On the perpetual unhappiness of my fellow doctors

What we now call ‘burnout’ is nothing new in medicine, nor are many of the structural problems that cause it. But motivating doctors to treat patients with humanity is as urgent as ever

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Last summer, I received a phone message from the wife of a patient. The message was shocking yet not shocking at the same time. Her husband, who had been my patient since I finished my residency in family medicine in 1993, had been found dead at the age of 58 on the living room floor.

An autopsy had been arranged, as is done in all such cases of unexpected death, but not yet completed. The coroner had told her that it was likely that he had died quickly, if not painlessly, from a heart attack. She had called to thank me for being his doctor for almost 30 years, and for my efforts over those many years to help him deal with his lifelong depression, his many accumulating health problems and his many attempts to quit smoking cigarettes.

It was the last of these problems that frustrated him the most. He was in thrall to his addiction and he deeply – viscerally – resented it. Together over the years we used every gambit in the physician’s repertoire – motivational interviewing, the nicotine patch and gum, various medications and, unusually for me, scare tactics – but nothing had ever really worked for long. He was one of the many patients during my years of practice whom I have failed to help overcome their problems, despite my best efforts. An unhappiness descended upon me for days afterward as I ruminated on the many ways that I might have done better.

For as long as I have been a physician, I have listened to my colleagues complain about their unhappiness and I felt that same unhappiness myself (just ask my family) – unhappiness that may come as a surprise to our patients and the public. How could the members of a profession with so much power, status and affluence be so chronically unhappy?

These days we call the pervasive unhappiness of doctors “burnout.” Burnout, just like unhappiness, is much more than disgruntlement. Yet burnout falls short, in most cases, of depression, since most of us experiencing it continue to work as we always have, but

talk wistfully of early retirement or making a career change. Some few have done it, but many remain in practice and grumble on.

Over the past decade a growing body of research published in prestigious medical journals has documented in meticulous detail the association between physician burnout and the impact of electronic medical records in practice. EMRs have radically changed the nature of the work that doctors do, pulling us away from face-to-face care of our patients toward increasing clerical and administrative work. The evidence is overwhelming that the greatest impact has been on front-line primary care physicians such as family doctors and emergency room doctors.

In the "good old days" of paper charts, for every hour I spent seeing patients in the clinic, I spent about 15 minutes of administrative time (following up lab tests or making referrals). These days the ratio is about one to one, as the amount of information that flows from various sources into EMRs has grown exponentially.

To cope with the increased burden, I now see fewer patients when I am in clinic. Many of my younger, more energetic, colleagues try to maintain their usual numbers of visits per clinic, then spend their evenings and weekends logged into the EMR. They are miserable.

But a longer look back into the past reveals that the unhappiness of doctors seems ever-present in the medical literature.

A generation ago, not long after I started practising, Dr. Richard Smith, then editor of the British Medical Journal, was asking the same question in an editorial called "Why are doctors so unhappy?" In the opening lines he wrote a familiar refrain:

"Doctors are unhappy. They are not all unhappy all the time, but when doctors gather, their conversation turns to misery and talk of early retirement."

After exploring some of the obvious causes of the unhappiness of doctors working in the British National Health Service at the time – feeling terribly overworked, undersupported and underappreciated by the public and especially politicians (sound familiar?) – he concluded that the causes were deeper and due to what he called "the bogus contract" between doctors and their patients.

From the patient's point of view, there were five features of the bogus contract, according to Dr. Smith. The first was that modern medicine could do remarkable things and solve many patients' problems. The second was that doctors could see inside patients and know exactly what was wrong. The third was that doctors knew everything that was necessary to know. Fourth was that doctors could solve all a patient's problems, even their social problems. Fifth, and last, was that in exchange for doctors' remarkable powers, the public gave the profession high status and high incomes.

Doctors' views of the bogus contract were markedly at odds with patients' views. First, all doctors know that modern medicine has limited powers. Second, we know that

medicine can be dangerous for patients. Third, all doctors know that we can't begin to solve all problems, especially social ones (and with the collapse of economic safety nets with the rise of neo-liberalism in developed countries like Canada, more and more social problems end up in doctors' offices). Fourth, doctors know that we don't know everything, but we do know how difficult many things are – diagnosis, for example. Fifth, experienced doctors know that the line between doing good and doing harm in medicine is very fine. Sixth, and last, Dr. Smith argued, doctors were keeping quiet about all this so as not to disappoint our patients and risk losing our high status and high incomes.

The bogus contract persists to this day, and in some ways is worse, given advances in medicine and a continued rise in public expectations of what doctors can do to prevent illness, treat disease and forestall death. But is the bogus contract the cause of the deepest and chronic unhappiness amongst doctors? Perhaps, but I think there are even deeper root causes that lie within the kind of people we select to become doctors and the way that we train them.

Much of my career as a family physician has been marked, in my view, by failure – failure, in retrospect, that medical school and residency did not adequately prepare me for. Looking back as I near the end of a long and – to an outsider looking in – successful career, it has been failure that has been a continuing cause of my own professional unhappiness and it is my failures that I recall more vividly than my successes.

The changes wrought by the EMRs over the past decade and the impossibility of meeting the demands of the bogus contract add to the significant burden of failure already built into the work of doctors. Embedded in the administrative tasks created by EMRs is the impossibility of ever staying completely on top of them – a form of failure. Embedded in the bogus contract is also failure – and the knowledge that we can never meet the oversold powers of modern medicine or the often-unrealistic expectations of our patients. Could it be that perceived failures account for the longstanding discontents of the profession? Could it be that by better preparing physicians for the fact that failure is inherent in practice, especially for family physicians, whose birth-to-grave practices mean that inevitably all our patients will suffer and die – the ultimate "failure" – we could mitigate the unhappiness of doctors?

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In his remarkable book If You Should Fail, English writer and professor Joe Moran describes in vivid detail how the Chinese invented written examinations in the early 7th century under the Sui dynasty, to select the brightest young men to serve the emperor. By the mid-17th century, at the beginning of the last Imperial Qing dynasty, China had a vast system of written exams to select the brightest and the best. From the mid-16th century onward, European religious missionaries visited China and, in admiration of this land "ruled by scholar-gentlemen," brought back and established similar systems so that by the 19th century written exams were the norm all over Europe. In Britain, the 1854 Northcote-Trevelyan Report recommended exams based on the Chinese model for entry to the civil service. Shortly afterward, the first public examinations for English

schools took place. This model is now widespread in both public and private schools and universities around the world. And it is the system that is used to select entrants to professional schools such as law, engineering and medicine just about everywhere.

As a result, doctors are great at taking exams and rarely, if ever, fail them – we are like the Chinese civil servants described in Joe Moran's book. In contemporary terms, the modern medical graduate is like the examination graduate in imperial China – "one bright star amid tens of thousands of failures," to quote Prof. Moran.

Admission to medical school is ever more competitive and requires the sustained ability to perform nearly flawlessly on exams from an early age until ultimate acceptance. Not only must medical school admission candidates be great at taking exams, they must be exemplary and successful in many other ways, too. At least one of my medical school classmates was an Olympic athlete, another heading for a career in the National Hockey League before he was accepted into medical school. Many of my classmates had excelled in music, dance and theatre and performed at a high level in the annual medical school musical show. My own accomplishments, though objectively quite good, seemed (and were) meagre in comparison.

It should be no surprise that such people, who are used to success in the meritocratic sense across most areas of life, might struggle to deal with the many ways that doctors fail and the pervasive unhappiness that results.

What kind of "failures" do doctors experience? It is hard to know where to begin.

All doctors experience failure in their work, but perhaps none more so than family doctors like me. Our days are fraught with difficulty and there are so many ways in which we can and do fail.

The first and most obvious is by making errors, especially errors of diagnosis, the subject of a well-known TED talk by Dr. Brian Goldman.

The busy family medicine clinic is littered with diagnostic traps for the unwary. Family doctors work in a low prevalence environment for rare but serious diseases and often will attribute a patient's symptoms to conditions that we much more commonly see – for example: run-of-the-mill high blood pressure when the person really has a rare neuroendocrine tumour.

To make matters worse, our patients don't always present with their diseases in the classical ways that we are taught in medical school. A man with advanced prostate cancer can present with bleeding gums, for example, rather than the more obvious urinary symptoms, and many other such examples abound in the case-report literature. That's because the very earliest signs of illness aren't taught in medical schools and even in the 21st century aren't fully known.

These are the things that must be learned, sometimes painfully for both doctor and patient, through experience. But such delays in diagnosis and missed diagnoses often

result in public criticism by specialists and anger and resentment from patients and their families, adding to failure a sense of humiliation and fear of medicolegal reprisal.

Failure to help change those of a patient's behaviours that inevitably lead to ill health and premature death – smoking cigarettes, alcoholism and other substance misuse, lack of exercise and overeating – is commonplace and a great source of professional unhappiness.

Addictive or unhealthy behaviours have deep roots that may be beyond what a doctor can do to change them and the tools that we use to try and help people change, such as motivational interviewing skills based on a famous and influential psychological theory called "The Stages of Change," often feel like a knife at a gunfight.

One of the most painful forms of failure is the failure of connection or empathy with patients. Family doctors have a unique job with a unique challenge. When starting and building a practice we are expected to take on "all comers" and find ways to connect with people with diverse values, backgrounds and life experiences so that we can give them the best possible care. Failure to connect is so commonplace that a whole movement called Narrative Medicine has arisen in the past two decades to help doctors expand their empathic range.

After more than three years of adapting to caring for our patients during the pandemic, failing energy is widespread, if not universal.

Recently an older patient in my practice came in to ask me to assist him in organizing a non-medical program to help him to stop drinking. Over the past decade he has struggled, unsuccessfully, to quit drinking, which became a problem particularly after his beloved partner died unexpectedly. Five years ago, he developed acute liver failure from alcoholic cirrhosis. What was supposed to be a routine follow up visit turned into a medical emergency, given the bad state he was in. I had to call an ambulance to my office to take him to the hospital.

Over the years, specialist colleagues and I have tried to help assuage his profound grief, get him to quit drinking, and imagine a healthier and better future for him using all the tools at our disposal, but other than very brief periods of abstinence, so far, we have failed. After so long, sometimes it feels tempting to give up.

In 1984, Canadian writer Robertson Davies delivered a lecture at Johns Hopkins University School of Medicine. He titled his lecture "Can a doctor be a humanist?" and made the focus of it a discussion of that ancient medical symbol the Staff of Caduceus, with its two warring snakes wrapped around it. One snake represents knowledge, science, or, in more contemporary terms, evidence. The other represents wisdom or humanism. Mr. Davies argued, even back then, that these two warring sides of medicine were out of balance, with knowledge and science dominating wisdom and humanism. Things are arguably even more out of balance these days.

How do family doctors like me maintain that humanist commitment to our patients that Mr. Davies saw as so essential to medical practice? How do we resist the despondency that can sometimes come with so much failure? How can we find happiness in the difficult practice of family medicine? It is hard to be prescriptive.

Intellectualization helps. There is comfort in knowing that Aristotle called medicine one of the “stochastic” arts and that mastery of a stochastic art is compatible with failure to achieve its end – good health. As he wrote “It does not belong to medicine to produce health, but only to promote it as much as possible.”

But the heart needs more. For me it has also been the combination of the many small moments of connection over time with my patients, the love and support of my own family and the support and shared experience of a small number of trusted colleagues – fellow travellers in the art of failure – that have made all the difference.

When all else fails, I open a desk drawer that contains, wrapped in a thick rubber band, a couple of dozen “thank you” cards I have received from my patients over the past three decades, and read some of them. It’s rarely the outcome of their struggles that they thanked me for, but the long-term commitment to caring for them regardless of their problems – and this I always try to bear in mind when unhappiness in practice comes to call.