertheless, there are other coping strategies that doctors use in order to handle difficult situations. Studies show¹⁶⁻¹⁸ that doctors and medical students develop mechanisms of personal development or adaptation in four main areas:

1. Self-awareness (personal-awareness)
2. Self-care
3. Sharing emotions and responsibilities
4. Developing a personal philosophy

From a holistic perspective, self-awareness involves the doctor's personal exploration of his/her weaknesses, emotions and limitations, not in a defeatist way view but as a starting point to develop capabilities. This personal reflection is difficult and requires detachment, often giving rise to shame that, in the long-term, leads to isolation, denial, frustration, rejection and depression. It is the job of the supervisor to recognize these signs in the resident. The perfect doctor does not exist even in so-called western medicine. There is always an idealization and worship of the almighty physician. There is a need to find an ideal balance between the ideal doctor and the level headed, sensible doctor aware of his/her limits but also interested in developing his/her skills. Some of the self-awareness strategies described come from reading "provocative" books, religious practice, extra-medical education, psychotherapy, metaphysical exploration (meditation, yoga), and analysis of emotions and automatic cognitions of the self.

Self-care corresponds to care of oneself, emotionally and physically, and it is a strategy which is often used by doctors. It allows one to balance the importance to give to the profession, family, friends or oneself and, consequently, allows the doctor to establish priorities. As the caregivers we are, doctors tend to find refuge in "giving to others" while neglecting to "give to ourselves"

However, studies^{17,19,20} have shown that those doctors whose personal lives weighed on their decisions felt that their li-

ves were balanced, often going against the expectations of their peers and their institutions. Some strategies used in this self-care area are:

- Shielding activities: Establishing limits for time devoted to work; having short breaks during the working day; dedicating some time exclusively to family
- Sleep time and regular meals
- Physically stimulating activities (exercise, sex, massage)
- Interests and friendships outside the field of medicine (sports, culture, music, religious activities, socializing and civil activities)

Sharing emotions and responsibilities is, unfortunately, something that most doctors neglect. Feelings of inferiority and failure and the inherent reluctance to ask for help means that they often do not share emotions. As a consequence, in most cases doctors act in isolation. There are other contributory factors such as feelings of omnipotence, responsibility and the power that society and they themselves have for centuries attributed to the role of medicine. The sharing of emotions and responsibility is nonetheless an important tool in the development of self-awareness. Environments which favour sharing are also conducive to personal growth. Examples of strategies include having multidisciplinary meetings, professional coaching, seeking out support from a senior member in the service and, in the case of residents, the creation of spaces for sharing opinions and fears.¹⁶

The development of a personal philosophy of life is also important for the personal and professional development of the doctor.²¹ At a time when medical knowledge is growing at the speed of light, the doctor enters a loop of routines where he/she easily forgets his/her purpose in life and why he/she has chosen this profession. Doctors often argue that during residency priority should be given to training at the expense of personal life in exchange for the achievements and rewards that will come in the future. This statement is utopian. Without the development of a personal philosophy that integrates professional and personal goals, the profession is in danger of becoming an escape, an addiction, a mechanism of feedback between knowledge-authority-investment with the consequent dehumanization of care. There is evidence that physicians who have used the process of developing a personal philosophy felt that the decisions they made were difficult, often breaking with the traditional expectations, but thanks to them they experienced a sense of the meaning of life which makes them more assured in their profession.²⁰

Conclusion

There is still a lot of taboo in the medical profession about how the situations we face affect us and our care. The importance of the way we approach emotions and personal development is also an issue which goes undiscussed. For centuries we have been taught to heal, be smart, not to fail, denying our own nature and how our emotions determine us. The pressures and demands of today's world can turn us into machines running on inputs and outputs, and where emotion is a sign of weakness, error is a sign of ignorance, and humanity a sign of impotence. Residents, by virtue of their status, are the

easy targets of this fallacy. We need to recognize that we are mortal and we are limited, that there are incurable diseases that patients die and not all can be cured. The practice of a reflective medicine is essential to ensure good results for the future, lest we fall into the deepest paradox of our profession: knowing how to take care of others while not knowing how to take care of ourselves.

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