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M Aase, J E Nordrehaug and K Malterud

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"If you cannot tolerate that risk, you should never become a physician": a qualitative study about existential experiences among physicians

M Aase,[1,2,3] J E Nordrehaug,[2,3] K Malterud[4]

[1] Department of Public Health and Primary Health Care, University of Bergen, Bergen, Norway; [2] Department of Heart Disease, Haukeland University Hospital, Bergen, Norway; [3] Institute of Medicine, University of Bergen, Norway; [4] Research Unit for General Practice, Unifob Health, Bergen, Norway

Correspondence to: Margrethe Aase, Department of Public Health and Primary Health Care, University of Bergen, PO Box 7804, N-5020 Bergen, Norway; margrethe.aase@isf.uib.no

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ABSTRACT

Background and objectives: Physicians are exposed to matters of existential character at work, but little is known about the personal impact of such issues.

Methods: To explore how physicians experience and cope with existential aspects of their clinical work and how such experiences affect their professional identities, a qualitative study using individual semistructured interviews has analysed accounts of their experiences related to coping with such challenges. Analysis was by systematic text condensation. The purposeful sample comprised 10 physicians (including three women), aged 33–66 years, residents or specialists in cardiology or cardiothoracic surgery, working in a university hospital with 24-hour emergency service and one general practitioner.

Results: Participants described a process by which they were able to develop a capacity for coping with the existential challenges at work. After episodes perceived as shocking or horrible earlier in their career, they at present said that they could deal with death and mostly keep it at a distance. Vulnerability was closely linked to professional responsibility and identity, perceived as a burden to be handled. These demands were balanced by an experience of meaning related to their job, connected to making a difference in their patients' lives. Belonging to a community of their fellows was a presupposition for coping with the loneliness and powerlessness related to their vulnerable professional position.

Conclusions: Physicians' vulnerability facing life and death has been underestimated. Belonging to caring communities may assist growth and coping on exposure to existential aspects of clinical work and developing a professional identity.

Although medical practice comprises existential, emotional and communicative issues in addition to the biomedical ones, Western medical training has not traditionally emphasised these aspects.[1–3] Facing human suffering and death, adjusting to the medical culture and developing a professional identity are stressful experiences for medical students.[4 5] Both physicians and students may have strong emotional reactions to patients' death. Grief-related job stress can lead to burn-out, which affects more than 50% of oncologists.[6] Coping models have been suggested,[7] and the importance of physicians' and medical students' emotional life and how it is affected by their education and job has been stressed.[8–10]

Still, little is known about how physicians cope with and communicate about other basic conditions of human existence that they are persistently exposed to. The authors shared a wish to direct attention towards existential aspects of medical education and clinical practice: MA as a recent graduate from medical school with her personal experiences as a medical student fresh in mind, JEN as an expert interventional cardiologist with a special awareness of interaction and professional identity, and KM as an experienced family physician with a lifelong dedication to dialogue. From these preconceptions, we set up a study to explore how physicians experience and cope with existential aspects of their work and how such experiences can affect their professional identities.

METHODS

We conducted a qualitative study based on semistructured, individual interviews.[11]

Participants

The first author (MA) interviewed 10 physicians (three of them women), aged 33–66 years. Two were interviewed twice for validity purposes. We strived for a purposeful sample, aiming for diversity in age, sex, place of education, religion and subspecialty. Physicians from almost every section of the department were recruited until saturation was reached. Participants were recruited among residents and specialists in cardiology, interventional cardiology or cardiothoracic surgery at a hospital department handling more than 6000 emergency admissions a year. These physicians are extensively exposed to mortality and acute, life-threatening diseases such as myocardial infarction, arrhythmias, dissecting aortic aneurysm and traumatic injury, some of them being on call for up to 72 h. In addition, one general practitioner was chosen to supplement and challenge the specialist sample.

Data collection

We used semistructured interviews (lasting 50 to 70 min) to collect data, from April 2006 until June 2007. The interview questions covered experiences at work of existential character, taking basic conditions of human existence as a starting point for every interview. "Basic conditions of human existence" are universal characteristics of human life, comprising fundamental phenomena we cannot avoid or escape as human beings. Concepts of this kind have also been applied in clinical practice.[12 13] We were inspired by the Norwegian philosopher Vetlesen,[14] who includes mortality, vulnerability, dependence, existential loneliness and relational fragility among the existential core

concepts. We found this cluster of phenomena to be clinically relevant as well as understandable for people with no formal philosophical education. Participants were asked open-ended questions such as: "Tell me about an experience with death that affected you" and "How do you cope with and communicate tough experiences of this kind?" The different existential core concepts were pursued very flexibly in the individual interviews, according to what appeared most adequate during conversation. All interviews were recorded on audio tape and transcribed by MA. Ethics approval was obtained from the Regional Committee for Medical Research Ethics (REK West). Except in one instance in which the interview was disturbed, none of the physicians reported negative experiences during or after the interview. Names were changed, and all participants received the manuscript before publication to ensure that confidentiality was properly taken care of.

Analysis

The analysis was performed in collaboration by the authors MA and KM, following systematic text condensation inspired by Giorgi.[15] Since KM is a general practitioner, the analysis was validated by someone outside the hospital environment. Analysis proceeded through the following stages: (i) reading all the material to obtain an overall impression, bracketing preconceptions; (ii) identifying units of meaning, representing different aspects of the physicians' experiences and coding for these; (iii) condensing and abstracting the meaning within each of the coded groups; and (iv) summarising the contents of each code group to generalised descriptions and concepts reflecting the most important experiences reported by the informants. Analysis was done stepwise, with new interviews supplementing the sample. We used an editing analysis style as described by Crabtree and Miller,[16] in which the categories were developed from the empirical data, rather than using a preconceived theoretical framework. Because we were inspired by Vetlesen,[14] our findings of course reflected different aspects of his basic conditions, but they were not organised in a theory-driven template analysis style.

RESULTS

Participants described a process in which they were able to develop a capacity for coping with the existential challenges at work. After episodes perceived as shocking or horrible earlier in their career, they at present said that they could deal with death and mostly keep it at a distance. Vulnerability was closely linked to the professional responsibility and identity, perceived as a burden to be handled. But these demands were balanced by an experience of meaning related to their job, connected to making a difference in their patients' lives. Belonging to a community of fellows was a presupposition for coping with the loneliness and powerlessness related to their vulnerable professional position.

Not very easy, but now I can live with death

The encounter with death was a central theme in this study. Old people's death was usually perceived as unproblematic and natural, as were conversations with old patients about death and risk. Deaths among children and youth, and sudden, dramatic or unexpected deaths, were experienced as "unacceptable", meaningless and difficult to keep at a distance. However, the participants reported that they had achieved a level of coping necessary to live with the exposure:

> It's not very easy; it's not that death is ok and simple to deal with—it's not like that. But you can live with it. (Oliver)

Some of the participants were convinced that being a physician influenced their view on their own death. It became particularly apparent when they identified themselves with their patients, in terms of age or family situation. All of them reported episodes of strong emotional reactions related to a patient's death or deadly diagnosis—to a greater extent if they were young and inexperienced:

> I just remember the feeling of someone. I can't remember who, can't remember the patient. I just remember that there were relatives there, just vaguely remember that I thought it was horrible and that they were there and that it hurt and was difficult—not practically, but that you just felt that you'd rather go somewhere to shed some tears instead of just staying calm, inform and leave. (Mike)

When asked what helped them coping with these situations, they mentioned conversations with colleagues, other members of the staff, their families or friends. Repressing their feelings, activities in their spare time such as hiking in the mountains and improving their own or the system's competence by memorising or upgrading guidelines, were other manners of coping. Follow-up after tough experiences was mostly lacking. Some of them emphasised personality traits that enabled them to deal with strong impressions; for example, one of the older cardiologists said, after having told of two dramatic episodes of death, a suicide included:

> I'm mentally strong by nature, I think. I don't lie awake at night and get nightmares from such experiences. Of course, it happens in certain situations that you wonder whether you did the right thing or not, but when something is definite, like this—after all, it was nothing I was responsible for or could be blamed for. It was a person I didn't know at all from before. So I cannot remember that it affected me at all during the time afterwards. However, it is a memory that sticks. (Keith)

Vulnerable responsibility

Experiences of vulnerability among the participants seemed to be closely linked to their professional responsibility and identity as clinicians. Being in charge of decisions and treatment was underlined as rewarding, but making a mistake that led to a patient's death was of course experienced as a tremendous burden and made them feel vulnerable. However, the participants said that they were aware of this being a part of the job, and that they had to cope with it. Some of them pointed to the responsibility of the system rather than just the individual:

> I'd been absolutely devastated if I'd been the one who "lost" that patient [a girl in her early twenties] … However, I've learned so much about medical mistakes, which to such a large extent are related to systems. You cannot walk around with that individualistic approach saying, "if it goes well, then it's my honour, and if it goes bad, it's my fault." That's not the way it is, because there's so incredibly much cooperation. And if you in your life as a physician do not dare taking the risk of making a mistake sometimes, including having a human life on your conscience, to put it straight, or a prolonged sickbed—if you cannot tolerate that risk, you should never become a physician. (Linda)

Being responsible for patients with complex, mental or deadly disorders, where the suffering is not easily dealt with or taken away, was a challenge that sometimes invaded the physicians'

lives also when they were off work. The general practitioner, who often was in charge of more or less unexplained disorders, said that she normally dealt quite well with her responsibility. However, from time to time the responsibility felt heavy:

> I usually sleep very well, but I must say this patient keeps me awake sometimes. I lie pondering a little before I fall asleep, or wake up early and discover that I've been thinking about him. It's difficult. I've talked to quite a few about him, and no one gives me good advice, because there's basically no solution or anything sensible one should or ought to have done. (Celine)

Other vulnerable situations mentioned were communication with patients' relatives after a sudden, unexpected death or when having made a mistake. Being tired and exhausted in the middle of the night, the feeling or demonstration of incompetence, and identifying themselves with the patients or their families could also evoke a feeling of vulnerability. According to one of the cardiothoracic surgeons, vulnerability was not primarily perceived on an existential level. By this he meant that he could feel vulnerable and inadequate as a physician, a professional, but it did not hit him fundamentally as a person:

> First of all you have to face that what you do is extremely dangerous. You can actually kill people if you do not do a proper job … Sometimes one gets scared, that's for sure. But that's on behalf of the patient. Sometimes you find yourself in a situation by the operating table where you really get palpitations and really get scared because you know that the patient is about to die and you better do something quickly. But that's on behalf of the patient; I've never felt existentially vulnerable. One feels vulnerable professionally speaking, and might feel inadequate, but not as a human being. (Dylan)

The meaningful difference

The physicians in our study found their work fundamentally meaningful and gratifying. Having the ability and power to improve patients' conditions and making a difference was underlined as essential. This outweighed the tough aspects of the job and made them bear up under strain. One of them described his ups and downs to be much interwoven with what he could perform:

> When it goes well and the patients are content, then it's amazing. You know you're one of very few who can do this. No one can cheat in this profession, as a heart surgeon … And when you're doing well and the patients are content and your colleagues are content, then it gives a great feeling of satisfaction. It's very rewarding, I think. But then you have to go down into the troughs that might be deeper than for many others. (Dylan)

Several participants described a state of powerlessness when confronted with challenges such as impossible demands, vague disorders or drug addiction. Cardiology and cardiothoracic surgery were emphasised as meaningful specialities where they to a large extent were able to fix the patients' problems, whereas lung diseases, family medicine and psychiatry were mentioned as more difficult areas in this respect:

> I regard it meaningful having the possibility to help people. If it's too much double-talk and mumbo-jumbo, and you don't make yourself useful, then it's not meaningful … One must do something good. Compared to working in general practice, I found it meaningful to govern and control things, keep some order, and structure the flow. It was more like logistics, actually, logistics of patients, looking after things to go well. But regarding the concrete physician work, it was very little that was doctor-meaningful. (Eric)

Most of the participants described themselves as perfectionists, and it really affected them when they made mistakes or were not able to do something. However, none of them regretted their choice of profession, and they basically reported coping with their tasks.

Fellowship of mutual understanding

Many of the interviewees reported a supporting community of fellows at work. An important feature of such a fellowship was the implicit mutual understanding assumed from colleagues and nurses, due to common experiences. This gave some of them a feeling of being part of a "destiny community", providing a diffuse kind of care and respect. When they needed someone to talk to, they usually turned to colleagues or other healthcare professionals, and occasionally to their spouses:

> The best thing is talking to people, those who are there knowing the patient and the entire situation. Sometimes I guess I talk to my wife about things like that … Sometimes one talks to a nurse on the ward, a nurse in the emergency room or the intensive care unit, or anaesthaesiologists. If I feel like talking to someone, I do. There are many whom you can go and talk to. (Sean)

Quite a few repudiated loneliness or exclusion as a problem in their job, even when making a mistake:

> On the whole there are people around you; that's the advantage. We very seldom stand all alone. Very seldom indeed. So there's always someone, nurses or other physicians, there are people around you, and most of them are reasonably humane. Nobody tramples on you when you're lying there. Then you get a little support. (Richard)

As a contrast, other participants described a medical culture of competition, pride and prestige, where you were supposed to be tough and perfect. They pointed at loneliness and lack of care, being taught to be strong and independent rather than being part of a team, as opposed to the nurses' culture. Relational fragility had been experienced in situations in which they were crucially dependent on superiors or other members of the staff and had been let down. They also described loneliness facing tough situations at night, in decision-making or in not being listened to in a team setting. Having experienced a child dying in her arms while she was running through the hospital corridors one night on call, where follow-up and support from colleagues were completely absent, one of them stated:

> I struggled with that for a long time. There was no culture at that time—and neither today, I think—of taking care of colleagues who are exposed to traumatic situations. I think it's just expected that we have enough inside to handle it … As a profession, we've got some kind of culture thinking that we are supermen, who are supposed to act accordingly and not have any problems coping with the harsh realities of life … I feel there's a lot of loneliness in our profession. (Fiona)

When asked if they missed any caring precautions at work, many of the physicians were satisfied with things as they were at present. They mentioned generosity and diversity as positive elements to be cultivated, as well as group sessions and a more extensive mentor arrangement for the interns and residents. A leadership taking account of the fact that physicians are not supermen and providing better working conditions was called for. However, some of them hinted that the simple "How are

you?'' or ''How did you experience that?'' from a colleague was what they wished for in hard times, be it a professional or private issue.

DISCUSSION AND CONCLUSIONS

Death and vulnerable responsibility are existential challenges that the physicians learnt to deal with in different ways, leaning on a community of fellows and on their own ability to make a positive difference in their patients' lives.

Transferability and validity

Our sample included physicians from one department at a university hospital. However, several of them also told stories from earlier periods of their career, working with lung diseases, anaesthesia or general practice, corresponding well with those from the general practitioner in our sample. Thus, our findings are drawn from a broader medical setting and may be applied in other contexts than a cardiology ward. The fact that all specialists recruited have a general education either in internal medicine or surgery, as well as general practice during internship, adds transferability to the material.

On the other hand, persons becoming cardiologists or cardiothoracic surgeons have chosen an extensive exposure to death and risky aspects of medicine, and other specialists might have a different approach and experience. The advantages of our sample are linked to the reflections and coping strategies they have been forced to make because of this high exposure, while at the same time illustrating a process familiar to almost every clinician. The interview with the general practitioner confirmed these assumptions, describing existential challenges similar to those of the other participants. However, the general practitioner, who faced vague social, grief-related or psychiatric problems to a greater extent than the hospital physicians, added other components to the vulnerable responsibility.

The participants seemed to describe their experiences in honest terms. Entering such a study presupposes a high sense of self-conveying and responsibility, making it meaningless to distort the truth on purpose. Furthermore, every one of them revealed vulnerable and less flattering sides of themselves and their careers, thus increasing the trustworthiness of their accounts. Finally, the interviewer's knowledge of the interviewees and their environment enhanced the communication, as has been shown in methodologically similar studies.[17–20]

Vulnerable responsibility

The findings in this study are consistent with previous research on physicians' experiences with death, revealing powerful stories and a call for supervision and educational sessions in this field.[21–23] Likewise, the quality of communication with patients, kin and team members is shown to be important when physicians assess the quality of the process of dying.[24] The transition from layperson to physician has been well described in anthropological literature,[1–3] and yet distinctive existential parameters attached to this development have not been thoroughly investigated. Our study adds to previous knowledge by describing some of these existential aspects, indicating that physicians' sense of vulnerability may be more linked to their responsibility and mistakes than to death itself. This was demonstrated through descriptions of death as an inseparable part of life and a physician's job, whereas being responsible for life and death was more complex and frightening. Fellowship and the ability to improve the patients' conditions may provide profound support and meaning for clinicians, whereas a lack of these increases the burden of loneliness and powerlessness inherent in their professional life. We approached the existential field supported by Vetlesen's theoretical perspectives,[14] including mortality, vulnerability, dependence, existential loneliness and relational fragility. This framework helped us achieve new insight, especially concerning the physicians' vulnerability.

When developing their professional identity, it seems important for medical personnel to obtain an appropriate balance between distance and closeness, as well as being able to act.[25] A study investigating how paramedics experience the cardiac arrest situation revealed a coping culture where an ''I can cope with anything'' way of acting was required.[20] Some of our participants gave similar accounts of the medical culture. Many of them described exhaustion and discomfort in the arena of vague or incurable illness and eventually chose to specialise in a field offering practical options for treatment and cure. In this setting, their responsibility and corresponding vulnerability seemed easier to handle. Our proposal is that an increased focus on and acceptance of physicians' vulnerability might improve development of a sustainable professional identity.

Although many of our participants initially reported that they were not used to thinking in these terms during their daily work, they reflected upon numerous episodes throughout the interviews. Our findings indicate that Western medical education may not be properly aimed at dealing with existential issues. Suggestions from our interviewees on how to take better care of physicians with extensive responsibility and life/death-exposure comprised a generous and diverse environment, good follow-up and debriefing, and time for what they regard as meaningful activities at work.

So what?

The importance of physicians' vulnerability facing life and death has been underestimated. Belonging to caring and considerate communities may provide a means of growth and coping when exposed to existential aspects of clinical work and developing a professional identity.

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