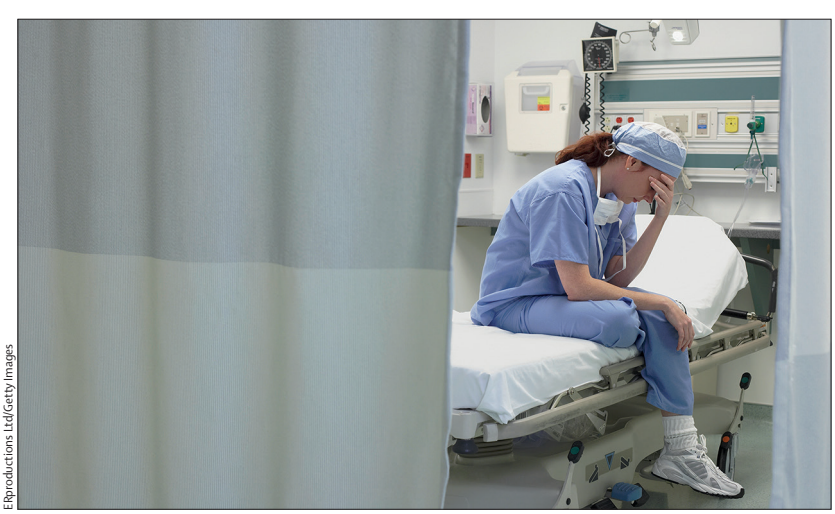
The art of medicine
Stories of shame

The American physician and writer, Danielle Ofri, tells the story of a near fatal mistake that she made at the beginning of the second year of her residency. A patient was brought to the emergency room in a diabetic coma, and although her initial management was fine, Ofri then made an error and "proceeded to nearly kill…[the] patient". Recognising her predicament, she called for senior assistance. When an explanation was demanded of her performance, Ofri's words dried up. Humiliation set in as she was questioned in front of her intern: "I could almost feel myself dying away on the spot. In fact, for many minutes, that seemed preferable…I wanted to evaporate, to disappear, to expire from that horrific moment of shame." Many years later, she bumped into her rescuer when they attended the same antenatal clinic. While they chatted easily about non-medical things, Ofri still sensed a residual impact from that event: "I doubted she even remembered…But for me, the shame of my error and the resultant loss of self-esteem would not release their grip."

Ofri's book, *What Doctor's Feel*, is part of a contemporary surge in medical genre writing, a literature that, to an extent, has become refocused on the personal challenges of professional practice. Among these volumes lie surgical memoirs, present-day accounts by those looking back on long careers (Henry Marsh and Stephen Westaby), and doctors earlier in their career (Gabriel Weston, Adam Kay, and Paul Kalanithi). They recount moments of discovery, success, and hope but also catastrophic failures and devastating mistakes. Many of these accounts do more than document interesting cases and, as in Adam Kay's *This is Going to Hurt*, often contain profound insights into the emotional impact of medical practice.

In *Do No Harm*, the neurosurgeon Henry Marsh writes of having an argument with some surgeons of another stripe over possession of office space. The row seems a trivial matter, especially to someone of Marsh's robust nature. But on this occasion he is unsettled by it, perhaps too bothered to perform surgery? He undertakes a complex operation, he makes an error; a nerve is cut. Later, he sees the result on the ward—the patient's face is "paralysed and disfigured". There is no escaping it and he "feels a deep sense of shame". This notion of feeling shame in response to one's errors is reiterated in the narratives of others, including Gabriel Weston's raw reflections on her surgical training in *Direct Red* and in Atul Gawande's *Complications*. The latter, a personal and critical analysis of medical error, details the aftermath of Gawande's own hesitation to perform an emergency tracheostomy, almost costing his patient her life: "I felt a sense of shame like a burning ulcer. This was not guilt: guilt is what you feel when you have done something wrong. What I felt was shame: I was what was wrong." But what is shame, why do doctors feel it in response to their mistakes, and is it a good or a bad thing?



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The philosopher Jean-Paul Sartre proposed that shame is inescapable in human experience, a basic element of human development that colours all aspects of our lives. Shame is not a linear or unitary emotion—experiences are varied and can depend on biology, biography, and context. Thus, an incident that invokes a mild twinge of embarrassment in one person can induce mortification in another. Unless dealt with, shame can be internalised and persist, sometimes with damaging consequences.

Doctors do not talk much about shame. The psychiatrist Donald Nathanson suggests that this is because shame itself tends to makes us especially uncomfortable. As another psychiatrist, Aaron Lazare, commented: "it is shameful and humiliating to admit that one has been shamed and humiliated". But health professionals appear particularly likely to encounter feelings of shame during their careers. Despite this, clinicians commonly project an image of being rational inquirers into health and disease, with little time for emotional exploration. Indeed, a doctor exposing such an inner self may perhaps be thought of as weak, or unprofessional.

Nathanson placed pride and shame at opposite ends of an affective axis, whereby shame is the result of the loss of pride, a failure to live up to personal or professional standards. Medical school attracts high-achieving perfectionists for whom failure is both uncommon and unwelcome. But medical training can be challenging and undermining, often subjecting individuals to demeaning pedagogic rituals. Humiliation endures as a clinical teaching tool, and bullying, unfortunately, persists. This sense of subjection experienced in the early stages

of medical education and training, may create a later susceptibility to being or feeling shamed.

And, a sense of powerlessness and vulnerability may not only be a matter for junior staff. Contemporary health and social policy has readjusted expectations of the profession. The new art of medicine increasingly entails walking a tightrope between the traditional ideals, values, and objectives of medicine, and those set by a target-oriented culture. The bureaucratic–clinical divide has created new avenues for medical practice and behaviour to be evaluated and viewed as blame or praiseworthy. The pressures and demands that structure these new possibilities for shaming are, of course, not limited to doctors. But, target-oriented policies can result in feelings of frustration, inadequacy, and failure for professionals treating people with complex problems and needs in a restrictive practice environment. The ensuing self-criticism, self-blame, and sense of shame can be isolating, and potentially lead to stress, and burnout.

A "deep sense of shame", according to Marsh, is also invoked when a doctor's "patients suffer or die as a result of their efforts". This "is made all the worse if litigation follows". Much of the distress of doctors who are sued seems attributable to the guilt and shame of causing harm, of failure, of exposure, of perceived loss of reputation in the eyes of peers, or the public. But if litigation, which is about a single allegedly negligent act, induces shame—what of a medical council inquiry? Here the regulator alleges that an individual is unprofessional or a poor professional—in essence that she or he is a bad doctor. It is a judgment not about an act but about the person the doctor is. And it is a matter that is adjudicated upon in public. The regulatory body does have the critical task of setting standards for medical practice, and of protecting the public from doctors whose conduct or performance falls below these values. However, this important goal is currently pursued through what appear to be public shaming rituals aimed at punishment and deterrence, rather than raising the standards of the profession. The consequent climate of fear is merely added to by contemporary political rhetoric and media hyperbole.

Does any of this matter? Is this not just part of the legal rough and tumble of modern clinical practice? In any case, does a sense of shame not have an important role in our moral or medical education? Certainly, shame has meant that Ofri will never again forget the management of diabetic ketoacidosis. Lazare argued that the ability of the professional to experience shame is healthy: "It means that we have ideals and a sense of pride and that we are social beings who care what others think about us." But shame can also be destructive. Authors write about surviving their own shame, but point to the stories of others who were deeply affected. Gawande refers to a surgeon whose patient died during a procedure: "Afterward, he could barely bring himself to operate. When he did operate, he became tentative and indecisive. The case affected his performance for months."

Nathanson constructed a compass of shame to indicate how individuals may internalise and deal with the emotion. Many of the possible responses seem inherently detrimental to doctors and their practice—avoidance, withdrawal, self-denigration, aggression, narcissism. In addition, shame is linked to the development of various mental health problems, including depression and addiction. Pamela Wible, an American family physician, has collected accounts of clinician suicides, narratives replete with shame that provide insight into the harshness and insensitivity of the medical world. Sadly, it remains shameful for a doctor to admit to suffering from any mental health problem and these continue to be stigmatised within the profession, perceived both as a weakness and as having negative career implications. As a consequence, doctors can become adept at concealing or masking such difficulties. It is unfortunate that at a time when medical students and clinicians are required to be increasingly responsive to patients' emotional states and needs, they are also expected to be resilient and less sensitive to their own vulnerabilities.

But clinicians are vulnerable and fallible humans. It is this humanity that motivates them to go beyond technically proficient treatment and travel with patients in their anxiety and suffering to provide care, compassion, and comfort. Yet such kindness is not always directed inwards for self-care or towards support for fellow professionals. Despite the importance of transparency about medical error and initiatives to ensure patient safety, there remains a culture of blame and shame in health care. And Nathanson's compass tells us how some practitioners might respond to the threat of shame, to the possibility of damage to personal or professional identity—they may conceal the problem; they may be aggressive and deflect blame elsewhere; they may feel unworthy of being a doctor and "drown in shame". None of these responses are healthy or useful. That doctors are willing to write about the emotional aspects of practice is important. Stories about shame inform us of how debilitating it can be, how it can impact upon relationships with colleagues and patients, how it may undermine personal and patient welfare, and how we might develop strategies to prevent or manage its more invidious manifestations. Appropriate support from peers and health-care organisations is critical to the minimisation of shame persistence, but can only be implemented if students and clinicians feel empowered to tell their stories in the first instance.

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Further reading

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