Flat-Lining Not Flourishing: Can the Virtues Help the Crisis in Medical Wellbeing

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1. Introduction

Compelling evidence demonstrates physicians in western industrial economies are not flourishing, irrespective of how this term is defined. Suicide and burnout rates among clinicians are the highest since measurements began decades ago. Most physicians know of a colleague who has taken their own life. A 2018 perspective written by an endocrinologist at St Vincent's Hospital Sydney, is sadly familiar. *"Over a matter of months, two female junior doctors committed suicide at our hospital, and more recently, suicide entered my inner circle with the death of one my close male colleagues … Such stories are not unusual in our profession."* (McCormack 2018). Indeed, they are not. There is a crisis in medical flourishing. Physicians are literally flat-lining through suicide, and burnout rates are growing.

This has not gone unnoticed by colleagues, medical educators or employers. The causes for burnout and suicide are multi-factorial and complex, including personality traits (Kalani *et al.* 2018), lack of work life balance (McCormack 2018), bullying (Powell 2011), and stigma associated with seeking treatment (Beyond Blue: 2013, 2019). The seriousness of physician burnout has triggered a plethora of interventions such as developing resilience, reducing working hours and returning to civility in the workplace. Training in mindfulness and yoga, promotion of exercise, inclusion of health food in vending machines are popular. Focusing on the individual, few pertain to the health-care organization. Results vary among medical specialties (Kalani *et al.* 2018). More recently, a focus on the organizational causes of why physician health has declined sharply has emerged. The changes in the organization of medical labour with flow on effects to working hours, autonomy and time for patient contact, is now of interest when considering improvements to physician wellbeing.

The conditions which shape how physicians deliver healthcare have been changing rapidly over several decades, with the last 10 years rocketing to unprecedented levels. Providing healthcare to a varied population, across multiple episodes of care, is complex and challenging, driving changes to standardize and maximize medical output. In the process, these developments have provided the conditions to reposition and subvert previous ideas of what constitutes a desirable therapeutic relationship, where a robust consideration of the virtues was understood as important for patient and physician flourishing.

Sitting at the top of the professional hierarchy, Medicine has transformed in the last two decades. Older style tropes of a trusted, all knowing, beneficent clinician, imbued with the virtues, acting in the interests of their patients as an unequivocal "good" in, and for society, have shattered. Berwick (2016), an influential leader in healthcare improvement in the United States of America, describes this period as "Era 1", the first of "3 Eras" in Medicine and Health Care. "Era 2" encompasses the current crises in healthcare organization with "Era 3" providing directions for the future. We draw on Berwick's (2016) typology, to open a broader discussion about how virtue ethics can contribute structurally to a flourishing life for individual physicians. Winding back the clock to restore physician sovereignty is neither possible nor desirable, yet avenues for improvements to physician flourishing are growing in urgency and virtue theory may be able to make a significant contribution towards improvements.

2. Transforming medicine.

The radical transformation of healthcare and medicine was triggered by the need to ensure safe care for ageing populations and patients with multiple morbidities, for which numerous and complex investigations, and interventions, were both available and expected. The scale of the problem required a new approach which Berwick (2016) terms "Era 2". Designed to deliver maximum benefit to burgeoning populations, a purportedly more "efficient" and "scientific", "lean" approach to delivering medicine emerged and rapidly was adopted. This process-based system of organizing healthcare developed from a hybrid of industrial workplace design (Taylorism), car manufacturing (Toyotism) and "Lean" manufacturing, with a "quality" (defect free quantity) approach to throughput (Winch and Henderson, 2009). "Era 2" characterized by accountability, scrutiny, measurement, incentives and markets had arrived (Berwick: 2016) demonstrating some spectacular successes, including reducing mortality and morbidity in the treatment of infections, timely care for stroke patients and response to myocardial infarction (Hartzband and Groopman: 2016).

Modern health care delivery systems measure each step of every healthcare interaction and process. This is documented, costed and compared, to maximize the return on investment of resources, and reduce variability and potential harm. These aims, accompanied by an explosion of technology platforms, inform pre-determined patient pathways, including the introduction of unpopular and wieldy Electronic Health Records. A drive for "continuous quality improvement", has produced unending pressure to provide medical care more quickly, cheaper and safer than before. Tools for accountability, scrutiny and surveillance introduced to regulate, govern and cost medical practice proliferate, reducing the time the physician can spend with the patient, and increasing data collection, of which only 25% is estimated as needed by Health Care Stakeholders in the USA (Berwick 2016).

3. Unintended consequences: physician burnout as a public health crisis

"Era 2" responded effectively to discrepancy and harms from medicine in the face of exponential health care needs, by providing guidelines and tools to direct medical thinking and reducing the need for independent clinical reasoning. The consultation, now largely scripted, follows evidence-based protocols for interaction, history taking, examination, diagnosis, prescription of interventions and follow up. In this mechanized approach to medicine, the virtues that contribute to what is "good" medical care may be missing from the script, as they are difficult to quantify.

Given the "unreflective instrumentalism" (Hofstadter 1963) that defines much of the delivery of contemporary medical care, it is not surprising that physicians are feeling the effects personally. Many physicians are not flourishing. Burnout characterized by *"feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy* (WHO: 2019) is rampant and has been declared a public health crisis in the USA (Jha, 2019). While studies of the rate of burnout in physicians vary across the United Kingdom (UK), United States of America (USA) and Australia, there is agreement that despite

the multifactorial nature of burnout and suicide; rates have been increasing. In Australia, a landmark study in 2013 found higher rates of burnout, depression and suicide in medical practitioners than the general population, with high levels of emotional exhaustion (32%) and cynicism (35%) identified. A UK 2017 Systematic Review of the identified prevalence of psychiatric morbidity among physicians from 17-52%. Burnout scores for emotional exhaustion ranged from 31 – 54.3%; depersonalization 17.4 to 44.5% and low personal accomplishment 6 – 39% with General Practitioners and Consultants having the highest scores (Imo 2017). In the U SA, nearly 50% report symptoms of burnout (Jha *et al*, 2019). Recently Han *et al.* (2019) estimated conservatively that approximately $4.6 billion in costs is attributable to physician burnout each year in the United States.

4. The contribution of virtues in medicine re-imagined.

Burnout physicians are working in a fragmented healthcare environment made intellectually arid via guidelines, time restriction with patients and high documentation burdens, inhibiting job control and feelings of autonomy (Waddimba *et al.* 2019). The predominate virtue driving contemporary healthcare would seem to be "utility" (Bain 2018). This is far from what the medical philosopher Pellegrino (1995) described, envisaging medicine as a moral endeavor where the moral work required takes place in the medical encounter where the virtues are demonstrated. Pellegrino (1995:270) positioned the virtues (Fidelity to Trust and Promise, Benevolence, Effacement of Self-Interest, Compassion and Caring, Intellectual Honesty, Compassion and Caring, Justice and Prudence), as integral to medicine, noting their endurance within medicine had extended past philosophy more broadly.

Virtues are character dispositions physicians bring to the clinical encounter to promote flourishing for the patient. If we accept the "eudaimonist thesis" (Snow, 2008) these dispositions also help physicians flourish as individuals. What is missing in the current discussion on the rapid deterioration in medical wellbeing is the recognition that creating space to cultivate and demonstrate the virtues may assist physician flourishing in addition to providing "good" patient care. While this makes sense theoretically, it seems a radical suggestion. Most discussions view physician flourishing as othered to the patient, the economy, or as a contributor to an important public good. While the status of the physician in relation to the patient is clear, viewing clinicians as worthy of flourishing in relation to themselves appears less significant. The ability to develop the virtues and use them in the clinical encounter benefits both the patient and the physician and this is a good thing in itself.

5. Conclusion: The flourishing clinician? What practical changes are possible?

In a matter of decades, the organization and delivery of medicine has completely transformed. This was important to address serious concerns on availability, variability and subsequent harm in medical care. The negative consequences of Era 2 are now recognized and physician burnout is part of these concerns. A third era for medicine characterized by nine changes to halt the "ravenous inspection and control" (Berwick, 2016:1329) of Era 2 has been proposed.

Seven of these changes provide a space to cultivate and use the virtues likely to help physicians (and patients) to flourish. The virtues identified by Arthur *et al.* (2015) : fairness, honesty,

judgement, kindness, leadership and team work and the idea of richer medical encounter where the moral work of medicine can occur (Pellegrino 1995) map remarkably well to seven of the nine changes proposed by Berwick (2016) for a new era in medicine and healthcare, "Era 3". Critically important is reducing mandatory assessment to free up time for a richer medical encounter. Others are: stopping complex individual incentives that promote gaming and unfairness; relinquishing professional prerogative when it hurts the whole (using kindness, judgment, fairness, team work and leadership); ensuring transparency (honesty, fairness, leadership); protecting civility (kindness, and team work; hearing the voices of the people served (leadership, kindness, teamwork); and rejecting greed (fairness and leadership).

These proposed changes are virtue friendly and theoretically should go a long way toward improving clinician flourishing. They act to control some of the situation factors (Arthur *et al.* 2015; Oakley, 2018) and restore time for a meaningful "virtuous" medical encounter.

A post-structural Foucauldian lens provides a more speculative view of how to manage the type of change required to re-introduce the virtues that promote physician flourishing. The Foucauldian analytics of normalization, discipline, biopower and governmentality, now well theorized and ably demonstrated across many aspect of social life resonate powerfully with contemporary methods of organizing the medical workforce and directing medical conduct described previously (Schiff and Winch, 2018). In the contemporary management of medicine, the focus on numbers or metrics inverts our previous understanding of the "medical gaze" (Schiff and Winch, 2018) and theoretically may lead to an opportunity for change. Modern metrics applied to the organization of medicine and physicians now well-established technologies that identify and compare physicians. The medical gaze has inverted. Physicians are now both the subject and object of government. Rates of burnout and suicide of physicians are visible, measured and costed. Physician flourishing is problematized in terms of potential failure of the healthcare system, constituting a "public health emergency", as we noted previously. In this case, the flourishing of physicians becomes a priority. Efforts to achieve flourishing may be directed via "practices of the self" (Foucault 1984), informed by theoretical and empirical work on the importance of the virtues to flourishing (which is growing apace) and supportive situational changes to practice, such as those suggested by Berwick (2016) for Era 3. This reflects Foucault's general premise that power can be modified in "determined conditions and following a precise strategy"(Foucault, 1980:13) and provides hope for improvement in clinician flourishing in the future.

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