Section

1

Introduction

1. Medical Humanities: History and Concepts
2. Medical Humanities: Need and Purpose
3. What Makes a Good Doctor?
4. Stress and Burnout Syndrome
5. Human Touch in Doctors

CHAPTER

1

Medical Humanities: History and Concepts

Juhi Kalra

Key Points

- The concept of medical humanities is ages old, when it was considered that medicine was an artful practice of science of health for the welfare of masses.
- Medical humanities is a multidisciplinary field, consisting of humanities, social sciences and arts, integrated in the undergraduate curriculum of medical schools.
- Though still in infancy, efforts are on the way in several medical colleges across India to introduce it formally.

INTRODUCTION

Cooper (2003) has quoted Sir William Osler's golden words that are a source of inspiration for the medical fraternity, *"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head"*.

In the old times, there was no clear demarcation between science and art. The Greek philosopher Aristotle believed that medicine was an artful practice of science of health for the welfare of masses (*The Works of Aristotle*, 1908). A mention of terminologies like *'humanitas'*—a love for humanity and *'misericordia'*—full of mercy have been quoted as early as in the first century AD, by Scribonius Largus who was physician to Emperor Claudius. The Greeks also used the term *'philanthropia'* to describe an attitude of kindness towards patients that can win a good reputation for the physician (Pelligrino, 2006). Evans (2002) refers to medical humanities as human experience of illness and disability.

But as times progressed, the middle ages saw the emergence of 'mechanical' and 'liberal' arts. Medicine fell into the category of mechanical arts. The word 'art', however, continued to be used in the context of science.

With emergence of laboratory research from 1870s to 1910, the practitioners of medicine got an additional label of 'scientist'. Sciences were divided into 'normative', 'analytical' and 'humanities'. Normative sciences had a regulatory approach and relied on ethics and jurisprudence to prove things right and wrong. Analytical sciences involved observation and experimentation with both natural sciences and the social sciences. They were governed by rules and dealt chiefly with cognitive component. The natural sciences included physics, chemistry and biology while economics and sociology were

grouped under social sciences. Much in contrast to analytical sciences which were oriented around techniques, cognitive observations and conclusions; humanities was a rather subjective comprehension of human actions and relied on value-based system.

As analytical sciences were gaining momentum in the era of industrialization, sciences were becoming synonymous with all that is 'observable' and 'quantifiable'. They were becoming boastful while offering causal explanations through their objective and reductionist approach. In the historic mention of Wassersurg (1987), we find a semblance of mechanicality of science and the enormous power it wields when he mentions that the inanimate scalpels, culture plates and instruments have superseded the humanitarian doctor, thus snatching away the credit of medical progress from him. This thought process led to the most obvious contradiction and an imminent need to humanize medicine.

It began to be proposed that arts can tone down the pompousness that arise from "I know it all", "I can prove it" of the science. The opponents of reductionist approach of science felt that illness can create an inexhaustible set of situations which need an artful critical analysis of patient narratives. It was being realized that non-scientific needs cannot be treated with mere scientific tools. It was evident that the practitioners of medicine must venture out from analytical labs and feel the microcosm of a hospital setting to look, read and hear beyond the confines of the books.

There was a time when physicians were the most revered and considered as the most learned people of the society. People looked up at them for their wisdom. The undeniable existence of a psychosomatic component in most diseases needed the amalgamation of arts with science because it was believed that this unique alloy of medical humanities will not only cajole expectations and emotions but also perhaps shall aid finding solutions to those left unattended in the ever deepening sorrow and pain of the disease and the infirmity. Since all that which goes on in the human mind cannot be comprehended from facts, figures, diagnostic scanners and cognitive probes, it was expected that 'arts and humanities' can complement science. It was further projected that this admixture will keep the practitioners grounded and help them look beyond the anatomy of cognitive facts.

John Stuart Mill (2020) feels *"it is important not only what men do, but also what manner of men they are who do it"*, and thus pointing that the inherently creative and artful communication in a doctor–patient relationship must retain its finesse to complete the technical jigsaw of symbols, facts, and figures. It was anticipated that arts, literature, poetry, philosophy and myriad components of humanities can infuse finesse in technical sciences.

WHAT IS MEDICAL HUMANITIES?

A lot of terminologies **(Box 1.1)** and definitions **(Box 1.2)** have floated in the context of medical humanities.

Several attempts to define humanities were made in the past **(Box 1.2)**. These elaborate descriptions have differed from the simplified version mentioned in the *Oxford Dictionary*.

BOX 1.1: Some terminologies in context of medical humanities from the Oxford English Dictionary

- **Humanities:** Learning or literature concerned with human culture
- **Humanism:** The quality of being human; devotion to human interests or welfare
- **Humane:** Characterized by sympathy with or consideration for others; compassionate; benevolent
- **Humaneness:** Humane quality or condition; compassionateness
- **Humanize:** Make human; give a human character to
- **Humanitarian:** A person concerned with human welfare

BOX 1.2: Definitions purported to describe medical humanities

- "An integrated, interdisciplinary, philosophical approach to recording and interpreting human experiences of illness, disability, and medical intervention…"—*Evans 2002*
- Medical humanities has been defined as "an interdisciplinary and increasingly international endeavor that draws on the creative and intellectual strengths of diverse disciplines including literature, art, creative writing, drama, film, music, philosophy, ethical decision making, anthropology, and history in pursuit of medical educational goals"—*Kirklin 2003*
- "An interdisciplinary field concerned with understanding the human condition of health and illness in order to create knowledgeable and sensitive healthcare providers, patients, and family caregivers"—*Klugman 2017*

Once such elaborate description of medical humanities came to the fore, the individual components like bioethics, narratives, art, poetry, music, sketching, sculpturing and theatre began to be explored in the context of medical sciences. Adrian Hill is acknowledged as the founder of art therapy in the UK. Hill introduced artistic work to his fellow patients, while he was receiving treatment for tuberculosis which is chronicled in *'Art Versus Illness'*.

Taking all these facts into consideration, for all operational purposes in this book, medical humanities is described as an amalgamation of medical sciences with arts, *viz.* philosophy, sociology, psychology, history, literature, theatre and arts, empathy, culture, and more importantly with ethics, communication, and professionalism in medical context, with interdisciplinary interaction and application of clinical skills with soft skills for patient care.

BIOETHICS AND THE MEDICAL HUMANITIES

The work of Edmund Pellegrino has emphasized that abstract ethical issues can be highlighted and discussed through narrative medicine. In his "ethics–humanities–medicine trialogue", he talked about narratives as an aid to 'humane approach' during diagnosis and treatment. In North America, bioethics and medical humanities were more coherently together; while in the United Kingdom, the medical humanities developed as a separate stream. Miles (1989) mentioned the need to incorporate medical ethics in the undergraduate and graduate training

programs and this finds a mention in reports of McElhinney and Pellegrino. But ethics continued to be part of the hidden curriculum. They were a part of some doctor–patient relationship courses and offered as electives until mid-1970s. But as the importance of ethics in medical education was recognized; they gained a greater footage and were offered as separate courses by early 1980s in the US.

In the midst of the debate and of the great felt need to humanize medicine, the term 'medical humanities' was first coined in 1948 by George Sarton. He first used the term 'medical humanities' in the pages of *ISIS*, a journal devoted to the history of science, medicine and civilization in the USA.

HISTORY OF MEDICAL HUMANITIES

Religion, history and philosophy, as these applied to medicine, were integral to the Department of Humanities at Pennsylvania State University (Penn State) College of Medicine, Hershey in 1967. Literature was added later in 1969. In the same year, *'The Society for Health and Human Values'* was officially launched. This was the first international organization that offered professional membership for those who believed that inculcating human values in medicine is paramount. Medical humanities was gradually but steadily gaining momentum, crossing geographical boundaries.

The University of La Plata medical school, in Argentina designed an optional medical humanities provision in 1976 while in the very same year Moore (1976) described the term 'medical humanities'. He also developed a short course, using literary extracts. This course enabled him to discuss issues like cultural sensitivities, philosophy and personal issues, as relevant to medical practice. In 1973, the *Institute of Medical Humanities* was founded at the University of Texas, Galveston and in 1979 Anne Hudson Jones became the first literature professor to join as faculty in a medical school. The year 1993 witnessed the historic inclusion of the medical humanities in undergraduate medical curricula by the General Medical Council (GMC). It brought a ray of hope for educationists, philosophers and physicians who had been keen at developing the discipline of Medical Humanities in the United Kingdom (Kirklin, 2003). Collaborative relationships developed between UK and Australia for carrying medical humanities forward.

Later, in 2003, medical humanities was introduced even into the postgraduate program at the University of Sydney and by 2005, it could be integrated into the medical curriculum of Australia (Gordon, 2005).

HISTORY OF MEDICAL HUMANITIES IN INDIA AND ASIA

Medical humanities programs are well established in many universities of the United States (US), the United Kingdom, and some parts of Western Europe, New Zealand, Israel and Canada.

Medical humanity has a shorter history in Asia where it is claimed to be introduced in Nepal in 2009 (Gupta et al, 2011). Shankar (2009) used a medical humanities model module at a medical college of Nepal.

Between the year 2010 and 2012, 'Theatre of the Oppressed' workshops began to be organized across four Indian and Nepalese cities. Such workshops were later actively pursued by the medical humanities group at University College of Medical Sciences, Delhi and later by KEM Mumbai and many others. Though '*Journal of Medical Ethics*' and '*Medical Humanities*' have been supporting and promoting publications in field of medical humanities and ethics for long; in Asian context the journal—'*Research and Humanities in Medical Education*' was introduced in India in 2014 and the '*Formosan Journal of Medical Humanities*' from Taiwan. Medical humanities programs have been initiated in many developing countries like Turkey, the Middle East, and South East Asia.

A need to evolve modules that address the local challenges, based on the socioeconomic challenges and cultural diversity in India is the need of the hour (Ramaswamy, 2012). Online discussions on humanities in India at several forums have emphasized the need to harness humanities in our interactions with patients (Kalra et al, 2016). In India, faculty members from UCMS, Delhi, have been making consistent effort to explore possibilities in field of medical humanities (Shankar, 2016). A number of initiatives at various medical colleges across India are indicative of the willingness to harness the much-needed change (Singh et al, 2015; Singh et al, 2012). The Centre for Community Dialogue and Change has conducted workshops on theatre of the oppressed (TO) in various institutions and has done pioneering work in popularizing TO among educators in India (Gupta et al, 2013). In the recent years, a number of states across India have taken active initiatives to include medical humanities in their teaching program (Singh et al, 2017; Saiyad, 2017).

The need to establish 'Medical Humanities Cell' in medical colleges has been identified (Supe and Burdick, 2006). Many other authors have expressed the need and ways and means of establishing medical humanities in medical colleges (Kalra and Singh, 2017; Joshi et al, 2018). Though still in infancy, a beginning has been made in India and some reports of encouraging its use have appeared.

CONCLUSION

Though still not a part of formal curriculum, the need for medical humanities is being discussed at various forums in India, small workshops being organized at various medical colleges across India. Efforts are on the way in several medical colleges where formal medical humanities department have been established. The AETCOM module is an effort to introduce the concept in Medical School Curriculum in India (MCI, 2018).

BIBLIOGRAPHY

- Batistatou A Doulis EA, Tiniakos D, Anogiannaki A, Charalabopoulos K. The introduction of medical humanities in the undergraduate curriculum of Greek medical schools: Challenge and necessity. *Hippocratia* 2010;14:241–43.

- Cooper SM. The Quotable Osler. *Journal of the Royal Society of Medicine* 2003;96(8):419.
- Evans M. Reflections on the humanities in medical education. *Medical Education* 2002;36(6):508–13.
- Gordon J. Medical humanities: To cure sometimes, to relieve often, to comfort always. *Medical Journal of Australia* 2005;182(1):5–8.
- Gupta R, Singh S, Kotru M. Reaching people through medical humanities: An initiative. Journal of Educational Evaluation for Health Professions 2011;8:5. Accessed on 20.04.2022. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110875/
- Gupta S, Agrawal A, Singh S, Singh NS. Theatre of the oppressed in medical humanities education: The road less travelled. *Indian Journal of Medical Ethics* 2013;103:200–03.
- Joshi A, Singhal A, Loomba P, Grover S, Badyal D, Singh T. Humanities in medical education. *Journal of Research in Medical Education and Ethics* 2018;8(SI):3–9.
- Kalra J, Singh T. Commentary on "Conversations". *Research and Humanities in Medical Education* 2017;4:72–76.
- Kalra J, Singh S, Badyal D, Barua P, Sharma T, Dhasmana D, Singh T. Poetry in teaching pharmacology: Exploring the possibilities. *Indian Journal of Pharmacology* 2016;48(7):61–64.
- Kirklin D. The centre for medical humanities, Royal Free and University College Medical School, London, England. *Academic Medicine* 2003;78(10):1048–53.
- Klugman CM, Peel J, Beckmann-Mendez D. Art Rounds: Teaching Interprofessional Students Visual Thinking Strategies at One School. *Academic Medicine* 2011;86:1266–71.
- Medical Council of India (2018). Attitude, ethics and communication (AETCOM) competencies for the Indian medical graduate. Accessed on 21.12.2022. Available from: https://www.nmc.org.in/wp-content/uploads/2020/01/AETCOM_book.pdf
- Miles SH, Lane LW, Bickel J, Walker RM, Cassel CK. Medical ethics education: Coming of age. *Academic Medicin*e 1989;64(12):705–14.
- Mill J (2020). The Collected Works of John Stuart Mill, edited by John M. Robson (1963–91), in 33 volumes,. Toronto: University of Toronto Press, London: Routledge and Kegan Paul.
- Moore A. Medical humanities: A new medical adventure. *New England Journal of Medicine* 1976;295(26):1479–80.
- Pellegrino E. Toward a reconstruction of medical morality. *The American Journal of Bioethics* 2006; 6(2):65–71.
- Ramaswamy R. "Medical humanities" for India. Indian Journal of Medical Ethics 2012; 9 (3). Accessed on 22.04.2022. Available from: https://doi.org/10.20529/ijme.2012.048
- Saiyad SM, Paralikar SJ, Verma AP. Introduction of medical humanities in MBBS 1st year. *International Journal of Applied and Basic Medical Research* 2017;7(Suppl S1):23–26.
- Shankar PR. Medical humanities in medical schools in India. *Archives of Medicine and Health Sciences* 2016;4(2):166–68.
- Shankar P, Piryani R. Using paintings to explore the medical humanities in a Nepalese medical school. *Medical Humanities* 2009;35(2):121–22.
- Singh S, Barua P, Dhaliwal U, Singh N. Harnessing the medical humanities for experiential learning. Indian Journal of Medical Ethics 2017;2[3 (NS)]:147. Accessed on 20.04.2022. Available from: https://ijme.in/articles/harnessing-the-medical-humanities-for-experiential-learning/
- Singh S, Khosla J, Sridhar, S. Exploring medical humanities through theatre of the oppressed. *Indian Journal of Psychiatry* 2012;54(3):296–97.

- Singh S, Singh N, Dhaliwal U. Promoting competence in undergraduate medical students through the humanities: The ABCDE Paradigm. *Research and Humanities in Medical Education* 2015;2:28–36.
- Supe A, Burdick W. Challenges and issues in medical education in India. *Academic Medicine* 2006; 81(12):1076–80.
- The Works of Aristotle. Translated into English under the editorship of JA Smith, WD Ross, Vol. VIII. Metaphysica, by WD Ross. Oxford: Clarendon Press, 1908.
- Wassersug J. Teach humanities to doctors? Says who? *Postgraduate Medicine* 1987;82(5):317–18.

CHAPTER

2

Medical Humanities: Need and Purpose

Sahiba Kukreja

Key Points

- Lack of empathy in current healthcare workers is a challenging aspect in patient care.
- Medical humanities is the amalgamation of arts and science.
- Introduction of medical humanities curriculum in health professional courses will result in better patient care.

INTRODUCTION

It was the summer of 1990, exams had ended, and it was time to leave school behind and enter a new period of our lives. I can never forget the two words of wisdom my biology teacher wrote for me as a school leaving message—"Be humane". Thereafter, the years spent in medical school and all the years of training that followed, never was there any mention of anything regarding this. It took a lot of trial and error to learn what the meaning of those two words was. What is the meaning of these words? According to the *Oxford English Dictionary*, the word humane means to be compassionate and benevolent. In no other profession is humaneness and humanities more applicable.

The history of medicine from the time of Hippocrates shows how societies have changed in their approach to illness and disease (Batistatou et al, 2010). Modern medicine which relies on facts, figures, and tests has lost the humanitarian touch. It is the loss of this humaneness which has made us realize the need for medical humanities.

Medical humanities is an interdisciplinary field of science that helps in drawing intellectual and creative strength from different fields such as history, literature, ethical decision making, etc. related to the field of medical education. The core strength of medical humanities is the imaginative non-conformist qualities and practices. According to Hall et al (2014), '*Through humanities-based perspective, learners can reflect on the impact of their personal and professional relationships with patients and their families*'.

EMPATHY: THE BASE OF MEDICAL HUMANITIES

The humanities, therefore, offers a more holistic and person-centered approach to care. While searching literature, I came across a statement '*some clinicians have*

empathy of a cadaver'. Medical education has done very little to ingrain empathy in the minds of young aspiring doctors (Shiand Du, 2020), while empathy is the base of medical humanities.

Empathy is a construct which falls in two domains, i.e. cognitive and affective domain.Under a cognitive domain, it has been defined as '*the imaginative transposing of oneself into the thinking and acting of another and so structuring the world as he does*' (Dymond, 1949). Considering affective domain, it has been defined as '*experiencing the emotional state of another*'. Empathy is very critical in building doctor–patient relationship, it has been an important link to positive patient outcomes, i.e. improvement in patient satisfaction, better compliance of the patient to doctors' advice, lesser relapse rates and autonomy of patient is also respected. Empathy has been discussed in detail in Chapter 8 of this book. Since it is the vehicle transporting medical humanities into medical students, the same has been touched here.

TRAUMATIC DEIDEALIZATION

The gradual development of negative qualities in the medical professionals has been the primary reason for an increase in the patient–doctor conflict and the resultant litigations against the doctors. This has been blamed on 'burn out' and/or traumatic deidealization which leads to an attitudinal change causing deflation, pessimism, emotional exhaustion, depersonalization and low sense of accomplishment among medical graduates **(Fig. 2.1)** (Jerald Kay 1990). Research states that 'compassion' and 'empathy' can be induced and the students may be trained for becoming more responsible towards their patients (Jeffrey and Downie, 2016). They may even begin considering their patients as a whole human being rather than a complex group of diseases. The primary way of achieving this is through ethical education to the medical students.

Plethora of documented evidence has also stated that a student often feels morally challenged during the tensed hospital environment (Parkes, 1985; Hellsten, 2015). An enriching survey conducted by Feudtner et al (1994) in final year medical students of six medical colleges in USA has stated that more than 50% of the students have agreed that their ethical principles have been eroded or lost and they have done something unethical during their medical practice.

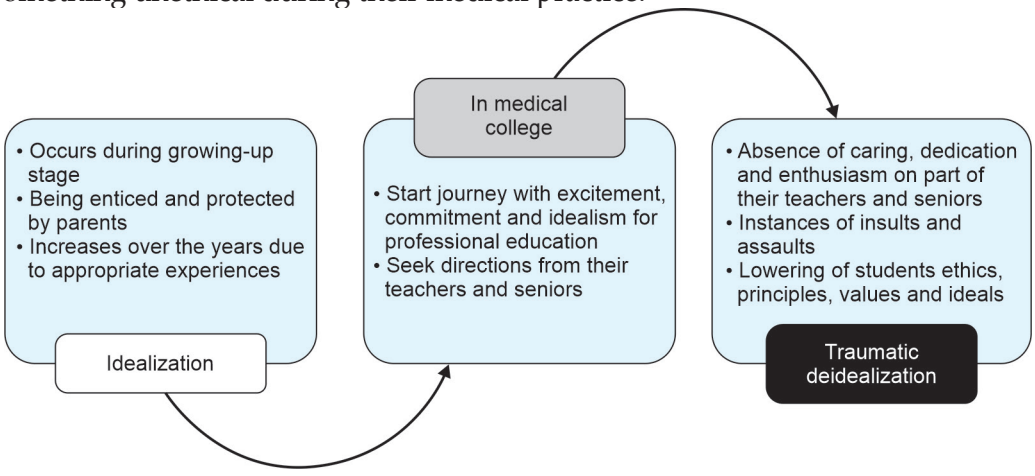

Fig. 2.1: Transformation from idealization to traumatic deidealization

Another study has documented that the medical students who are exposed to unethical situations often feel encouraged to have a dual code of ethics. One ethical code is used in personal life, while the other ethical code is developed as a physician (Genuis, 2006). Most of the students in this study felt that their ethics will eventually degrade with advancement in their profession.

In another study, the majority of doctors felt that the teaching of medical ethics was highly unsatisfactory during their medical course (Mashayekhi et al, 2021). Most of the students reported that their senior doctors followed unethical practice. Most of the junior doctors suffered due to this unethical practice of their seniors. Experiencing unethical practice by the seniors resulted in the gradual erosion of morals and ethics of the junior doctors.

This unfortunate disillusionment with the medical culture necessitates the inclusion of humanities and bioethics into medical curricula as an attempt to stop this decay and restore the sanctity of this profession.The main aim of teaching bioethics to the medical graduates is to allow the inculcation of required reasoning skills in them. These skills are necessary to help them overcome the dilemmas that they might experience during their practice in the near future. It also gives them the opportunity to amicably resolve these dilemmas using the knowledge attained through the course and by the experience that they would obtain during their practice.

PURPOSE OF TRAINING IN MEDICAL HUMANITIES

The claim that introduction of medical humanities in the curriculum will help our students to become better doctors has another interesting aspect to it. The term 'better' suggests that our young physicians will be able to take care of their patients more effectively, if they study medical humanities. Difference in overall personality of a medical graduate with and without medical humanities depicted in **Fig. 2.2.** (Birkeland et al, 2013). Learning to become a good doctor is not something which

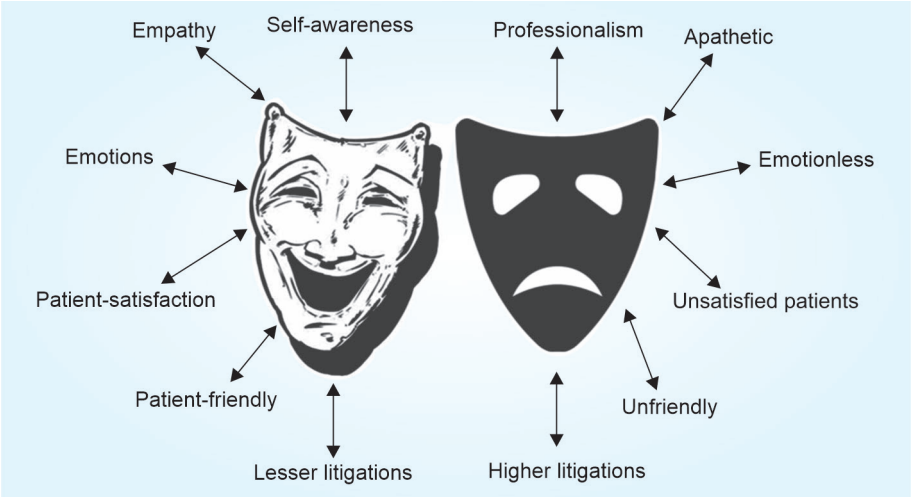

Fig. 2.2: Difference in overall personality of a medical graduate with (left) and without (right) medical humanities

happens overnight. It involves a process of character formation that requires years and years of role modeling and guided practice. Medical humanity is based on the fundamentals of good communication skills, empathy, professionalism, as well as self-awareness related to the social and cultural aspect of healthcare (Dobie, 2007). However, given a thought, it conveys the message that earlier physicians did not attend any associated course and grasped these skills through years of experience. Thus, healthcare professionals may learn all these skills during their years of practice.

Despite all this, 'medical humanities' feels right and medical educators worldwide are talking enthusiastically about it and I think that these educators are doing this selflessly to preserve and cater to the essence of the medical profession. The main objective of medical humanities is to integrate the field of humanities in medical curriculum (Eichbaum, 2014). This would help the budding healthcare professionals to become kinder to the patients and will help them understand the difference between life and death. It allows medical professionals to adapt empathy during their practice. It inculcates the important principle of morality and ethics in medical students and prevents the reinforcement of negative aspects of the medical profession, viz. cynicism, feeling of entitlement, and vanity.

WAYS AND MEANS OF INTRODUCING HUMANITIES

Humanities education is both an active as well as passive mode of teaching morals, ethics, and professionalism to the budding medical graduates. This passive education has to be implemented with the help of some formal tools such as didactic lectures, ethics rounds, standardized patients, etc. Another important method for this purpose is the use of realistic care-based discussions. These formal tools can only be implemented with the help of the available resources and manpower. Since the success of any education is based on the strength of its roots, therefore, this education can be made useful, only if it is implemented during the beginning of a medical course. This course can be made successful, only if it is integrated in the medical curriculum. This would ensure that medical ethics is considered as the main course instead of a series of boring lectures.

Medical humanities need to be integrated both horizontally and vertically during the five and half years of medical course. Though philosophers might be considered as an ideal choice, but the medical ethicists with years of experience and knowledge are best suited for teaching medical graduates and postgraduates. These ethicists are considered as an expert of medical techniques, problems, and associated ethics.

It is important to understand that the aim of teaching a medical graduate surgery or obstetrics is not to create a specialist surgeon or obstetrician, but it is done for ensuring that each medical graduate has at least a basic knowledge regarding these fields and the ability to recognize the diseases associated with it. This would allow them to provide the treatment for the disease within the limits of their abilities and refer the patients who are beyond their capacity of intervention to a specialist or a well-equipped healthcare facility. In a similar manner, medical bioethics allows the creation of medical bioethicists who are able to identify ethical dilemmas during

their practice and apply the appropriate reasoning skills for overcoming these dilemmas (MacRae et al, 2005). This would involve the use of appropriate reasoning skills attained using the gained knowledge, and experience obtained during years of practice. It is important to regularly evaluate the progress of ethical education and to resolve any and every problem faced, related to medical ethics.

Countries like the US, where training of bioethics was made compulsory several years ago are still facing several issues such as—identifying the curriculum of medical ethics to be followed, teaching pattern, and the eligibility requirements of the teachers who would be designated for teaching these skills. All these issues have to be carefully assessed and individually resolved.

CONCLUSION

Much wider variations in the curriculum are usually observed between the institutions of different countries. The driving factor behind these variations is the difference in values and cultures. Medical humanities are a combination of science with arts, which allows an insight into the human illness, suffering, perceptions of professionalism; and responsibilities to themselves, patients, and colleagues. This field enhances analytical and observational skills. It imparts the basic requirements of empathy as well as self-reflection. This course is essential for helping the medical students in overcoming the negative aspects of healthcare studies by improving their perception of empathy, respect, self-awareness, and genuineness.

BIBLIOGRAPHY

- Batistatou A, Doulis EA, Tiniakos D, Anogiannaki A, Charalabopoulos K. The introduction of medical humanities in the undergraduate curriculum of Greek medical schools: Challenge and necessity. *Hippokratia* 2010;14(4):241.
- Birkeland S, Christensen DR, Damsbo N, Kragstrup J. Characteristics of complaints resulting in disciplinary actions against Danish GPs. *Scandinavian J Primary Healthcare* 2013;31(3):153–57.
- Dobie S. Reflections on a well-traveled path: Self-awareness, mindful practice, and relationship-centered care as foundations for medical education. *Acad Med* 2007; 82(4): 422–27.
- Dymond RF. A scale for the measurement of empathic ability. *J Consulting Psychology* 1949;13(2):127.
- Eichbaum QG. Thinking about thinking and emotion: The metacognitive approach to the medical humanities that integrates the humanities with the basic and clinical sciences. *The Permanente J,* 2014;18(4):64.
- Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Acad Med* 1994;69(8):670–79.
- Genuis SJ. Dismembering the ethical physician. *Postgraduate Med J* 2006;82(966):233–38.
- Hall P, Brajtman S, Weaver L, Grassau PA, Varpio L. Learning collaborative teamwork: An argument for incorporating the humanities. *Journal of Interprofessional Care* 2014;28(6):519–25.

- Hellsten SK. Ethics: Universal or global? The trends in studies of ethics in the context of globalization. *Journal of Global Ethics* 2015;11(1):80–89.
- Jeffrey D, Downie R. Empathy—can it be taught? *J of Royal College of Physicians of Edinburgh* 2016;46(2):107–12.
- Jerald Kay. Traumatic deidealization and the future of medicine. *JAMA* 1990;263(4): 572–73.
- Mashayekhi J, Mafinejad MK, Changiz T, Moosapour H, Salari P, Nedjat S, Larijani B. Exploring medical ethics' implementation challenges: A qualitative study. *Journal of Education and Health Promotion* 2021;10. DOI: 10.4103/jehp.jehp_766_20.
- MacRae S, Chidwick P, Berry S, Secker B, Hébert P, Shaul RZ, Faith K, Singer PA. Clinical bioethics integration, sustainability, and accountability: the Hub and Spokes Strategy. *Journal of Medical Ethics* 2005;31(5):256–61.
- Parkes KR. Stressful episodes reported by first-year student nurses: A descriptive account. *Social Science & Medicine* 1985;20(9):945–53.
- Shi M and Du T. Associations of emotional intelligence and gratitude with empathy in medical students. *BMC Medical Education* 2020;20:116. Accessed on 22.12.2022. Available from: https://doi.org/10.1186/s12909-020-02041–4.

CHAPTER

3

What Makes a Good Doctor?

Sahiba Kukreja

Key Points

- Patient care is the primary role of a doctor.
- There is a necessity for probity in the medical field.
- Besides empathy and compassion, effective doctor–patient communication is an important factor for better patient care.
- Lifelong learning is an obligation for being a good doctor.

INTRODUCTION

"A good physician treats the disease. The great physician treats the patient who has the disease." (Sir Dr. William Osler). Healthcare has been defined as an important and integral part of the society that helps in diagnosing, treating, and preventing physical or mental diseases in a patient. An efficient healthcare system is dependent on a well-trained and empathetic doctor who caters to the requirements of the patient as well as their attendants. The relationship between a doctor and patient has shifted from professional to interactive (Szleza´k et al, 2010). The doctor is now expected to be on the same pedestal as the patient and explain the pros and cons of the treatment to the patient in a detailed manner.

The lack of such interactions between a patient and a doctor has resulted in a sudden increase in the malpractice lawsuits filed against the doctors (Ranjan et al, 2015). The major reason behind this surge in lawsuits is an absence of clear communication among the doctors and patients. It is necessary for a doctor to understand the emotions, feelings, and worries of their patients.

It is important to understand that there is no good or bad doctor. The basic education and training provided to these professionals is almost the same everywhere. The difference lies between the extra social skills inculcated in them. Clinical practice is always considered paramount in contrast to all possible attributes, yet it is insufficient when practiced alone. Clinicians have their own perception regarding the various essential attributes of a good doctor. A good doctor is not just an excellent clinician, but he/she has to have a strong commitment towards self, family, and community that he/she serves.

TEN TOP RANKED ATTRIBUTES

A doctor may ensure better care of the patient by implementing system-based practice (SBP). In SBP, a physician is required to understand the correlation among the patient care and system as a whole. The system can then be modified in a manner that can benefit and improve the patient care, thus focusing towards the whole system instead of system components. There is also a need to focus on interpersonal skills, something that is lacking in the healthcare system these days. This would need collaboration among different specialists, thus ultimately benefiting the patients. There is also a need to focus on interpersonal skills, something that is lacking in the healthcare system these days. This would require collaboration among different specialists, thus ultimately benefiting the patient. There are other attributes besides clinical skills which are important to be a good doctor.

As per the extract from the graduate medical education regulations 2018, an Indian Medical Graduate must be capable of functioning as per the roles of a clinician, leader and member, communicator, lifelong learner, and professional. All these roles help a doctor become effective for the community first and then alleviate themselves as per global standards. A Delphi survey of clinicians has identified some of them and they have been rated on the Likert scale from 1 to 10, where 1 is the most important attribute **(Table 3.1)** (Lambe and Bristow, 2010). Though there were many attributes, the top rated are included in this review. In a study by Dopelt et al, 2022 parallel surveys were conducted on 1000 physicians and 500 participants from the general public, reported that the most important attributes of a good doctor according to the physicians they surveyed was their humaneness, empathy, knowledge, professionalism, credibility, honesty, caring and devotion. Whereas participants from the general public reported knowledge, professionalism, credibility, honesty, humaneness, listening and patience as attributes of a good doctor.

TABLE 3.1: Key attributes of a good doctor as rated and ranked during Delphi survey (Lambe and Bristow, 2010)

Key attributes	*Delphi panel ranking*
Recognition that patient care is the primary concern of a doctor	1
Probity (being honest, trustworthy and acting with integrity)	2
Good communication and learning skills	3
Recognition of one's own limits and those of others	4
Pro-social attitude (has empathy and is non-judgemental)	5
Ability to cope with ambiguity, change, complexity and uncertainty	6
Commitment to lifelong learning, competence and performance development	7
Compassion	8
Motivation and commitment	9
Ability to be a team player	10

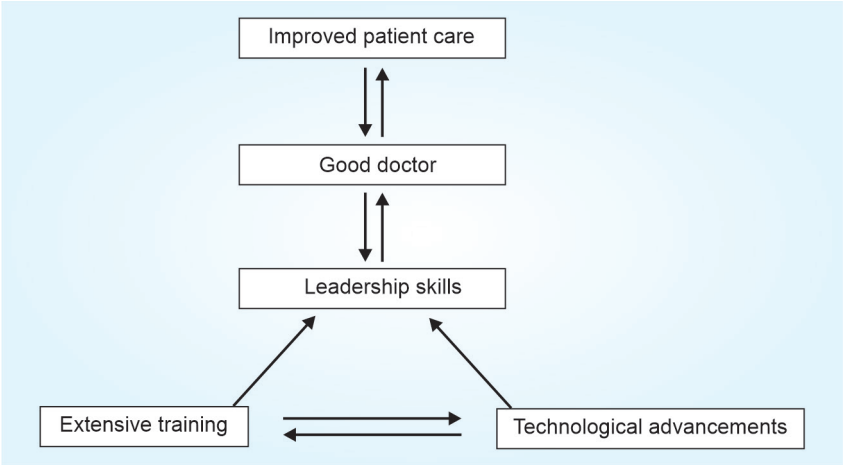

Fig. 3.1: Improving patient care

Unfortunately, the medical curriculum until now provides no formal training; only clinical skills are imparted to the students. In this review, an effort has been made to compile and identify some of these attributes and possible methods of inculcating them.

LEADERSHIP SKILLS: REVOLUTIONIZING HEALTHCARE SERVICES

The key attribute of a good doctor is to provide accurate diagnosis and treatment to the patient. It is necessary to ensure that the patient recovers physically, socially, and mentally (Naglaa et al, 2021). There are several ways of ensuring that the doctor considers patient care as an extremely important part of their profession. In addition to clinical responsibilities, it is imperative for the physician to serve as leaders and advocates at individual and community level **(Fig. 3.1)** (Warren and Carnall, 2011).

They are required to have knowledge and leadership skills in clinical settings, research, funding process, organizational details, governance, and for any other leadership roles. An effective leader can ensure that the patient is taken care of in the healthcare setup and the staff workers act in an organized manner. As stated by Lao Tzu, '*A leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves*'. It was always perceived that one is born as a leader and the leadership skills cannot be taught. On the contrary, several articles have stated that leadership is the sum of important qualities that can be taught to an individual through teaching and rigorous training (Rogers, 2005; Cheang, 2011; Volz-Peacock, 2016). Some of the methods that can be commonly applied for this purpose are self-directed learning, one-to-one coaching, action learning, seminars, mentoring, and experiential learning (Warren and Carnall, 2011).As rightly stated by John Quincy Adams, '*If your actions inspire others to dream more, learn more, do more and become more, you are a leader*'.

LIFELONG LEARNER: THE COMPETENT NOVICE

We are aware of the aphorism that learning should continue from cradle to the grave, those who do not, ultimately becomes frustrated and burnout (Teunissen and Dornan, 2008). The medical field is dynamic and ever evolving. Each day a number of research articles are published with information regarding newer diseases and newer interventions, earlier unknown to mankind. Therefore, it is a must for a physician to keep themselves updated through reading, or discussions, etc. Being a knowledgeable doctor adds to one's values and will help them in getting recognition at local level as well as globally. Ever-increasing knowledge helps a practitioner in decision making and planning new strategies for patient care. It is important for continual professional development that all doctors should reflect on their practice. This will help them to identify their own learning needs (Hanis, 2019).

Lifelong attributes can be acquired by seeking content or skill-oriented feedback from others. Quality feedback provided by staff and patients can help in continual improvement or can provide new and better perspectives. Another method of learning is to think back on the challenges faced by the physician during their practice and frame new and relevant questions. These questions have to be answered by the physician using available resources, thus adding to the current knowledge (Teunissen and Dornan, 2008). The confidence expressed by the practitioner and the doubts experienced have to be rightfully balanced. Questioning and doubting personal actions and knowledge can provide continual learning experience.

PROBITY: AN INTEGRAL PART OF A GOOD DOCTOR

Ethics and moral principles are an integral part of the medical field. The relationship between a doctor and patient cannot merely be termed as professional with context to consumerism. This field has to consider the importance of empathy, honesty, integrity, morality, decency, trustworthiness, honour, etc. Such moral values can lift up the spirits of patients and their attendants, thus helping the doctor in providing better care. It has been rightly stated by Stephen Covey: '*When you show deep empathy towards others, their defensive energy goes down, and positive energy replaces it. That is when you can get more creative in solving problems*'.

The factor of trust and respect among the doctor and patient helps in building a better relationship among them. This could improve the treatment and recovery rate of the patient. The Hippocratic Oath taken by the physicians is a clear reminder of the importance of ethics in the medical field (Askitopoulou and Vgontzas, 2018). The physician is also required to remember that they are a part of the society, and will always stay in an equal position with others. They should maintain a humane and empathetic approach towards their patient.

The declaration of Geneva and Helsinki clearly indicates the importance of ethics in physician's life (Parsa-Parsi, 2017). It highlights the fact that the physician has to make informed decisions, thus the patient or the attendant has the right to know the true and honest condition of the patient, or the actual outcome of a procedure (Laurie, 2014). The autonomy and dignity of the patient has to be rightfully addressed by the doctor. This provides the patient with satisfaction that they are taking the front

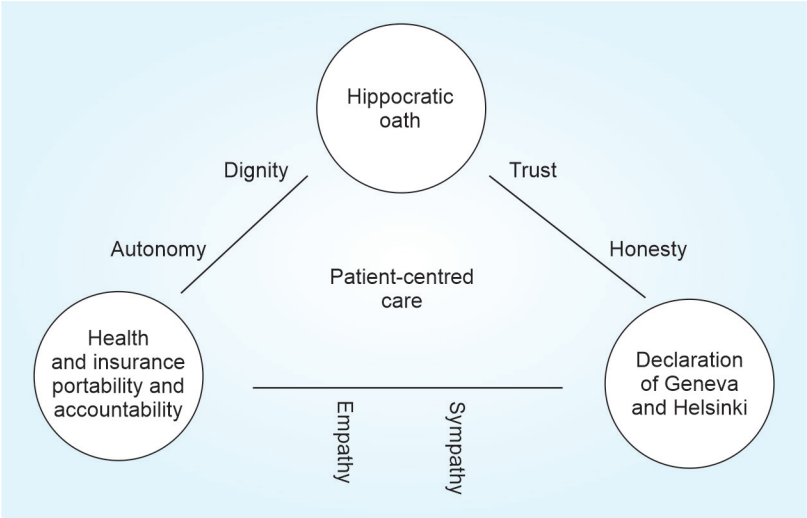

Fig. 3.2: Probity as an essential characteristic of patient care

seat in deciding their treatment protocol. Dignity is a crucial moral principle that the doctor has to follow at all the times. It is important to consider the patient as a fellow human being and treat them accordingly **(Fig. 3.2)**. This allows the patient to have trust and respect for their doctor (deBronkart, 2015). The attribute of probity, if followed, helps to reduce the number of legal lawsuits (Pringle et al, 2015).

The Health and Insurance Portability and Accountability Act of 1996 highlights the importance of dignity and privacy of each and every patient enrolled in the healthcare system (Huntington and Kuhn, 2003). The Act has revolutionised health centres and physicians worldwide. It has introduced legalities or the right of a patient to file a lawsuit for malpractice or for distributing personal information without taking prior consent. The principle of informed consent has helped in providing transparency regarding the medical treatment or procedure to which the patient is going to be subjected. It has helped the patient in making crucial decisions regarding their health by weighing the pros and cons of the treatment (Act of 1996). It has considerably reduced the malpractice and experimental behaviour of certain physicians. This has led to the provision of the much anticipated patient-centered care (Cherry and Fan, 2015).

COMMUNICATION SKILLS: NECESSITY OF THE HOUR

Communication skills are an essential and integral part of human nature. It helps in understanding and interpretation of feelings, and emotions. These skills are especially important in the field of healthcare. Doctors are required to be continuously in contact with patients, their attendants, and other human resources associated with them, thus making communication an essential aspect of healthcare facilities. Effective communication skills are dependent on both the verbal and nonverbal cues of an individual. The verbal skills are necessary for developing a better bond with patients (Pulvirenti et al, 2014). Interaction in common vernaculars can build-up trust among the patients and may help in building rapport (Almutairi, 2015).

Verbal communication is often hampered due to poor health literacy among patients, as observed in a number of surveys (White, 2008). It has been observed that cases of health illiteracy result in lack of understanding of instructions given by the physician and fewer queries by the patients. It is, therefore, the duty of a doctor to analyse the level of understanding of their patients, and thus explain to them the procedures and treatment regimens accordingly.

The nonverbal communications are essential in complementing the verbal communication (Friedman, 1979). These nonverbal communication skills help patient in understanding the emotions and care provided by the physician. These skills include smile, fear, and grimace expressed by the patient and the comforting touch, facial expression, and communication skills of the physician. It has been observed that in some cases such communications may act as placebo, thus resulting in improving the health and well-being of the patient (Shapiro and Morris, 1978).

Workplace violence is another area of concern for doctors these days, conflicts can arise between attending physicians and patients/paramedical staff/other fellow doctors. These ongoing conflicts can affect the staff morale, therefore conflict management can be recognised as an important part of competence in clinical communication (Saltman, O'Dea, Kidd, 2006). More about communication skills have been detailed in Chapter 6 of this book.

COMPASSION AND EMPATHY: NECESSITY FOR QUALITY CARE

Compassion is defined as the feeling of concern for the suffering of patients. Such feelings are extremely important for the health and well-being of the patient (Kass, 2001). Similar to compassion, empathy deals with understanding and sharing of emotions and feelings of the patient. Patients and their attendants often consider these as essential attributes (Heyland et al, 2010).

Some of the challenges for instituting compassion and empathy among physicians are increased specialization, fragmentation of the healthcare system, explosion of information, technological advances, and traditional education that teaches a physician to maintain distant relationship from their patients (Qidwai, 2017). Nonetheless, despite the hindrance, the advantages will always outweigh the challenges. Patients are often more cheerful and positive in the presence of a compassionate and empathetic doctor.

The lack of empathy in physicians is primarily due to the hypothesis that it may increase the risk of burnout (Picard et al, 2016). These soft skills which form important attributes of a good doctor can be taught by literature, art, creative writing, drama, films, music, and philosophy. These tools can help in making doctors more empathic, observant, tolerant, reflective, and appreciative of language making them distinct from robots and more humane (Banaszek, 2011).

INDIAN MEDICAL GRADUATE

Medical Council of India (MCI) has defined Indian Medical Graduate (IMG) in its new guidelines as a graduate—*possessing requisite knowledge, skills, attitudes, values and*

Fig. 3.3: Roles of Indian Medical Graduate

responsiveness, so that she or he may function appropriately and effectively as a physician of first contact of the community while being globally relevant (MCI, 2019).

In order to perform his role as IMG, the graduate is required to perform certain roles **(Fig. 3.3)**. Needless to say, these roles in themselves stand tall as attributes of a good doctor.

The IMG should be a:

- Clinician, who understands and provides preventive, promotive, curative, palliative and holistic care with compassion.
- Leader and member of the healthcare team and system.
- Communicator who communicates with patients, families, colleagues and community in a humane, ethical, empathetic, and trustworthy way.
- Lifelong learner who is committed to continuous improvement of skills and knowledge.
- Professional who is committed to excellence, is ethical, responsive and accountable to patients, community and the profession.

There are many competencies earmarked under these roles. Inculcating these competencies and performing these roles are certainly going to make a doctor a good 'Indian Medical Graduate'.

CONCLUSION

Besides clinical skills; good communication skills, skills to build interpersonal relationships, empathy, professionalism, understanding sociology of disease, compassion are some of the attributes of a good doctor (list is not exhaustible). These attributes though picked up by students during training by watching role models, the same now needs to be inculcated by direct teaching–learning.

BIBLIOGRAPHY

- Act A. Health Insurance Portability and Accountability Act, 1996. *Public Law* 1996;104-91.
- Almutairi KM. Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. *Saudi Medical Journal* 2015;36(4):425–31.
- Askitopoulou H, Vgontzas AN. The relevance of the Hippocratic Oath to the ethical and moral values of contemporary medicine. Part I: The Hippocratic Oath from antiquity to modern times. *European Spine Journal* 2018;27(7):1481–90.
- Banaszek A. Medical humanities courses becoming prerequisites in many medical schools. *Canadian Med Ass J* 2011;183:441–42.
- Cheang PP. Learning about leadership: A personal account. *Med Teach* 2011;33(6):491–93.
- Cherry M, Fan R. Informed consent: The decisional standing of families. *J Medicine and Philosophy* 2015;40(4):363–70.
- deBronkart D. From patient centred to people powered: Autonomy on the rise. *BMJ* 2015;350: h148.
- Dopelt, K., Bachner, Y.G., Urkin, J., Yahav, Z.; Davidovitch, N.; Barach, P. Perceptions of Practicing Physicians and Members of the Public on the Attributes of a "Good Doctor". Healthcare 2022, 10, 73. https://doi.org/10.3390/healthcare10010073
- Friedman HS. Nonverbal communication between patients and medical practitioners. *J Social Issues* 1979;35(1):82–99.
- Hanis T (2019, June 01). *The importance of lifelong learning for a doctor.* CIMS today; Sept 28, 2016. https://today.mims.com/the-importance-of-lifelong-learning-for-a-doctor.
- Heyland DK, Cook DJ, Rocker GM, Dodek PM, Kutsogiannis DJ, Skrobik Y, et al. Defining priorities for improving end-of-life care in Canada. *Canadian Med Ass J* 2010;182(16): e747–52.
- Huntington B, Kuhn N. Communication gaffes: A root cause of malpractice claims. *Proceedings (Baylor University, Medical Center)* 2003;16(1):157–61.
- Kass NE. An ethics framework for public health. *Am J Public Health* 2001;91(11):1776–82.
- Lambe P, Bristow D. What are the most important non-academic attributes of good doctors? A Delphi survey of clinicians. *Med Teach* 2010;32(8): e347–54.
- Laurie G. Recognizing the right not to know: Conceptual, professional, and legal implications. *J Law, Medicine and Ethics* 2014;42(1):53–63.
- Medical Council of India. The regulations on graduate medical education, 1997–Part II, 2019. Accessed on 18.12.2022. Available from: https://www.mciindia.org/ActivitiWebClient/open/getDocument?path=/Documents/Public/Portal/Gazette/GME-06.11.2019.pdf
- Naglaa A, El-Sherbiny, Eman H, Ibrahim, Nashwa Sayed. Medical students attitude towards patient centered care, Fayoum medical school Egypt. *Journal of Medicine* 2021;57(1):188–93.
- Parsa-Parsi RW. The revised Declaration of Geneva: A modern-day physician's pledge. *JAMA* 2017;318(20):1971–72.
- Picard J, Catu-Pinault A, Boujut E, Botella M, Jaury P, Zenasni F. Burnout, empathy and their relationships: A qualitative study with residents in general medicine. *Psychology, Health and Medicine* 2016; 21(3):354–61.
- Pringle J, Johnston B, Buchanan D. Dignity and patient-centred care for people with palliative care needs in the acute hospital setting: A systematic review. *Palliative Medicine* 2015;29(8):675–94.

- Pulvirenti M, McMillan J, Lawn S. Empowerment, patient-centred care and self-management. *Health Expectations* 2014;17(3):303–10.
- Qidwai W. Challenges in providing compassionate healthcare in current modern era of advanced technology. *Saudi Journal of Medicine and Medical Sciences* 2017;5(2):185–86.
- Ranjan P, Kumari A, Chakrawarty A. How can doctors improve their communication skills? *J Clinical Diagnostics and Research* 2015;9(3):JE01–04.
- Rogers J. Aspiring to leadership—identifying teacher-leaders. *Med Teach* 2005;27(7): 629–33.
- Saltman DC, O'Dea NA, Kidd MR. Conflict management: a primer for doctors in training. *Postgrad Med J* 2006;82:9–12.
- Shapiro AK,Morris LA. The placebo effect in medical and psychological therapies. In: Garfield SL, Bergin A (Eds). *Handbook of Psychotherapy and Behaviour Change: An Empirical Analysis.* New York, NY John Wiley & Sons, 1978;369–410.
- Szleza´k NA, Bloom BR, Jamison DT, Keusch GT, Michaud CM, Jamison DT, et al. The global health system: Actors, norms, and expectations in transition. *PLoS Medicine* 2010;7(1):e1000183.
- Teunissen PW, DornanT. Lifelong learning at work. *BMJ* 2008;336(7645):667–69.
- Volz-Peacock M, Carson B, Marquardt M. Action learning and leadership development. *Advances in Developing Human Resources* 2016;18(3):318–33.
- Warren OJ, Carnall R. Medical leadership: Why it is important, what is required, and how we develop it? *Postgraduate Med J* 2011;87(1023):27–32.
- White SP. Assessing the nation's health literacy: Key concepts and findings of the *National Assessment of Adult Literacy (NAAL) American Medical Association Foundation*, 2008.

CHAPTER

4

Stress and Burnout Syndrome

Medha Anant Joshi

Key Points

- Stress or distress affects the physical, physiological and psychological wellbeing of a person.
- Burnout is a multi-dimensional syndrome seen in persons associated with human-oriented jobs.
- Burnout may reduce the patient safety, and self-efficacy of healthcare professionals.
- Different coping strategies are adapted by different persons for different stressful situations to overcome stress.
- Coping is a dynamic process that involves both cognitive and behavioural responses to stressful situations.

INTRODUCTION

We have often heard students and sometimes even teachers say this after a very busy semester, '*I am totally stressed out or I am just so exhausted*'. Is this stress, exhaustion and burnout related to the work that they are doing or is it just that some people are not able to take on extra workload and feel this way? Or, when a caregiver shows signs of burnout is it due to her job demand or emotional attachment to her patients?

STRESS

Certain optimum level of stress is considered as appropriate for being productive and creative and is accompanied with good mental and physical performance. The words 'eustress', and 'distress', describe the positive and negative aspects of stress in a person's life. This positive stress is helpful especially when faced with challenging and difficult tasks. But when the optimum stress levels are negatively influenced by internal and external factors, it manifests as physical and psychological disorders and is described as distress.

Stress during higher education can lead to mental distress and affect the learning. High levels of anxiety and depression have been reported among college students from all parts of the world. The concepts of stress, mental distress and self-perceived depression overlap to a great extent (M. Dahlin et al, 2005).

Stress can be experienced not only during professional studies, but also before, during the transition from undergraduate to professional level, and after, and during the transition to the practicing professional. The cause of stress among the university students may be attributed to academic work, environment, time management, personality traits, and financial burden (Heins et al, 1984). Psychological distress is reported in literature among medical students quite frequently as compared to

general population (M. Dahlin et al, 2005; Dyrbye et al, 2006, 2011; Tyssen et al, 2004).

High levels of stress seen in university students, especially during the university examination time, affects their health causing high degree of dropout. Family conflicts, female gender, few sleep hours and poor academic performance are the other stressors among university students.

BURNOUT

The term burnout was first coined by Herbert Freudenberger in 1974 in the USA in context of "staff burnout" and correlated job dissatisfaction with work-related stress (Freudenberger, 1974). He described it as a syndrome affecting mostly the persons holding jobs with high ethical and social responsibilities.

In the World Health Organization International Classification of Diseases (ICD), 11th revision (Berg, 2019), burnout is included in section on "problems related to employment and unemployment" and is described as *'feelings of energy depletion or exhaustion, increased mental distance, or feelings of negativism or cynicism related to one's job and reduced professional efficacy'*. In ICD 11 it is identified as an occupational related ailment and not a medical illness.

Burnout has been identified as an occupational risk for people dealing with human-oriented professions; be it healthcare, education or caregivers. In all these vocations, altruism, i.e. to be selfless and put others' needs first, to go beyond the call of duty to ensure that the patient's, student's or client's requirements are met to the best of one's ability, are taken as primary responsibilities. And then there are organizational factors such as funding, or policies that result in increased workload and reduced resources that affect the person working in such environment. Not only these but other professions where client is considered supreme are also getting affected by the stress and burnout syndrome (Maslach and Leiter, 2016).

As described by Maslach and Jackson (1981a), burnout is a three-dimensional syndrome, manifested as excessive emotional exhaustion that is associated with cynical attitude, and an inclination to gauge oneself negatively especially in relation to their work with patients or a declined sense of personal accomplishment **(Fig. 4.1)**. Feeling of being emotionally strained and having worn-out one's emotional resources is referred as emotional exhaustion. Depersonalization (now labelled cynicism) refers to a negative, callous and detached or inappropriate

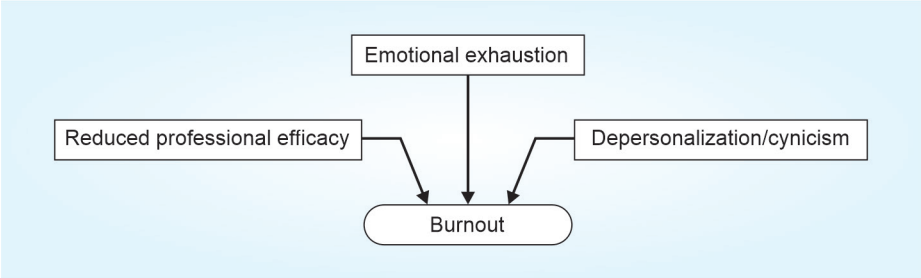

Fig. 4.1: Main dimensions of burnout

attitude towards the people one works with, such as patients, clients or students. When someone assesses his/her own work performance negatively, it denotes reduced personal accomplishment (Schaufeli et al, 2017) or inefficacy. Of these three components, emotional exhaustion has been shown as the key component of the burnout and affects the work performance the most (Wright and Bonett, 1997).

While most of the researchers agree on what burnout is, there seems to be no agreement about what it is not. Many a times the terms stress and burnout are used synonymously; conceptually and theoretically it would be better to treat these two terms separately (Guglielmi and Tatrow, 1998).

Theoretical framework divides burnout in three models (Oranje, 2001):

- ***The interaction model:*** This model considers burnout as a problem arising out of one's inability to cope up with real or perceived stressors in their work environment.
- ***Response or physiological model:*** When an individual experiences both mental and physical exhaustion when stuck in a situation that results in a heavy emotional toll.
- ***Environmental stressor model:*** When the stressors like organizational working atmosphere results in burnout, for example, lack of social support between teachers and students, colleagues or superiors trigger burnout syndrome (Brouwers and Tomic, 1999).

BURNOUT AMONG TEACHERS

As seen with other human services, burnout has been reported among teachers, too. If teachers continue working even if burnt out, this will have a negative effect, not only on their physical and mental health, but will adversely affect students and educational system. Burnt out teachers manifest irritability and difficulty in handling students' disruptive behaviour in the classroom (Evers et al, 2004). Students look up to teachers for guidance and as role models. A stressed or burnt out teacher affects the learning environment and ultimately the educational goals of the institution. A burnt out teacher who shows very little interest in her/his students' progress, is likely to induce apathy among students, cynicism towards students, absenteeism and finally a decision to leave the job. Burnout in teachers is associated with poor physical health, too (Guglielmi and Tatrow, 1998).

Changes in medical education, healthcare system and public expectations have increased the demands on medical teachers. When the occupational demands on the medical teacher exceeds his/her capabilities and resources, it invariably results in stress and burnout (Harden, 1999). Three main factors are associated with stress in teachers—total workload and day-to-day work demands, and lack of autonomy to carry out the work, requirement to adapt and adopt teaching–learning (TL) approaches with which the teacher is not familiar.

Work burden in medical teachers is related to factors such as increased number of students without suitable increase in number of teachers, and continuous teaching throughout the year without adequate breaks that leaves no time for teachers to

recover from the work stress. Another important factor contributing to stress is the new curriculum with early clinical exposure, where clinicians are expected to start teaching right from year one. This invariably results in increased workload.

Another factor causing stress and burnout is the multiple roles a teacher is expected to take on and the teacher's ability to meet these expectations. With the new curriculum, the teacher is expected to take part in integrated teaching, student-centred learning strategies, carry out multiple performance assessments, give feedback to student and be a mentor, in addition to the regular teaching in her/his own subject. He/she may not be adequately prepared to take up the new roles and additional responsibilities.

Curriculum evaluation, quality assurance and accreditation documentation add to the work demands. The workload is increased both in terms of quality and quantity. A clinical teacher has to balance between the clinical work, teaching responsibilities, research activities and administrative responsibilities within the given time. Such pull from multiple directions may lead to reduced performance and job dissatisfaction.

When the teacher is not very clear about his/her role and responsibilities in the newer teaching/learning strategies such as problem-based learning, community based teaching or integrated teaching, this leads to role conflict and ultimately to stress and burnout (Davis and Harden, 1999). In general, teaching load in medical education is high and more demanding. In such a situation, any change itself is likely to induce stress.

Three models of stress have been proposed to explain the relation between the stressed and stressors.

Person-environment fit model (Harrison, 1978): According to this model, when the job demands and the person's ability to meet those demands do not match, it results in stress.

The effort-reward model (Siegrist, 1996): When the efforts made to meet the work demands do not match with the financial rewards or the promotions, likelihood of stress are high.

Demands-supports-constraints model (Payne and Fletcher, 1983): As per this model there is a lack of support or resources to meet the increased demands resulting in stress. Most of the times, changes in medical curriculum are expected to be implemented without much thought for additional resources, either in terms of manpower or infrastructure or financial requirements, leading to stress.

Stress Management Approaches in Medical Teachers

Stress in medical teachers is a potentially critical issue that needs to be addressed at individual and institutional level with suitable strategies. Some of the suggested approaches are (Harden, 1999):

- Make the roles and responsibilities of the teachers clear while implementing any change.

- Try to match the capabilities of a teacher with the roles expected of them.
- Reward the commitment and efforts of the teacher who excels in his/her work.
- Distribute the workload in such a way that no one teacher is overloaded.
- May be time is right to employ a few clinicians for teaching only, thereby reducing the workload on other clinicians.
- Reducing the top-down approach and giving more autonomy to teachers for planning their teaching learning strategies.
- Faculty development programs to be conducted for all faculty members before introducing any new teaching or assessment approaches.

BURNOUT AMONG POSTGRADUATES, RESIDENTS AND CLINICIANS

The intense emotional stress that the doctors face in their workplace makes them more prone to burnout. The detrimental consequences of work-related stress and burnout could result in mental depression, medical errors that might ultimately affect the patient safety and potential compromise of quality of care.

Postgraduate (PG) training seems to put the PGs under stress leading to burnout, the seeds of which might have been sown during undergraduate studies. Due to stress they may fail to develop an appropriate professional relationship with the patients, and make proper diagnostic or treatment decisions (IsHak et al, 2009). A variety of factors contribute to burnout in physicians, and seems to be a cumulative, long drawn process (ME Dahlin and Runeson, 2007; Dyrbye et al, 2006; McManus et al, 2004). The prevalence of burnout increases as the PG progresses from 1st year to final year. They also become more cynical and less humanistic during the course of study. Both of these may lead to emotional exhaustion and depersonalization, causing burnout. Prevalence of burnout is shown to be correlated with the subject specialty (Martini et al, 2004) with obstetrics and gynaecology and psychiatry residents showing highest burnout rate and family medicine, the least.

Factors Causing Stress and Burnout in Residents

Common stressors reported by residents are: Time demands, inapt time management, work planning, organization of work and studies, and interpersonal relationships (Cohen and Patten, 2005). Other stressors that lead to burnout are dissatisfaction with clinical faculty, mood fluctuations, and marital status (Martini et al, 2004). Poor work environment, poor career development, poor work-life balance and financial worries were other stressors identified **(Fig. 4.2)** (Zhou et al, 2020). Patient violence and suicide aggravate burnout among psychiatry PGs.

Being married and having children seems to have a calming effect and less stress. Logically, having added responsibility of a life partner and children would lead to additional stress, but parenting seems to have a softening effect on residents and a protective effect against burnout. Having a child during residency has shown to make the residents less cynical, decreased their suicidal tendency and made them more humanistic (Collier et al, 2002).

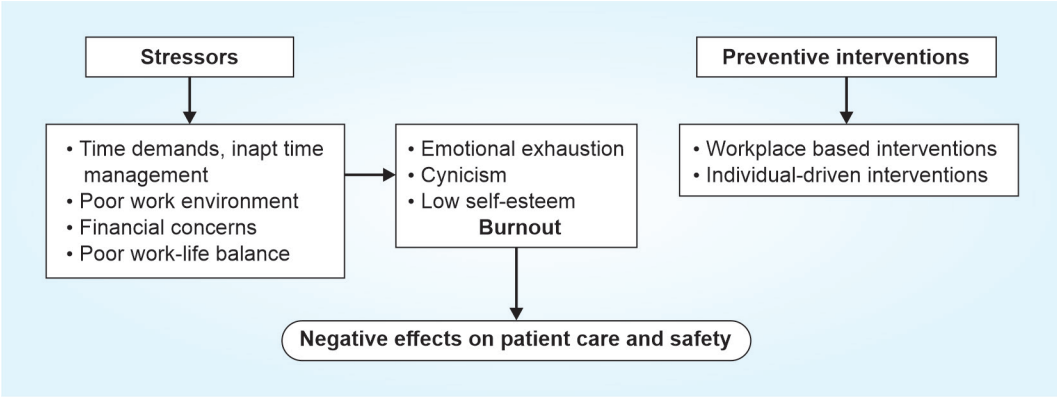

Fig. 4.2: Stressors, effects and preventive interventions for burnout during post graduation

Clinicians seem to manifest the burnout dimensions sequentially, with emotional exhaustion appearing initially. If not identified and treated, it proceeds to depersonalization in an attempt to deal with exhaustion; finally, the capacity to face the demands of work lessens, resulting in feelings of low self-esteem (Gracino et al, 2016).

Influence of Burnout on Patient Care

Stressed or burnt out PGs and clinicians end up making more number of medical errors, have difficulty in rapport building and making accurate diagnostic decisions **(Box 4.1)**. The Accreditation Council for Graduate Medical Education (ACGME) decided to restrict the work hours of residents to 80 hours/week, and no more than 24 hours duty, in July 2003, with the intention of reducing the burnout rate during residency. Though this step has had positive effect on burnout, it has negatively affected the academic activities and surgical work of residents (Martini et al, 2006).

BOX 4.1: Burnout among residents/postgraduates

- It is due to a complex interaction between environmental stressors, genetic susceptibilities, and coping ability.
- It can contribute to multiple physical symptoms, psychological symptoms, and substance abuse.
- It affects quality of life, ability to provide reliable and safe patient care, quality of learning and teaching
- The negative impact of burnout on patient care includes chances of medical errors, patient safety risks, and reduction of quality of care.

Interventions to Reduce Burnout during Post Graduation

Interventions may be implemented at two levels: Interventions at workplace, and interventions at individual level.

Workplace-based interventions include: Stress reduction programs; increasing awareness of burnout among faculty and staff; ensuring a reasonable workload; introducing them to various other clinician's roles such as teaching, research, and supervision; formal mentoring program; team building exercises and emotional intelligence training; programs to support residents to handle both personal and professional issues, under strict confidentiality; and programs that teach residents about time management, stress management, meditation and other relaxation techniques.

Individual: Interventions to reduce stress and burnout among residents include—consulting peers when faced with difficult cases; spending leisure time with peers, sharing laughs, voicing challenges at workplace; developing work-related social network—this can be done when attending conferences, lectures or workshops; performing physical exercise, meditation reduces anxiety and depression and hence chances of burnout; mindfulness techniques, yoga, reflective writing, spiritual activities, scheduled daily breaks for rest, music, massage, and enjoying nature; mentors and faculty members serve as role models and practice some of these techniques for the residents to follow.

As Maslach (2003) summed up effective solution for preventing burnout—'*If all of the knowledge and advice about how to beat burnout could be summed up in 1 word, that word would be* ***balance****—balance between giving and getting, balance between stress and calm, balance between work and home.*'

BURNOUT IN MEDICAL STUDENTS

Medical students at various stages of their training show signs of stress and burnout (Dyrbye et al, 2010). Of the triad of burnout syndrome, high emotional exhaustion is more prevalent among medical students. Students at different stages of study such as preclinical students, paraclinical students and interns have different stressors that cause distress and burnout. First years exhibit emotional and physical exhaustion, whereas paraclinical and clinical students start showing signs of cynicism. Final year students stress out because they feel the education system is not preparing them adequately to face the future with confidence.

Stressors in Medical Students

The academic stressors such as heavy curricular load, tight time schedule, demanding and different educational environment, and dissection of the dead bodies are common for new entrants to medical college. The active, student-centered teaching/learning strategies adopted in medical education, which are quite distinct from the ones the students were familiar with during their pre-medical days, becomes a stressor. Language barrier, especially when coming from vernacular background, that leads to faulty communication with peers and teachers, adds to the distress.

As they progress to 2nd year, contact with very sick patients, dealing with serious illnesses and death, and lack of time for leisure activities with family and friends are contributing factors for inducing stress. Lack of support from teachers and not clear about their roles act as stressors as students' progress in their studies. Lack of feedback from teachers appears to be a common stress factor through all years of medical studies (M. Dahlin et al, 2005; Dyrbye et al, 2006).

Social factors such as staying away from family for the first time, adjusting to new place of living and study, cultural shock for students coming from smaller places are some of the social stressors identified in first year students. Social and family expectations add to the stress levels.

Financial problems, as well as uncertainties of the future once they become interns, self-awareness of incompetence to practice independently are the triggers for stress and burnout during the later years of undergraduate studies.

Effects of Distress and Burnout in Medical Students

Even if a student shows signs of any one of the three dimensions of the burnout syndrome, it is likely to interfere in their studies as well as manifest in the form of physical symptoms such as drowsiness, fatigue, eating disorders, migraine, emotional instability, and may lead to alcohol and substance abuse (Arora et al, 2016). Psychological morbidity, anxiety, depression and suicidal ideation are much higher in medical students as compared to general, population (Dyrbye et al, 2011; Heinen et al, 2017; Moffat et al, 2004). This is a major problem as burnout affects professionalism, leads to dropout, and desperate measures, and results in higher levels of suicide.

Interventions for Coping

Personal traits such as adaptive behaviour, healthy lifestyle, optimism, resilience, greater flexibility, and problem-solving capacity are helpful in copying with distress and burnout. Higher self-efficacy results in mental and physical wellness. Further stress reduction practices like meditation, yoga, relaxation techniques must be adopted. Peer support groups are very important, as are mentorship programs and faculty support and feedback on a regular basis. Students must be encouraged to participate in co-curricular activities. At the same time, psychological and career counselling facilities must be made available free of cost.

To address issue of stress and burnout, many medical colleges have started student support groups and other activities that could reduce their stress levels and future burnout. Individual student may develop his/her survival attitude as a copying strategy with the hope that the stressful situation will improve once they enter post graduation.

It is essential to select prospective medical students with necessary ability and commitment to pursue career in medicine, to ensure that they understand the demands, and challenges they are likely to face in this profession. Training in humanities would go a long way to teach them to be altruistic, committed to their goals of serving the sick and improving the health of the community.

BURNOUT AMONG CAREGIVERS

Care giving can be rewarding as well as a demanding work. It is observed that the negative consequences outway the positive effects of care giving. Caregivers could be categorised into two categories—informal and formal caregivers.

Informal caregivers are those individuals who willingly take the responsibility of caring for a relative or a friend who is ill, facing disability, or any condition that requires specific care (Schulz and Tompkins, 2010). They occupy an important place in enhancing the psychological well-being and physical health of the people suffering from disability and inadequate functioning. Informal caregiver burnout was first described as 'spouse burnout syndrome' (Ekberg et al, 1986). They will be able to carry out their task if they are physically and psychologically in good health. Hence, it is essential to focus on the extent and influence of burnout among caregivers to ensure their effectiveness.

Informal caregivers show more emotional exhaustion, and, to a lesser extent, depersonalization and reduced personal accomplishment (Gérain and Zech, 2021) as compared to non-caregivers. Informal care giving is associated with increased levels of depression and anxiety, extreme fatigue, stress, anger, frustration, feeling overwhelmed, poorer self-reported physical health, compromised immune function and increased mortality. They feel socially isolated and the financial loss, if they had to stop working (Dharmawardene et al, 2016).

Formal caregivers who are engaged in taking care of geriatric population, those with chronic neurological diseases such as Alzheimer's or dementia, or those providing care at palliative centres or nursing homes are more prone for burnout. This may be due to the frequency of deaths observed, and the stress of caring for physically dependent patients afflicted by severe chronic diseases (Blanchard et al, 2010; Gosseries et al, 2012). Younger age, female gender and workload, especially at night are the predisposing factors for burnout. Burnout in the caregiver may result in absenteeism, leaving the job, depression or suicide (McGilton et al, 2013; Piers et al, 2012).

Burnout can have significant consequences on the quality of care. It increases the risk of neglect and abuse, especially in geriatric population (Bužgová and Ivanová, 2011; McDonald et al, 2012). A direct impact on patient mortality is observed, too (Wallace et al, 2010).

Preventive measures to improve satisfaction at work and mitigate burnout among informal care givers include:

- Doing relaxing activities such as cooking, going to place of worship, or taking on leisure activities they used to do prior to becoming the primary caregiver.
- Allowing caregivers regular leisure time.
- Counselling—finding someone with whom they can share their feelings. Consult a professional if need be.
- Maintaining sense of humor—it is okay to laugh and be humorous to lighten up the stressful moments.
- Build a local support system.

- Mindfulness meditation, focused concentration, open awareness, body/internal focus, nature/external focus, yoga, tai chi, qigong.
- Institutional support groups or Balint groups may also prevent exhaustion.

ASSESSING STRESS AND BURNOUT

Instruments to measure stress: The stress can be assessed using wide range of measures, like:

- Beck's Depression Inventory (BDI) (Peterlini et al, 2002; Stewart et al, 1997)
- General Health Questionnaire 12 (GHQ-12) (Guthrie et al, 1998)
- Symptom Checklist (SCL) (Bramness et al, 1991).

It can be monitored using specific measures such as:

- Perceived Medical School Stress (PMSS) scale (M. Dahlin et al, 2005)
- Higher Education Stress Inventory (HESI) (Stewart et al, 1997)

Instruments to measure burnout: One of the most popular instruments was introduced by Maslach and Jackson in 1981, the Maslach Burnout Inventory (MBI) (Maslach et al, 1996; Maslach and Jackson, 1981b). The MBI is designed to assess the three dimensions of the burnout experience. Later on, versions specific to educators (MBI-ES), human service workers (MBI-HSS) and for students (MBI-SS) have been constructed and widely used.

The Bergen Burnout Inventory (BBI) (Salmela-Aro et al, 2011) assesses three dimensions of burnout at work. The Oldenburg Burnout Inventory (OLBI) assesses the two dimensions of exhaustion and disengagement from work (Halbesleben and Demerouti, 2005). The Copenhagen Burnout Inventory (CBI) (Kristensen et al, 2005), and the student version (CBI-SS) is another widely used inventory to measure burnout in general population and students, respectively.

COPING WITH STRESS

All of us have faced stressful situations in our lives, some time or the other. How each individual responds to stress is quite different, a situation considered as stressful by one person may not be perceived as stressful by another. As per the transactional model of stress and coping (RS Lazarus, 1984), the experience of stress is an interaction of the person and the situation. A situation considered as harmful, intimidating or challenging and that cannot be handled with the available resources are perceived as stressful. Here the resources are one's personality, education, previous experience, age, physical and mental health, social support and finances (Stephenson and DeLongis, 2020). The intellectual and behavioural responses implemented to face the situation is called coping (Folkman et al, 2000). Both effective and failed attempts at managing stress are included as coping.

As coping strategies vary from person to person and from one situation to another it is very difficult to match a particular stressor to a definite coping method. Coping is an active process and persons who change their coping style to suit the situation are considered effective copers. For example, the initial response to a diagnosis of

chronic neurological disease is invariably denial, but as the person and his family members accept the diagnosis, they start adapting to the situation gradually.

Tripartite model of coping has been proposed (Stephenson et al, 2016) that addresses different functions of the coping process.

1. ***Problem-focused coping:*** This is either focused on the situation when the efforts are directed towards changing the situation or focused on changing ourselves, such as learning new skills to increase personal resources. The steps involved in former coping mechanism include defining the tricky situation, thinking of alternative solutions, comparing these alternatives in terms of their likely costs and benefits, picking the most possible solution, coming up with a plan, and then implementing it.

   If a situation is perceived as highly threatening, this coping strategy may not work. It is best suited for situations which are considered to be amenable to change. For example, problem-focused coping will not work when one is trying to cope with a death of a loved one. In such situations the emotional-focused strategy may be more effective.
2. ***Emotional-focused coping:*** The principal aim of this strategy is to reduce the emotional distress. This could be tried through distancing oneself from the situation, or avoiding it. This type of denial strategies are frequently used during cognitive behavioural therapies (Stephenson et al, 2016).
3. ***Relationship-focused coping:*** It is very important to maintain social relationships during the coping stage (Coyne and Smith, 1991). It is important to keep in mind the effect of one's coping efforts that might have on the close relations. Relationship-focused coping strategies pay attention to providing support, responding compassionately, and trying to resolve issues (O'Brien and DeLongis, 1996) However, such relationship-focused strategies have shown to have both positive and negative effects on the relationships.

Based on the situation, these coping functions can be combined effectively. Contextual factors such as the type of the stressful situation, the personality of the individual, and social context can all impact whether or not a particular coping strategy will be effective.

RUST OUT

As the name suggests, rust out is burnout's boredom-based counterpart **(Fig. 4.3)**. Instead of work overload, if someone has to do an uninspiring job that fails to stimulate, is much below one's capabilities, the person may 'rust out'. Occupational psychologists believe that the harm caused by boredom may exceed that caused by overwork. Unchecked rust out can lead to depression and even physical symptoms. Similar to rusting of the tool, this too is a slow, long drawn process.

It is most commonly seen in midlevel and younger faculty. The causes identified are—lack of empowerment, paperwork overload, endless meetings, repetitive tasks, and no scope for creativity.

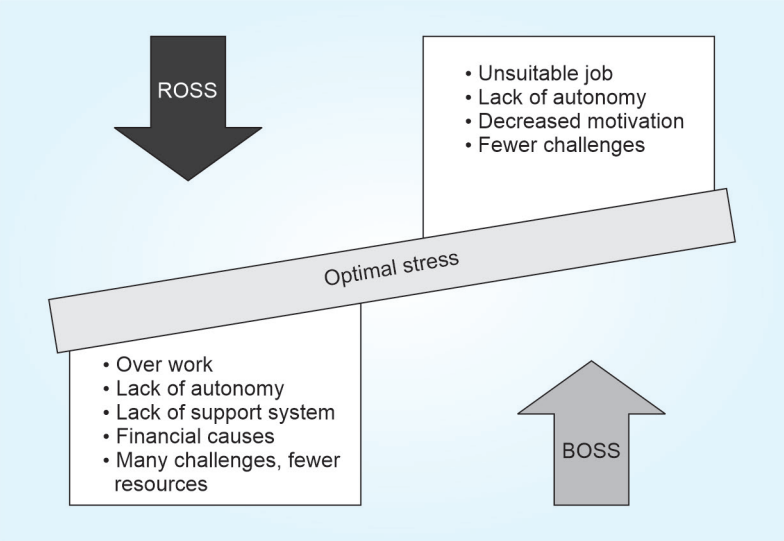

Fig. 4.3: Relation between burnout stress syndrome (BOSS) and rust out stress syndrome (ROSS)

This syndrome can be seen in students, too, especially those who are very bright, talented or gifted. They may find the routine teaching in the class too dull or boring and may stop attending the classes. This 'one size fits all' method of teaching may gradually result in loss of interest in the studies, leading to dropout or depression. Rust out may be seen in another set of students, those who do not have any motivation in pursuing their studies, having been forced to take up a professional course which is not of their choice. They become disinterested and apathetic. This rust out stress pushes them towards alcohol and substance abuse (Arora et al, 2016).

Whether rust out is affecting the employees or the students, the institutional administrators should recognize this entity and have strategies in place to prevent it. It is important to ensure that people skills and jobs match and that the workplace has, that little bit of stress (optimum) that is good for employees **(Fig. 4.4)**.

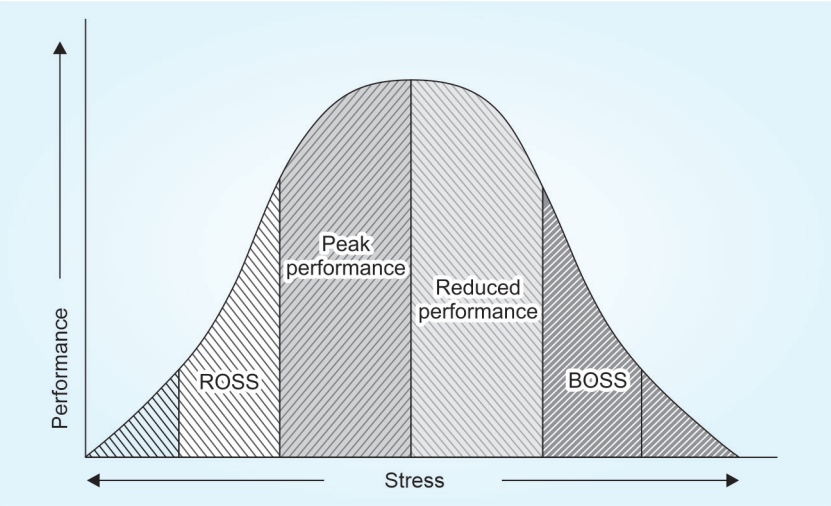

Fig. 4.4: Relationship between stress and performance

The first category of students should be identified during the initial phase and given additional, stimulating inputs. The second category needs to be counselled, mentored and monitored to prevent the rust out.

CONCLUSION

Stress and burnout are commonly seen in persons working in human-oriented jobs including teachers, physicians, medical students and caregivers. It is a complex phenomenon that reflects the interaction between environmental stressors, personality of the individual, and coping styles. Burnout can result in physical, and/or psychological symptoms, and substance abuse, all of which can have a bearing on the person's quality of life, ability to provide sustainable and safe patient care, quality of learning and teaching, and the overall morale of a caregiver.

Burnout must be addressed by leadership in academic institutions and hospitals. As we move toward national healthcare reform and attempt to upgrade our approach to training UGs and PGs, attention must be paid to personal well-being. This is critical to produce effective, humane next generation of physicians.

BIBLIOGRAPHY

- Arora, A, Kannan, S, Gowri, S, Choudhary, S, Sudarasanan, S, and Khosla, PP. Substance abuse amongst the medical graduate students in a developing country. *The Indian Journal of Medical Research:*2016;143(1):101–3.
- Berg, S. WHO adds burnout to ICD-11. What it means for physicians. *American Medical Association, Physician Health.* July 2019.
- Blanchard, P, Truchot, D, Albiges-Sauvin, L, Dewas, S, Pointreau, Y, Rodrigues, M, Xhaard, A, Loriot, Y, Giraud, P, and Soria, JC. Prevalence and causes of burnout amongst oncology residents: A comprehensive nationwide cross-sectional study. *European Journal of Cancer* 2010;46(15):2708–15.
- Bramness, JG, Fixdal, TC, and Vaglum, P. Effect of medical school stress on the mental health of medical students in early and late clinical curriculum. *Acta Psychiatrica Scandinavica* 1991;84(4):340–45.
- Brouwers, A, and Tomic, W. Teacher burnout, perceived self-efficacy in classroom management, and student disruptive behaviour in secondary education. *Curriculum and Teaching* 1999;14(2):7–26.
- Bužgová, R, and Ivanová, K. Violation of ethical principles in institutional care for older people. *Nursing Ethics* 2011;18(1):64–78.
- Cohen, JS, and Patten, S. Well-being in residency training: A survey examining resident physician satisfaction both within and outside of residency training and mental health in Alberta. *BMC Medical Education* 2005;5(1):1–11.
- Collier, VU, McCue, JD, Markus, A, and Smith, L. Stress in medical residency: Status quo after a decade of reform? *Annals of Internal Medicine* 2002;136(5):384–90.
- Coyne, JC, and Smith, DA. Couples coping with a myocardial infarction: A contextual perspective on wives' distress. *Journal of Personality and Social Psychology* 1991;61(3):404.

- Dahlin, ME, and Runeson, B. Burnout and psychiatric morbidity among medical students entering clinical training: A three-year prospective questionnaire and interview-based study. *BMC Medical Education* 2007;7(1):1–8.
- Dahlin, M, Joneborg, N, and Runeson, B. Stress and depression among medical students: A cross-sectional study. *Medical Education* 2005;39(6):594–604.
- Davis, MH, Harden, RM. AMEE Medical Education Guide No. 15: Problem-based learning: a practical guide. *Medical Teacher* 1999;21(2):130–40.
- Dharmawardene, M, Givens, J, Wachholtz, A, Makowski, S, and Tjia, J. A systematic review and meta-analysis of meditative interventions for informal caregivers and health professionals. *BMJ Supportive and Amp; Palliative Care* 2016;6(2):160. https://doi.org/10.1136/bmjspcare-2014-000819
- Dyrbye, LN, Harper, W, Durning, SJ, Moutier, C, Thomas, MR, Massie Jr, FS, Eacker, A, Power, DV, Szydlo, DW, and Sloan, JA. Patterns of distress in US medical students. *Medical Teacher* 2011;33(10):834–39.
- Dyrbye, LN, Thomas, MR, Power, DV, Durning, S, Moutier, C, Massie Jr, FS, Harper, W, Eacker, A., Szydlo, DW, and Sloan, JA. Burnout and serious thoughts of dropping out of medical school: A multi-institutional study. *Academic Medicine* 2010;85(1):94–102.
- Dyrbye, LN, Thomas, MR, and Shanafelt, TD. Systematic review of depression, anxiety, and other indicators of psychological distress among US and Canadian medical students. *Academic Medicine* 2006;81(4):354–73.
- Ekberg, JY, Griffith, N, and Foxall, MJ. Spouse burnout syndrome. *Journal of Advanced Nursing* 1986;11(2):161–65.
- Evers, WJ, Tomic, W, and Brouwers, A. Burnout among teachers: Students' and teachers' perceptions compared. *School Psychology International* 2004;25(2):131–48.
- Folkman, S, Lazarus, RS, Dunkel-Schetter, C, DeLongis, A, and Gruen, RJ. (2000). *The dynamics of a stressful encounter*. In: Higgins ET, Kruglanski AW (Eds), motivational science: Social and personality perspectives. Psychology Press; pp. 111–117.
- Freudenberger, HJ. Staff burn-out. *Journal of Social Issues* 1974;30(1):159–65.
- Gérain, P, and Zech, E. Do informal caregivers experience more burnout? A meta-analytic study. *Psychology, Health and Medicine*, 2021;26(2):145–61.
- Gosseries, O, Demertzi, A, Ledoux, D, Bruno, MA, Vanhaudenhuyse, A, Thibaut, A, Laureys, S, and Schnakers, C. Burnout in healthcare workers managing chronic patients with disorders of consciousness. *Brain Injury* 2012;26(12):1493–99.
- Gracino, ME, Zitta, ALL, Mangili, OC, and Massuda, EM. Physical and mental health of medical professionals: A systematic review. *Saúde Em Debate* 2016;40:244–63.
- Guglielmi, RS, and Tatrow, K. Occupational stress, burnout, and health in teachers: A methodological and theoretical analysis. *Review of Educational Research* 1998;68(1): 61–99.
- Guthrie, E, Black, D, Bagalkote, H, Shaw, C, Campbell, M, and Creed, F. Psychological stress and burnout in medical students: A five-year prospective longitudinal study. *Journal of the Royal Society of Medicine* 1998;91(5):237–43.
- Halbesleben, JR, and Demerouti, E. The construct validity of an alternative measure of burnout: Investigating the English translation of the Oldenburg Burnout Inventory. *Work and Stress* 2005;19(3):208–20.
- Harden, RM. Stress, pressure and burnout in teachers: Is the swan exhausted? *Medical Teacher* 1999;21(3):245–247.

- Harrison, R van. Person-environment fit and job stress. *Stress at Work* 1978;175–205.
- Heinen, I, Bullinger, M, and Kocalevent, RD. Perceived stress in first year medical students-associations with personal resources and emotional distress. *BMC Medical Education* 2017;17(1):1–14.
- Heins, M, Fahey, SN, and Leiden, LI. Perceived stress in medical, law, and graduate students. *Journal of Medical Education* 1984;59(3):169–79.
- IsHak, WW, Lederer, S, Mandili, C, Nikravesh, R, Seligman, L, Vasa, M, Ogunyemi, D, and Bernstein, CA. Burnout during residency training: A literature review. *Journal of Graduate Medical Education* 2009;1(2):236–42.
- Kristensen, T, Borritz, M, Villadsen, E, Christensen, KB. The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work and Stress* 2005;19(3):192–207.
- Martini, S, Arfken, CL, and Balon, R. Comparison of burnout among medical residents before and after the implementation of work hours limits. *Academic Psychiatry* 2006;30(4): 352–55.
- Martini, S, Arfken, CL, Churchill, A, Balon, R. Burnout comparison among residents in different medical specialties. *Academic Psychiatry* 2004;28(3):240–42.
- Maslach, C, Jackson, SE. Maslach Burnout Inventory—ES Form (MBI) [Database record]. APA Psyc Tests 1981. Accessed on 24.12.2022. Available from: https://doi.org/10.1037/t05190–000.
- Maslach, C, and Jackson, SE. The measurement of experienced burnout. *Journal of Organizational Behavior* 1981b;2(2):99–113.
- Maslach, C, Jackson, SE, and Leiter, MP (1996). *MBI: Maslach burnout inventory.* Consulting Psychologists Press Palo Alto, CA.
- Maslach, C, and Leiter, MP (2016). Burnout. In: *Stress: Concepts, cognition, emotion, and behavior* (pp. 351–357). Elsevier.
- McDonald, L, Beaulieu, M, Harbison, J, Hirst, S, Lowenstein, A, Podnieks, E, and Wahl, J. Institutional abuse of older adults: What we know, what we need to know. *Journal of Elder Abuse and Neglect* 2012;24(2):138–160.
- McGilton, KS, Tourangeau, A, Kavcic, C, and Wodchis, WP. Determinants of regulated nurses' intention to stay in long-term care homes. *Journal of Nursing Management* 2013;21(5):771–81.
- McManus, IC, Keeling, A, and Paice, E. Stress, burnout and doctors' attitudes to work are determined by personality and learning style: A twelve year longitudinal study of UK medical graduates. *BMC Medicine* 2004:2(1):1–12.
- Moffat, KJ, McConnachie, A, Ross, S, and Morrison, JM. First year medical student stress and coping in a problem-based learning medical curriculum. *Medical Education* 2004;38(5):482–91.
- O'Brien, TB, and DeLongis, A. The interactional context of problem-, emotion-, and relationship-focused coping: The role of the big five personality factors. *Journal of Personality* 1996;64(4):775–813.
- Oranje, AH (2001). Van ouderenbeleid tot lerarentekort [From Policy on Elderly Workers to Teacher Shortages]. *Nijmegen: Mediagroep KUN*.
- Payne, R, and Fletcher, BC. Job demands, supports, and constraints as predictors of psychological strain among schoolteachers. *Journal of Vocational Behavior* 1983;22(2),:136–47.
- Peterlini, M, Tibério, IF, Saadeh, A, Pereira, JC, and Martins, MA. Anxiety and depression in the first year of medical residency training. *Medical Education* 2002;36(1):66–72.

- Piers, RD, Van den Eynde, M, Steeman, E, Vlerick, P, Benoit, DD, and Van Den Noortgate, N. J. End-of-life care of the geriatric patient and nurses' moral distress. *Journal of the American Medical Directors Association* 2012;13(1):80-e7.
- Salmela-Aro, K, Rantanen, J, Hyvönen, K, Tilleman, K, and Feldt, T. Bergen Burnout Inventory: Reliability and validity among Finnish and Estonian managers. *International Archives of Occupational and Environmental Health* 2011;84(6):635–45.
- Schaufeli, WB, Maslach, C, and Marek, T (2017). *Professional burnout: Recent developments in theory and research*. 1st edition. Routledge.
- Schulz, R, Tompkins, CA (2010). Informal caregivers in the United States: Prevalence, characteristics, and ability to provide care. In: *Human Factors in Home Healthcare*. Washington, DC: National Academies of Sciences Press.
- Siegrist, J. Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology* 1996;1(1):27.
- Stephenson, E, and DeLongis, A. Coping strategies. *The Wiley Encyclopedia of Health Psychology* 2020;55–60.
- Stephenson, E, King, DB, and DeLongis, A (2016). Coping process. In *Stress: Concepts, cognition, emotion, and behavior* (pp. 359–364). Elsevier.
- Stewart, SM, Betson, C, Lam, TH, Marshall, IB, Lee, PWH, and Wong, CM. Predicting stress in first year medical students: A longitudinal study. *Medical Education* 1997;31(3):163–68.
- Tyssen, R, Hem, E, Vaglum, P, Grønvold, NT, and Ekeberg, Ø. The process of suicidal planning among medical doctors: Predictors in a longitudinal Norwegian sample. *Journal of Affective Disorders* 2004;80(2–3):191–98.
- Wallace, SL, Lee, J, and Lee, SM. Job stress, coping strategies, and burnout among abuse-specific counselors. *Journal of Employment Counseling* 2010;47(3):111–22.
- Wright, TA, and Bonett, DG. The contribution of burnout to work performance. Journal of *Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior* 1997;18(5):491–499.
- Zhou, AY, Panagioti, M, Esmail, A, Agius, R, Van Tongeren, M, and Bower, P. Factors associated with burnout and stress in trainee physicians: A systematic review and meta-analysis. *JAMA Network Open* 2020;3(8):e2013761.

CHAPTER

5

Human Touch in Doctors

Narendra Nath Laha

Key Points

- Human touch in doctors plays an important role in patient care. 'The doctor–patient relationship' has been and remains a keystone of patient care.
- Empathy is a cornerstone of healthcare profession.
- Understanding psychology is important in doctors. The psyche of a patient decides the treatment modality.

INTRODUCTION

Human touch in doctors for patients makes a relationship which is the keystone of care. The faith factor has to be developed. The doctor should be more interested in patient care rather than earning money. Psychology plays an important role. Sympathy and empathy are important. Positivity and bed side manners are important. Ample time should be given to the patient. Modern tools in patient care are needed. Attendants should be attended. Financial barriers have to be overcome. Robot needs thinking. High-tech interactions have gained legality and popularity.

A doctor is basically meant to treat patients. Obviously the job is to reduce suffering. There is a huge list of medicines. But to give the correct medicine, a doctor is needed. 'The doctor–patient relationship has been and remains a keystone of care: The medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation and support are provided' (Dorr and Mack, 1999).

In the present era doctor–patient relationship has touched a low ebb. The faith factor has vanished. It is strictly on the professional basis that treatment is going on. If the patient recovers then the doctor is good otherwise he/she is bad to worse. The big question is that who is responsible for this debacle?

This brings us to the question of human touch in doctors. This is a fact that this touch is fast vanishing. But it is needed that human touch in doctors should come. If a student enters the medical profession then it should be for the love of it and with a spirit to serve the suffering humanity. If it is for the lure of money, then he/she may be happy but will leave behind grim faces. *'A core element of physical examinations is human touch. Touch is a dominant form of nonverbal communication used in clinical care.*

Although nonverbal communication is addressed in many medical school curricula, the focus tends to be on body language and use of gestures rather than the intimacy of touch' (Kelly et al, 2014).

THE CHANGING SCENARIO

Is the medical profession a business? In the present era this is becoming a truth. But that is not good in the long run. One can earn money from the patient, but should leave behind a recovered patient with smiling faces all around.

Understanding psychology is important in doctors. The psyche of a patient decides the treatment modality. A doctor should understand this. One cannot treat every patient with the same yardstick. This means that the doctor should first understand the thinking of the patient and then explain the treatment. This is a part of human touch in treatment.

In any era, human to human transaction is very important. There are many points besides the disease which needs understanding by the doctor. This only comes when the doctor talks with the patient. This will make treatment more successful.

There are three things in doctor–patient relationship. They are sympathy, empathy and not bothering at all. Empathy is needed because the doctor is in touch with the patient although complete relationship is not developed. This barrier is important. *'Throughout medical school, my instructors stressed the importance of empathy, generally defined as the understanding of and identification with another person's emotional state. Sympathy and empathy, commonly confused with each other, are not the same. Sympathy is a statement of emotional concern while empathy is a reflection of emotional understanding. The applications of empathy are widespread and are especially relevant in fields such as medicine where the successful treatment of patients depends on effective patient–physician interactions'* (Elliot, 2007).

It is the job of the doctor to bring the patient out of isolation and depression. Disease itself is a big cause of isolation and depression. Encouragement is essential from the doctor's side. Facts can be told in a nice manner. This is an art which has to be developed in every doctor. Positivity should be encouraged in the patient. In the present era this is very important in every sphere of life. Counseling helps a lot.

SMALL CHANGES: HUGE REWARDS

Bedside manners are a very important part of treatment. The doctor should be immaculately dressed. This means decent clothes with no shabbiness. This creates a very good impression on the patient. Soft speaking is also helpful. Using the correct words helps. If the patient is rough in talking then also the doctor should be cool. The conversation should start with 'namaste' or 'good morning' or 'any form of greetings'. It is universal facts that the practice of medicine, the scientific part of medical practice, changes with time as we develop better techniques for diagnosis and improved therapies for treatment; but the art of medicine remains constant over the millennia because human nature is unchanging. Patients bring fear, anxiety, and self-pity into the exam room. It has always been the doctor's responsibility to

calm their fears and provide hope. The accomplished doctor has a bedside manner that is humane and compassionate, empathetic and supportive (Silverman, 2012).

The doctor should give ample time to the patient. One should never go by the clock. This does not mean that time should be wasted. There should be justified time for every patient. It should not be that one is looked after too much and the other is neglected. Listen to the patient and show interest. Sometimes the patient talks things which are not worth it. But that also should be heard carefully. For, this is the art of history taking. In case of psychiatric patients this is more important to make a correct diagnosis. We all are aware that 'being a physician' always has been a busy job. Achieving the goal of comprehensive patient-care requires time, availability and effective use of the local healthcare system, along with a broad spectrum of medical knowledge (Dugdale et al, 1995).

Patients are more interested to see their doctors in person rather than on live. Their problems lessen on seeing their doctor. Tele-consultation, though an effective method of dealing with shortage of doctors, fails to provide human touch. Doctors themselves can adopt a novel approach to deal with shortage of physicians and time—the working staff should be trained by the doctor. Perhaps he/she spends more time with the patient than the doctor. So, if the doctor is the base for diagnosis, the working staff may form the core for carrying out instructions and caring for the patents. Employees should be taught how to use the modern tools. Healthcare information technology (IT) tools help providers and patients to manage vital health information. They also help improve the quality of care and make healthcare more cost-effective for providers and patients. Such tools include—electronic health records, referral trackers, patient portals, remote patient monitoring, computerized provider order entry.

Taking care of attendants is a very important part of treatment. They are of different types and usually one of them is hostile. They should be explained everything in detail. All questions should be heard to and explained. A very important element is the human touching of the patient. In the present days, this is at low ebb. Because of the corona epidemic the doctors avoid touching the patients. This issue needs to be addressed. The non-touch technique is OK but the patient is seldom satisfied. Every doctor has to solve this problem in his/her own way.

The doctor should encourage the patients so as to develop a positive attitude. Almost every patient is in a negative frame of mind. It is the job of a doctor to use encouraging words and help in making a positive frame of mind of the patient. The guarded prognosis can be explained to the attendants, but the patient should always be given a positive understanding. It is documented in the literature that extreme positive thinking may promote alternative forms of medicine that ultimately substitute effective treatment, and this is unethical. The emphasis on positive thinking for cancer patients may be too burdensome for them. Likewise, unrestricted positive thinking is not necessarily good for mental health (Andrade, 2019).

Faith is a very important factor in patient care. It takes a long time before the doctor can make his/her impact on the society. A serving job with only the purpose

of solving the disease should be the prime thinking in the mind of the doctor. Once a faith is developed then treatment becomes easier and rewarding.

Financial barriers have to be overcome. What is the use of writing a host of investigations when the patient cannot afford to even have two square meals in a day? Each patient has to be treated by individual methods. Number of times patient has to be referred to another doctor. This reference should be explained to the patient in full. Today is the era of specialties and super specialties. This does not hamper the prestige of the referring doctor. But it is very important that the reference should be correct.

THE CLASSICAL TRIAD

It is the trio of patient, doctor and pharmacist which can deliver goods in today's world. The disease and patient care revolves around these three. A mistake from any one is a blunder. The patient should not hide anything from the doctor. The doctor should make a correct diagnosis and prescription. The pharmacist should give the correct medicine. All this is possible if the human touch is there between the three.

The time is coming when robot will treat the patient to the extent that surgery also will be done by them. But can the robot treat the mind? Satisfaction of the patient can only come when human touch will be there. One must learn to combine technology with treatment. But technology cannot be everything. Every investigation must be correlated with the clinical picture. And for that, human relationship of the doctor and patient is very essential. High-tech interactions have gained legality and popularity. The doctor should take ample advantage of this and help the patient even if physical presence is not possible. It is the communication which is important rather than the method. The doctor should know the method of giving the bad news. This is an art. This is the most difficult part of the medical profession.

Every time the doctor sees the patient, the prescription should be new. This gives satisfaction to the patient that the doctor is taking special care. Scribbling on the same prescription every time becomes irritating. Though, for stable patients with chronic treatment, who has reported for routine check-up, a change of treatment regimen may be uncalled for. Balance of mind of the doctor is very important. He/she should approach the patient with a smiling face and nice talking. This is only possible if the doctor is cool in his/her mind.

CONCLUSION

Treatment of the patient is an art and science both. This art comes gradually. Taking care of illness and the disease person physically is important aspect of medical practice, but equally important is the art of taking care of the emotions and mind of the diseased person and his/her attendants. In the sunset of life, the doctor should feel satisfied that he/she has been honest to the profession and done his/her best.

BIBLIOGRAPHY

- Andrade G. The ethics of positive thinking in healthcare. J Med Ethics Hist Med 2019;12:18. Accessed on 30.09.2022. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7166246/pdf/JMEHM-12-18.pdf.
- Dorr GS, Mack L Jr. The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies. *J Gen Intern Med* 1999;14(Suppl 1):S26–33.
- Dugdale DC, Epstein R, Pantilat SZ. Time and the Patient–Physician Relationship. *J Gen Intern Med* 1999;14(Suppl 1): S34–40.
- Elliot HM. The Role of Empathy in Medicine: A Medical Student's Perspective, Virtual Mentor: *American Medical Association Journal of Ethics* 2007;9(6):423–27.
- Kelly M, Wendy T, Lara N. Keeping the Human Touch in Medical Practice. *Academic Medicine* 2014;89(10):1314.
- Silverman BD. Physician behaviour and bedside manners: The influence of William Osler and the Johns Hopkins School of Medicine. *Proc (Bayl Univ Med Cent)* 2012;25(1):58–61.