What Do Doctors Find Meaningful about Their Work?

Although medical practice has always been difficult and the risk for burnout close at hand, most practitioners have found that the joys and satisfaction of their work have prevailed over the challenges, enabling them to sustain a lifelong commitment to service. Thirteen years ago, we began to conduct workshops to help practitioners reflect on their own experiences in practice and discover and explicitly identify what it is about the practice of medicine that is meaningful to them. We believed that with a clear understanding of what nourished and sustained them, clinicians could attend more consciously and intentionally to enhancing that which was meaningful and attenuating that which was depleting.

Over the ensuing years, the question of meaning in medical practice has acquired greater urgency (1). Rapid changes in the structure and process of health care have altered doctors' roles, prerogatives, and financial compensation and have left many doctors feeling besieged (2). Their attention increasingly has been given over to the business of medicine and to bureaucratic procedures that do not contribute directly to improving health. A growing number of physicians are leaving practice prematurely through early retirement and disability (3, 4). The opportunity to recognize and reconnect with what is most meaningful about practice may be remoralizing to doctors and may help them advocate for their needs more clearly. Such an understanding may also help the leaders and managers of health care organizations access professional roles and clinical processes that allow physicians to maintain their vitality.

Physician satisfaction has been linked to physician relationships, collegial interactions, physicians' personal sense of competence, and (in an inverse manner) bureaucratic aspects of the practice environment (5–11). With few exceptions (12, 13), this research has been based on survey results. To complement and deepen insights from this research, we offer words from practicing physicians on themes they choose to write about. We describe the themes that recur in stories written by doctors about meaningful professional experiences, and the lessons they hold.

Source and Analysis of the Stories

Between 1989 and 1995, we conducted workshops titled "Meaningful Experiences in Medicine" at annual meetings of the American College of Physicians and the Society of General Internal Medicine. At the beginning of the workshops, we asked doctors to write a brief account of a work-related experience that they found meaningful, defined as "something that you found to be important and fulfilling or that reaffirmed your commitment to medicine." After writing for 5 to 10 minutes, participants gathered into groups to share their stories and explore issues that emerged from them. At the conclusion of the workshop, we invited participants to give their stories to a facilitator, who collected them for research and teaching. An estimated 75% to 80% of participants did so, resulting in 83 stories.

We studied the stories by means of narrative analysis, a method of classifying stories according to categories that emerge from repeated readings (as contrasted with classification according to a priori categories) (14). Two of us independently read 20 randomly selected stories to generate a provisional scheme for summarizing and describing the stories (for example, by situation, characters, plot, significance to narrator). These two authors and a third reread the same 20 stories to categorize the specific themes within each dimension of the classification scheme. We then applied our scheme to 20 additional stories and found that our existing set of dimensions and themes was adequate for describing the stories. We then applied our scheme to all the remaining stories.

Themes

Most of the stories involved one of three major themes (and there were many instances of overlap): a fundamental change in the doctor's perspective, a connection with patients, and a difference made in someone's life.

Regarding the first theme, doctors changed their perspectives about themselves, their roles, human nature, illness, and patient care after being part of a profound event or emotional experience with a patient or sharing or reflecting on their own life experiences. One such story reads as follows:

> First home visit to GG [a 4-year-old with retinoblastoma]. Smells, staleness, roaches climbing walls. One-eyed . . . dignified, needy and grasping/clinging. But allowing one angry plea—can't you do something? The agony of "nothing more to do" other than help her son die comfortably. Survivor's guilt. Utter isolation—abandoned by family, needed by kids. Why is she not broken? She has no resources I'd fall back on—no education, family, friends, spiritual framework. Watching (and smelling) her son's head rot with visibly creeping retinoblastoma. . . . Helping his wasted little boy body stand up to pee. Why is she not crushed? Why am I not crushed seeing her?
>
> . . . after a visit like that, you could draw two conclusions about the world. First is that it is a capricious, horrifying place where tragedy ultimately beats us down. Or, that in the face of tragedy, there can be heroic, even victorious love.

Witnessing or reading about this experience may be viscerally disturbing. This doctor, however, went beyond his initial reaction to be inspired by the mother's courage

and acts of love for her son. In fact, these stories about changes of perspective frequently described transformational experiences. Physicians often expanded the boundaries of their role as scientifically detached observers and prescribers of tests and treatments. They recognized their patients as fellow human beings, rather than objects of care.

Many physicians developed an empathic engagement over the course of longstanding relationships with patients, but the following story describes an abrupt confrontation with a patient's humanity.

> I was taking care of a . . . woman with multi-system failure, and I had to insert a central line. I struggled and struggled with the line and was so focused on the small triangle of flesh . . . that I didn't notice she had died until the monitor alarm went off. . . . When I pulled the drape off her face, I saw she was dead. I was terrified—by the feeling I had killed her—and by knowing I could so completely disconnect from someone as a person and treat her as a triangle of flesh, a tube to be cannulated, a problem to be mastered.

This doctor is shocked by her own detachment, but her shock may have led to an emotionally generated recognition that doctors can objectify their patients all too easily.

The second theme is about connecting with patients in moments of intimacy. These moments occurred in the course of relationships lasting anywhere from hours to decades, and in settings ranging from mundane to profound. One doctor wrote:

> I had followed her for several years after she presented with a 40-pound weight loss and an SBO [small bowel obstruction] that turned out to be a carcinoid tumor of the small bowel. . . . [She] had a cord compression and was treated by failed RT [radiation therapy], and finally was readmitted with a UTI [urinary tract infection] and dehydration. . . . Nearing the end, . . . I spoke to her. "The end is coming soon, . . . do you have anything more you need to say?" And she opened her eyes and said, "Honey, I love you." And I said, "I love you too" and she cried, and I cried while I held her hand and stroked her hair. She died several hours later.

In this story, intimacy arose from the patient's emotional expression and the doctor's willingness to respond personally and genuinely. In fact, even the language changed from technical medical jargon to personal narrative.

Some moments of connection resulted from doctors being moved by their patients' humanity. Others were associated with doctors sharing their own emotions and life experiences.

> A patient whom I have seen for a number of years . . . was in the office last week. We were discussing how she was doing when she suddenly looked at me. She touched the side of my head and exclaimed, "You're getting so gray! Are you worrying too much?" For that moment, our roles were entirely reversed, and I felt her warmth, affection, and concern for me as a person. We then spent 10 minutes or so discussing our lives and what was important to us. Afterwards, I felt extremely satisfied with what I was doing in medicine. . . .

The third and most common theme in the doctors' stories was making a difference in someone else's life. These were success stories, but not of brilliant diagnoses or adroit technical interventions. Most of these stories took place in the context of chronic, incurable conditions, or end-of-life care. In these situations, the doctors themselves were the principal therapeutic agents. They felt awed and deeply rewarded that their mere presence could be healing and comforting to patients:

> She had a sudden COPD [chronic obstructive pulmonary disease] exacerbation and was admitted. She was terribly disappointed. Over the next few days she improved. She looked at me and said, "You know, whenever I see you, I feel better. My breathing is better and I feel more relaxed." She touched me and said, "Thanks for all you're doing."

Doctors were often surprised to be thanked in the absence of cure or significant improvement. Some experienced a shift from frustration that they could not eradicate a chronic symptom to affirmation for continuing to care for their patients and do their best. One doctor recounted a final visit with a patient who had a chronic itch and who was relocating:

> She'd seen three consultants without improvement. I'd worked hard to understand her symptoms, but had not been able to diagnose the problem or provide relief. She had been quite discouraged. I felt I'd let her down. . . . As the visit ended, she said, "You're the best doctor I've ever had." I felt she understood how much I wanted her to do well and how hard I'd worked to be supportive. It felt really good.

DISCUSSION

We explored internists' meaningful experiences through a narrative analysis of stories written during workshops. A factor of self-selection in those who attend such workshops is bound to occur. Nevertheless, we were struck that nearly all the doctors, although given deliberately general and nondirective instructions, described a nontechnical, humanistic interactions with patients as experiences that fulfilled them and reaffirmed their commitment to medicine. Rather than recounting tales of diagnostic and therapeutic triumphs, they uniformly told stories about crossing from the world of biomedicine into their patient's world. They described how relationships deepened through

recognizing the common ground of each person's humanity. More than vehicles for medicine or surgery (15), these doctors discovered and were deeply gratified by the intrinsic healing capacity of simply being present.

We were impressed that most stories took place in settings typically associated with medical failure—death and progressive chronic illness. Perhaps, in these settings, practitioners focused less on medical technology, which allowed them more time to recognize their own and their patients' courage and strong emotions. Doctors found meaning in giving up an unrealistic, but protective, sense of control and security and becoming more present with their patients (10). In the absence of curative options, they sought other ways to help their patients: by appreciating them, maintaining their dignity and comfort, and even expressing love to them.

Recent studies found that at least one third of patients' symptoms do not have an exact medical diagnosis (16, 17). Therapy for these symptoms can be disappointing and dissatisfying for patients and doctors (18). While failing to cure an illness may be a common source of frustration for doctors, participants in our study found ways to stay connected to their chronically ill or symptomatic patients and felt privileged to be healers when these patients expressed appreciation for their care. The essence of primary care may well be the unwavering presence of doctors at the sides of their patients, whose suffering may be as common and pathologically benign as an itch and as dramatic and life-threatening as metastatic cancer.

During the workshops, we also observed that doctors felt the process of writing and talking about the stories was both profound and helpful. The process stimulated clarification of personal values and priorities, created a context for peer support (which doctors often seem to resist), and fostered recognition of opportunities to make constructive changes in their professional lives. This process fits with the emerging concept of "narrative medicine" (19). As described by Charon, by writing and reading stories about caring for sick patients in trying situations, physicians can bridge the divide that separates them from their patients, themselves, colleagues, and society, and have fresh opportunities for respectful, empathic, and nourishing medical care (20).

A growing body of research shows that the patient–physician relationship is the most consistently reported and powerful determinant for physician satisfaction (5–9, 21). Some of the experiences we discussed, including connecting with patients and gaining an understanding of the physicians' role, parallel stories written by students, housestaff, and attendings about their most meaningful patient on an inpatient rotation (22), and by physicians during a personal growth interest group (23). Housestaff found patient relationships to be healing at the end of their stressful residency training (24). Similarly, the overarching characteristic of students' accounts of important interactions with patients was their strong empathic identification with their patients (25).

As we proceed with the changes demanded by 21st-century health care, it is important for physicians to remain mindful of their values, service traditions, and sources of professional fulfillment. The general decline in physician satisfaction and the growing number of physicians who leave practice prematurely constitute a major loss of skill, seasoned professional judgment, and capacity for leadership and mentoring (1, 2). The use of narratives we describe affirms the benefit that doctors may receive if they reflect deeply in a supportive environment on the personal meaning of their work. Creating environments that foster, rather than inhibit, meaningful experiences may help improve recruitment, retention, and professional satisfaction. Medical students interviewed stated that the most important way to increase the attractiveness of internal medicine would be to have more effective and satisfying relationships during medical training (26).

CONCLUSION

We now have a better and richer understanding of what doctors find meaningful about their work. The internists in our study wrote about miracles and mistakes, sharing their own lives and their patients' lives, witnessing profound experiences, and receiving acknowledgment for a job well done. Through these events, they were rewarded unexpectedly with a deeper appreciation of what it means to be a human being and a doctor, and of how their caring actions, not just their technical ability, was so important to their patients.

The doctors who participated in our workshops found the process of exchanging stories to be valuable and personally renewing. They experienced a sense of community and reaffirmation. Amid so much discussion of what is wrong with medicine, the workshops seemed to help them remember what is right. With a clearer understanding of what nourishes and sustains them, doctors can be more proactive in advocating for their needs, and, if assured of this, may be more capable of embracing other changes that need to happen.

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