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The Time Management of Compassion

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Abstract

In the managed care era, the physician-patient relationship is clearly under distorting economic pressures. Greater awareness of relational factors can aid physicians in forming solid relationships despite those constraints and can provide compassion as well as achieve liability prevention through understanding the broader dynamics of intimate relationships.

Introduction

The ancient and honorable doctor-patient dyad has by now thoroughly dissolved into algorithms of medical economic data. Washed away as well in the data stream is the distinction between the two complementary elements of health "care": treatment and healing.

Treatment refers to the application of technique; healing refers to a body's reparative responses to illness or injury. Many assume and a lot of evidence supports the notion that patient-physician psychology affects healing, at least indirectly, by fostering a patient's willing cooperation with treatment. However, managed medicine allots precious few moments in which to establish a physician-patient alliance sufficient to support healing. Therefore, the medical new world order may be said to manage "health" or "health treatment" rather than health "care."

The physician-patient alliance is also, and not coincidentally, the best protection for conscientious practitioners against the frivolous perception of malpractice. Patients may easily feel alienated from physicians who seem uninterested in them and unmoved by their plights. Some of these patients may be moved to file lawsuits in order to reclaim the human recognition of which they feel deprived by managed medicine. As Alan Stone[1] wrote:

> By bringing competitive market forces into medicine, managed care has demonstrated that the right financial incentives can reverse a century of rising professional standards and make health care just another mean and lean downsizing industry.... Market forces have inevitably had a devastating impact on traditional medical ethics, which is rooted in the doctor-patient relationship.... Patients cannot sue a [managed care] plan for damages even if its protocols, restrictions, and incentives clearly caused them harm. They can still sue doctors and hospitals, but not the [managed care] organizations....

Economists think this is just fine. A healthcare economist, while a psychotherapy patient, reminded a colleague several years ago of the

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conventional wisdom that underlies managed medicine: "The traditional physician does not really treat patients. We can show statistically that what physicians do is determined more by the effect of treatment on physician income than by what might actually treat an illness. Anyway, in general, it is the prevention of illness in the population, and not the medical treatment of individuals, which mostly improves overall life expectancy."

To reconcile our sense of physician role with the forces of medical economics and to protect ourselves as best we can from the impatient, litigating mind, we must face a conceptual as well as a practical problem. Economic models cannot account for or describe an alliance such as that between the physician and the patient, because economic transactions are at best zero-sum. As a result, economic transactions are intrinsically adversarial.

Newtonian laws describe the dynamics of motion as actions and reactions, or equal and opposite exchanges. These actions and reactions balance each other so that overall there is no net change. In perfectly Newtonian style, microeconomics describes fair exchanges of goods and services for money. Just as in the interaction of bodies in motion, in an economic transaction there can be no net change. One gains only as the other loses. Hence, economic modeling, inherently, can only promote adversary psychology and not alliance psychology. In zero-sum transactions, therefore, there can be no "alliance" in which both parties may gain or conspire together against an outside force, such as an illness.

When physicians are employees of "macro" economic corporations, the situation is worse for alliance psychology than is "zero-sum." Working for a corporation, a physician employee's duty is first fiscal—to create "surplus value" that may pass along the corporate, alimentary canal toward the coupon clips of shareholders. The ethics of personal treatment must yield to the necessity of profitability.

To promote the physician-patient alliance as necessary for both proper care and litigation prevention, we must encourage new thinking.

First, we shall briefly recount the foundational mythology of the physician as healer. Then, we shall present a model of the stages of identification between physician and patient, which are the same as may describe the development of any intimate relationship. These stages will imply steps physicians may take to enhance their perception as compassionate healers. Finally, we shall consider how the mathematical abstractions of medical economics may be transformed, at least metaphorically, so that they may take the need for healing into account.

The Physician as Healer

The association of treatment and healing appears in the relationship between Asclepius and Chiron, which represents the mythic basis of Western medicine.[2]

In Greek myth, Asclepius was the first physician. His familiar symbol is the caduceus, an insignia in which a snake coils around a staff. Asclepius was a son of the god Apollo; Apollo rescued Asclepius from his unfaithful mother's womb as she lay on her funeral pyre and gave the infant to the centaur Chiron, who taught Asclepius the skills of medicine. These skills included the ability to revive the dead—an art which Asclepius practiced with notable success. Hades, god of the underworld, complained to the chief god, Zeus, about this feat. Zeus, fearing that the practice of resurrection would upset world order (Asclepius was acting without managed care authorization), killed Asclepius with a lightning bolt.

A rarity among the nasty lot of centaurs, Chiron was a compassionate and loving individual; a veritable male mothering figure. Among the immortal Chiron's other wards were the classic heroes Achilles and Jason.

Herakles (Hercules), in a battle with centaurs, accidentally but painfully and incurably wounded Chiron with an arrow. To end his eternal pain, Chiron gave away his immortality and exchanged places in the underworld with Prometheus, the divine, prime benefactor of humanity in Greek myth.

The story of Chiron and Asclepius leads us meaningfully to the story of Prometheus, a son of Zeus but a representation of human individuality.

Prometheus, as mentioned, was the chief benefactor of humanity in Greek mythology. In some stories, Prometheus actually creates humanity. He was a trickster who outwitted Zeus and stole fire from the gods to bestow upon humans. In response, Zeus punished Prometheus horribly. Eventually, Herakles rescued Prometheus from Hades by offering the suffering Chiron to Zeus in his place.

Taking Prometheus as one punished for the "original sin" of individuality, which means using one's wits against authority, the stories of Chiron, Asclepius, and Prometheus prefigure the founding story of Christianity. The suffering Chiron redeems humanity from death by giving up his immortality in favor of Prometheus. Chiron suffered and died for our sins, redeeming humanity from hell.

These stories also hint at a modern psychology of medical healing consistent with our larger culture, as if to suggest that every physician needs to be like what some would call "Doctor Jesus." Without the sense that a physician, to some extent, can share one's suffering, even the ability to raise the dead is insufficient health care.

However, a culture of compassion cannot easily arise in a managed treatment environment. The managed care organization cannot represent itself as the wounded healer, despite any advertising campaign. Most concretely, and especially because patients cannot sue them, managed care corporations cannot be vulnerable to patients.

The following sections present a brief course in psychology as it applies to the physician-patient relationship.

The Developmental Psychology of Physician-Patient Relationships

The single characteristic word without which there is no such thing as psychology is *identification*. Most fundamentally, identification refers to the assignment of what one perceives to a category or type. Thus, one may identify a flying object as a bird, or an antique chair as a Louis XIVth. In psychology, one identifies types of other people as distinct from oneself by the roles they play in one's mind—starting with "mother," and moving on to "father," "sibling," and "physician"—and maybe also on to such prejudicial types as "villain," "terrorist," "blond," or "queer." As one matures, one moves from "identifying others as," to "identifying *with* others as." A sense of mature, healthy self arises from the sum of the roles one plays for those others with whom one identifies.

However, in social terms, "self and other" are often indistinguishable from "innocent versus guilty," as though some people may be guilty simply of being different from oneself or of not being "like us." It is interesting to note that to "categorize" derives from the Greek root word "kategoria," meaning "accuse"; the Hebrew root "KTG" also means "accuse."

The identification of others as types of people different from oneself thus likely precedes the development of identification with others as fellow members of the same category or type. Eventually, one may grow to realize that one is a person, and that one's parents are also people, but likely not more quickly than parents may realize that their children are distinct and separate people from themselves.

"Stages" of Healing

I propose that there are four developmental stages of psychological identification leading to the separation of a child from his or her family as a whole, intact being, as which one may identify with others as beings very much like oneself. I find these stages more or less in operation over the course of any intimate or loving relationship, and I refer to them as I explain marital difficulties to couples whom I treat in psychotherapy. The four stages are:

- *Idealization* (how an infant perceives a mothering parent, and the parent's total power to gratify or destroy);
- *Mirroring* (by age 2 years, how a small child must perceive his or her parents, as they may actually relate and respond to the child with compassionate understanding);
- *Internalization* (by age 3 years, as a child starts to retrieve the idealized and mirroring attributions from one's parents and works to internalize them to be able to perform these functions for oneself);
- *Separation* (by age 6 years, as a child goes off to school, beginning to function as oneself).

The four stages repeat themselves with the onset of puberty and adolescence, and several times subsequently over the life cycle. Healing seems to develop within the physician-patient dyad in just this sequence.

First, just as a small infant must idealize parents, a patient must have "faith in" or otherwise "idealize" his or her caretakers. Physicians may "idealize" themselves in simple ways—for example, by wearing white coats, hanging credentials discretely on their office walls, and perhaps by occasionally clucking wisely. Regardless of such made-for-television role playing, a physician must attract confidence in and respect for his or her competence and good intentions. Sufficiently idealized figures may impart a mighty placebo effect: they can make one "feel better" simply by being present at the bedside.

Mirroring exists when a subject sees him or herself reflected back in another's understanding; mirroring makes one feel that he/she exists within the consciousness of the "mirroring object." By age 2 years, every child requires such mirroring because of the newly discovered power to displease parents during potty training. The subjective patient develops in the dyadic relationship with the idealized physician only as the physician "object" can "mirror" the patient, which means the physician must deal well with what the patient may feel upset about.

Thus, in the second stage of healing, patients and their families will need physicians to help them comprehend and accept what is happening. A physician must not fail to communicate a sympathetic understanding of the patient's condition and experience.

In wholesome childhood development, a child internalizes both the idealized and mirroring images of the parents in the creation of an "ego," or stable point of view. By internalizing functions formerly attributed to the parents, a child comes to be able to idealize, understand, and accept oneself.

In the third stage of identification as it applies to "healing," a patient must be able to "internalize" his or her caretakers as ideal (providing treatment) and mirroring (providing compassion) so that the fourth stage of psychological "separation" from treatment may occur. The fourth stage implies the developing capacity to survive both the illness and the treatment, with minimal posttraumatic disruption.

In the first idealized stage of identification, caretakers are perceived as omnipotent, as "above" oneself. In the second stage, caretakers are perceived as suffering servants, as "below" oneself. This distinction exists in traditional societies as the difference between "fathering" and "mothering," and in traditional medicine as the rank distinction between physician and nurse. In today's medicine, the functions of various practitioners are more ambiguous. In the absence of the traditional reassurance of clear roles as related to clear ranks, especially with the reduction of "physician" to "provider," careful attention must be paid to how one interacts with the patient, less the patient be reduced to merely a "client" or a "customer."

In developmental psychodynamic psychology, the inability to unify "idealized" and "mirroring" figures accounts for a multitude of sins, including the psychopathology of many mental and personality disorders.

However, it is the failure to mirror which most of all accounts for the psychology of many malpractice suits, and not so much the disappointment in idealization one would expect as a consequence of presumed incompetence. The natural history of any intimate relationship (including marriage) will pass through the four stages of identification. It is predictable that any important relationship will begin with idealization and pass on to the need for mirroring once the "honeymoon" of idealization is over. Unless the relationship with a patient includes adequate mirroring, the inevitable fall of the physician from the pedestal due to his or her crumbling feet of clay will be truly shattering.

For internalization to take place in the healing process, and for separation to take place from the healing process, physicians and other caretakers must be able to play the compassionate "healing" role. The patient must not simply imagine or infer a physician's compassion. The physician must feel it and know how to convey that feeling to the patient.

Conveying Identification

How can the physician convey his/her "identification" to the patient? What can one do with moments to spend? The four stages of identification may suggest specific salutary actions.

The physician must be able to be idealized, meaning that he or she must appear prepared, calm, organized, methodical, and knowledgeable.

At the risk of being simplistic, I suggest first that a physician review a patient's chart—and pause long enough to allow the chart information to settle

in the brain—before entering the examining room. One must not appear rushed. By not needing to refer to the chart during the examination to recall information such as the patient's name, a physician will demonstrate simple courtesy and, more importantly, will model internalization. The physician will have "internalized" the patient sufficiently for him/her to be perceived as mirroring the patient; the physician will appear "to care."

The physician must actively demonstrate mirroring; the physician must convey interest in the patient's fears and hopes. One must ask the patient what he or she may fear, and demonstrate foreknowledge of what the patient may expect. A physician must provide reasonable access to follow-up conversations (eg, via telephone or e-mail).

Avoid relying on general questions such as, "Anything else I should know?" Be sure to find something important about which to ask follow-up questions. Ask the patient to refine or go deeper into a matter that he/she has brought up. Running down a list of symptoms does not necessarily demonstrate interest in the patient.

The physician must support internalization, which includes taking the time to discuss how a patient may follow his/her treatment instructions. Leave nothing about treatment to the patient's imagination. Follow-up appointments during which the physician exhibits recollection of the patient are very important. Signs of internalization predict a wholesome separation from treatment, rather than a resentful and disappointed abandonment.

Among the signs of internalization leading to a successful separation from treatment is sticking to a regimen. Are prescriptions filled? Is diet improved? What are a patient's supports? Does the course of illness threaten the well-being of a spouse?

Conclusion: A Lesson in Compassion From Modern Physics

I offer these stages of identification in the healing relationship specifically to argue for attention to patient care in a manner not to be dismissed as sentimentality. Were there time and space, I would continue this argument into the very nature of scientific perception.

I can say no more than this. It is widely understood that the quantum physicists of the early 20th century revised the notion of scientific objectivity, which previously theorized an absolute distinction between an observer and what could be observed. The new physicists realized the importance of the fact that nothing can be measured without affecting what is measured. While the amount of air released from a tire to measure its pressure does not importantly alter the remaining pressure in the tire, observing an object on an atomic scale or smaller does radically affect it. As a result, for example, one cannot measure both the position and the momentum of an atomic object at the same instant. Insofar as an object has position, it is a discrete particle fixed in time and space at the instant of its observation. However, insofar as an object has momentum, it is in motion, and so cannot have any specific position—as though it were a wave.

So, objects on the atomic scale as "wholes" must be perceived not as made up of objective properties existing all at the same moment, but as made up of complementary properties impossible to measure simultaneously. The resulting picture at any given moment of any atomic or subatomic object as a whole resolves only into a blur of uncertainty.

This 20th century "Uncertainty Principle" explains the world as we must participate in it producing paradoxes as we go, rather than as we may "objectively" observe it. The statistical mathematics of the Uncertainty Principle measures exactly how uncertain one may be in a given situation.

Observations on the atomic scale, therefore, reveal the wave-particle duality of matter and energy, in which entities sometimes seem to behave as discontinuous particles, and at other times as continuous waves. However, the larger the scale of the observation, the more the behavior of objects of matter is particle-like, and the less such behavior is wave-like. By the time an object reaches the size of a golf ball, there are no discernible wave properties, except as a ball may seem to move out of the way as one swings at it with a club.

Physical and social scientists mostly perform macroscopic, objective studies, summing the interactions of hosts of presumptive particles, which may just as well be either molecules of air, or human voters or consumers. We physicians work more as molecules within the population balloon than as social scientists measuring overall effects from outside of the balloon. Operating as we do at the atomic scale of human intimacy, as far as the economists looking at us are concerned, we physicians and patients exist in the difficult to imagine domain of wave-particle complementarity.

Healing and treatment are the complementary aspects of health care at the physician-patient micro level. Treatment phenomena, all of which may be described as provider-consumer interactions, may very well add up to follow macroscopic, economic laws. In such interactions, there is no qualitative difference between the parties—provider and consumer are simply interchangeable particles. However, in our roles of physician and patient, we constitute wave phenomena—which amount to nothing that is measurable as they fold into the big picture.

It is only the failure of these relations as they come back to haunt us quantitatively in malpractice suits which directs our attention to these issues. It is as though our collective "wave phenomena" are offended because they are ignored, and strike back with a vengeance.

Understanding healing and treatment as a kind of wave and particle duality, perhaps we "can get some respect" from those economic scientists who would relegate our human relations to the dust bin of mythology, as well as from those business people who are alarmed at malpractice costs. Shame on us for needing to attend to elementary human relations only because "it costs us." Nevertheless, I hope that presenting a picture of the "stages of identification" may assist the discussion of these relations in an "objective" manner.●●●

References

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