The BASICS Part V — "C" is for Community

Forging healthy, "genuine" communities among physicians

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The following article is the fifth in a six-part series on the fundamental principles of physician self-care. The "BASICS" series offers practical suggestions for stress management, improved health and well-being, and building resilience.*

"C" is for Community

In and through community lies the salvation of the world.[1]

This is the first sentence of a book written by psychiatrist M. Scott Peck, entitled *The Different Drum — Community Making and Peace*. This is a powerful statement indeed, and I use it to introduce the concept and role of community in physician resilience and well-being.

Just what is meant by "community" in this context? The dictionary defines community as a group of people living together, subject to the same laws and having common interests and characteristics.[2] Community defined this way usually includes a common geographical location for its members as well.

But this is not what Dr. Peck meant by community in his statement above, and it's not the meaning I'm considering when thinking about physician health.

True community must be experienced to be understood. Sometimes it helps to describe the absence of a thing in order to better understand its presence.

Thomas Krizek, a surgeon, compared life in his professional community to swimming with sharks.[3] He said that the rules for swimming with sharks were surely written for surgeons: Any unidentified colleague is a shark until proven otherwise; don't bleed — it attracts more sharks; get out of the water if someone else is bleeding; counter aggression with more aggression.

Dr. Krizek describes a tough, aggressive, suspicious, uncaring grouping of colleagues who are unlikely to reveal their own pain and injury to one another, much less come to the aid of a colleague should his or her problems become known. This might seem like an indictment of surgeons, but it comes from one of their own. And, when I repeat this metaphor to other specialty groups, I am all too often aware that there is resonance with this depiction.

This metaphor also suggests a community that does not tolerate individual differences. You're either a shark, or you're not.

As far as I'm concerned, this is the description of anti-community — even though this is a grouping of individuals in the same place, with common interests, following the same rules, often implied and modeled, rather than overtly stated. This is a place of personal achievement, even at the expense of others. This is a realm where weakness is ill-advised, where others are regarded with suspicion, and mutual support is unlikely.

This kind of place does not feel right, does not foster collegiality, and, too often, is in some way part of the backdrop in the lives of distressed or ill physicians seeking help from the Physician Health Program.

Barriers to community

Medicine has long been a profession that supports the credo of rugged individualism. From the first day of medical school onward, we are reminded of our specialness, that we were selected as a few from the many who would be physicians, that we are the "cream of the cream."

We are taught the skills to cure, deal with crisis, and comfort our patients. We are trained as leaders of the health-care team. The fact that the ultimate responsibility for our patients rests with us is a repeated theme, and we take that seriously.

We learn at the bedside, in clinical rounds, and through rigorous examination that, in the end, our success as professionals rests upon our own efforts and personal, sometimes arrogant, authority.

Self-doubt and fear of failure are probably common to all of us, but that is a carefully guarded secret. Not wanting to risk being judged as less than our colleagues, these and other "shortcomings" remain cloaked within our professional white coats. Feeling like impostors, we try to appear confident and secure when the truth is something else. We become dishonest with ourselves and others.

Our experience of criticism in training is sometimes hurtful. As a result, later in our careers, feedback from others, even constructive, is difficult to hear and accept without feeling threatened.

Sadly, some of us become bystanders in our own professional neighbourhoods. Ignoring our human "first nature," as described by Clarkson[4] — to be connected and interdependent, we turn away from colleagues in pain, impropriety in the workplace, ethical dilemma, or other uncomfortable challenges around us in our professional environment. Maybe this is due to our own past experience, stress, fatigue, overwork, ignorance, or ambition. Maybe something else.

So not wanting to get involved becomes "second nature" to us. We avoid really opening ourselves to others or providing a safe place for them to be with us. We fail to join with one another in a meaningful way.

Genuine community cannot form in an environment like this.

Genuine community

Then what is community? Scott Peck says: "If we are to use the word meaningfully we must restrict it to a group of individuals who have learned to communicate honestly with each other, whose relationships go deeper than their masks of composure, and who have developed some significant commitment to rejoice together, mourn together, and to delight in each other, make others' conditions our own."[5]

Let's consider how these principles and others can combine to create healthy medical communities.

Genuine community is inclusive. All kinds of doctors, regardless of specialty, cultural origins and gender, doctors in training, and allied health professionals, may belong.

When I was a clinical clerk in my last year of medical school, a nurse in the emergency department said one sentence to me that stands out in my memory. Marked by my short white jacket and yellow name badge, I responded to a page to see a patient in consultation. The nurse, seeing me approach, said, "If your senior resident isn't right behind you, turn around now and go away." I felt hurt, rejected, a very minor member, if that, of the health-care team.

A healthy community is self-aware. Its members aren't afraid to examine its status and functioning. Such a medical community will pause once in a while to ask: "How are we doing?" Just as personal inventory is important, so is a collective one. Through retreats, medical staff meetings or other mechanisms, a healthy medical community will have members meet, discuss, reflect, plan, and be open to change.

And, being a safe place, all members of the community will be free to speak honestly. All constructive criticism is welcome. Incessant complaining, even silent, unexpressed concerns, are part of the problem. Active engagement in medical community processes and politics is the solution.

In healthy medical communities, senior members offer the benefits of their experience through mentorship, willingly sought and accepted by its junior members.

All members of a community like this are open to giving and receiving feedback. Once, in a meeting of medical leaders I was addressing about disruptive behaviour, a surgeon offered his opinion that, in the OR culture, "off colour" or sexist jokes were understood as being acceptable. Shortly afterward, as the meeting concluded, two women who worked

in the OR approached the surgeon and politely told him that they, and others, did not share his perspective. They risked offering feedback. I felt I was witnessing healthy community in action.

Sometimes there is conflict in communities, even healthy ones. But conflict in genuine community is resolved skillfully by active listening to one another, reflection and decision-making guided by effective leaders. This is conflict resolved with grace instead of the aggressive feeding frenzy of the shark tank.

In a genuine medical community, the myth of personal invulnerability is discarded. Instead, our strengths, weaknesses, and individual differences are honoured and accepted. This has implications regarding optimal use of our professional abilities.

For example, doctors with certain disabilities are offered accommodated work that still makes use of their talents and experience.

The same is true for doctors who wish to retire gradually, still offering valued service based on their experience, but without need to take on-call responsibilities or other duties they can no longer manage comfortably.

And, of course, recognizing the possibility of individual suffering due to personal, emotional problems is also accepting the truth in any real community. Beyond acceptance is the ability to offer assistance without shaming or stigmatizing. In healthy medical communities, we can reach out to one another in safety.

Conclusion

We all live and work as part of groupings we call communities. Some will have elements of what I am calling genuine, healthy community; some not. Genuine community usually takes time and effort to form.

We know when we are experiencing dysfunctional community because it drains our energy. Some callers to the PHP describe professional environments that are rigid, unsupportive, lacking in creativity, hurtful places to be.

Many other callers come from caring, encouraging and helpful workplaces. Sometimes, it is just such a community that inspired the caller to reach out. We know we are a part of a healthy community because we feel rewarded, energized and joyful about being a member of it.

Genuine community is at once human, humane and healing. Genuine community fosters resilience in its members. **OMR**

References

1. Peck MS. *The Different Drum: Community-Making and Peace*. New York, NY: Simon and Schuster; 1987. p. 17.
2. *Funk & Wagnalls Standard College Dictionary*. Canadian ed. Toronto, ON: Fitzhenry & Whiteside Ltd; 1982.
3. Krizek TJ. Ethics and philosophy lecture: surgery...is it an impairing profession? *J Am Coll Surg* 2002 Mar;194(3):352-66.
4. Clarkson P. *The Bystander: An End to Innocence in Human Relationships?* Toronto, ON: John Wiley & Sons; 2006. p. 17.
5. Peck MS. *The Different Drum: Community-Making and Peace*. New York, NY: Simon and Schuster; 1987. p. 59.

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