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Thank you for this kind introduction and the opportunity to discuss with you the (i) the relevance of what I call - in reference to the patient-centered approach - physician-centered research, and (ii) to present some results of a bi-national study conducted at Lausanne University Hospital in Switzerland and Higashi Sapporo Hospital in Japan. This reseach has been funded by different souces, such as the Swiss National Foundation for Scientific Research, the Swiss Aacademy for Medical Sciences and the Leenaards Foundation.

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First, I think - and I hope to provide you in the following with good arguments for my thoughts - that it is important to care about and for patients, but it is also important to care about and for clinicians.

Clinicians are not neutral elements of the health care system, they are affected by their « outer » world, the context within they work, and they are affected by their « inner » world, the psychic apparatus with its unconscious and conscious forces. The resulting lived experience of clinicians impacts on patients, the practice of medecine and the health care system.

We have therefor launched a call for physician-centered research, which has been answered by different founding bodies, the ones mentioned on the first slide, but also the Swiss Cancer Research Foundation.

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To what kind of influences form the „outer“ and „inner“ world are the physicians subjected to?

First, the most outer circle : the society affect physicians in different ways; for example dominant discourses exist on medicine (for example that medecine is powerful), death and dying (for example that therapeutic obstinacy is widespread in medicine); there are also high expectations associated with increasing distrust and judiciarization of the medical field, leading to „defensive medicine“; or the

modifications of the patient-clinician relationship, I will later provide an example, affecting the lived experience of clinicians, etc.

Second, the institutional context and work environment: institutional constraint, such as the demand for productivity and efficacy or the increasing administrative tasks, influence the lived experience of physicians; but also the fragmentation of care with a lack of continuity and on the same time the standardization of care, which diminish physicians' autonomy and creativity, physician shortage, and so on.

Third, the socialization and relational ties with peers and other health care professionals also affect clinicians. For example the so-called hidden curriculum in the medical studies, which highly values the more spectacular and prestigious disciplines, such as neurosurgery ; or the hierarchical organization of the medical system, to which some respond with conformisme, I will provide an example ; or infighting and competition to which some respond with corporatisme, etc. In a recent study which will be pubslished in the journal „Dreaming", we investigated Lausanne University's Bachelor and Master medical students' dreams: they do not dream about patients, they dream about exams, performance and competition….

Fourth, the clinicians emotions and psychological health: their fears, burnout, cognitive dissonance when doing things or omitting things they perfectly know it's harmful for the patient, leading to cynisme, frustration or substance abuse, or lack of engagement; or their own biography which interferes with the care of the patient, I will also provide an example.

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As promsed, some clinical example may illustrate these influences from the „outer » and « inner » world of clincians, and how they affect the physician, the patient, their relationship and medical care.

First example, influences on the clincian from the societ : we observe that the introduction of shared decision making in medecine not only changes the way decisions are taken, but also - in young physicians - lead to a shift of responsability. Upon patient's demand for guidance, some young physicians

answer : « I only provide information, you decide ! », ignoring that some patients - for all kinds of reasons - are not capable to assume this responsability. The physician-patient relationship thus leaves the paradigme of paternalisme and enters a new one, a relationship which ressemble the one between teacher and pupil. This new model creates at times difficulties for the patient and a certain dissatisfaction for the physician.

Second example, the institutional context : our hospital, in view of the increasing judiciarization, has opened in the middle of the hospital a center where patients and their significant others can adress a complaint, which will be handled by mediators, who then attempt to mediate between the patients and the concerned health care professionals. This center certainly helps to diminish the legal complaints ; however, a qualitative study of physicians who were concerned with such a complaint indicates that some of them live this experience rather as a traumatic, leaving them with the impression that our hospital cares more about patients than clinicians and reporting that after such a complaint, they changed their practice towards a defensive medicine in order to protect themselves.

Third example, the socialization of clincians within the hospital: about three years ago, I supervised a young oncologist who showed me his filmed consultations. One consultation was most striking: an elderly patient with advanced cancer was obviously very ambivalent about the chemotherapy treatment. Upon my remark, that this patient seems to oppose chemotherapy, he answered : « Yes, indeed, if I don't accompany her to the nurses for the chemo, she just goes home right away…. ». When I said that I don't know, if this is really correct, since she seemed competent to decide, he agreed, but answered : « I asked the senior oncologist, he looked at the CT-scan, and said: she responds very well, continue chemo; so that's what I do. This seems somehow unbeliveable, but conformisme within hierarchical systems exist. In this situation it lead to cognitive dissonance within the physician, affected the patient's well-being and produced therapeutic obstinacy. I am quite confident that if the young physician would have at least explained to the senior oncologist that this elderly lady's showed concerns and resistance, the senior oncologist would have agreed to discuss the matter and/or stop treatment.

A final example on how the „inner world", in this case clinician's biography, affects the clincian and the relationship with his patient. A nurse came to see me

out of a strong guilt feelings, and reported that during night shift an elderly patient with prostate cancer complained about pain, but then refused pain medication, which provoked her to shout: well, it's up to you to decide, or you have pain or you take pain killers ! During our discussion, which first turned around the issue of how to understand the patient's stance, be it as an expression of fear from medication or a manifestation of his wish for autonomy, I asked her about the anger she experienced, and thinking about the situation, she stated that she was not only angry, but very anxious … because, the patient refused medical advice. And she stoped and said: if I would have refused medical advice, I wouldn't sit here in front of you. It turned out that about five years ago, she had treatment for a melanoma, an experience which still affected her a lot, and made it, for example, still now impossible for her to plan for the future. This insight lead her to seek psychotherapeutic help.

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So, the lived experience, I hope I have convinced you, is relevant. What do we know about clinicians' lived experience? Not so much ; the literature focuses on burn-out, psychopathology (mainly depression and substance abuse of physicians) and job satisfaction or dissatisfaction. But the lived experience is much broader, as discussed before.

In a prior project, we have investigated clincinas (physicians and nurses working in internal medicine, geriatrics, oncology and palliative care of different hospitals) by means of Focus Group in which they were invited to talk about the difficulties they encounter in end-of-life care. Most surprisingly, clincians talked about their patients and the lack of comptence they experience in end-of-life care; they also talked about communication challenges, but they did not talk spontaneously about the influences of their « outer » and « inner world » on their experience and on their work. We called these the « unvoiced topics » and this result inspired us to investigate if physicians are unaware of « outer » and « inner » world influences, or if they would mention them, when invited to do so. That's how we started the bi-national project, which I will now briefly present to you.

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Who is we? In Lausanne Céline Bourquin, an anthropologist and linguist, with whom I work since many years, and Sandy Orsisni, a psychologist; both work as researchers in my service. And in Sapporo Dr. Terui (the medical director of Higashi Sapporo Hospital), myself, my wife, Dr Machino (a senior palliative care physician) and Dr Ishitani (the President of Higashi Sapporo Hospital).

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What did we do? We included 33 Swiss physicians (20 of them men) and 18 Japanese physicians (12 of them men); they came from different hierarchical levels and worked in various disciplines, such as geriatrics, palliative care, oncology, internal medicine, gastro-intestinal medicine, emergency medicine and surgery. These physicians were confronted with pictures, a method called photo-elicitation, which is used in sociology, with quotes from peers, and with short sequences of soundless and blurred films, inspired by projective methods from psychology. The goal was to facilitate physicians narratives, that's why we called the material narrative faciltators.

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First level we investigated : the society's influences on physicians' lived experiences.

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We showed them headlines of recent newspaper articles which addressed different issues, such as physicians, patients, the physician-patient relationship, medical care or the health care system. And we asked them to react and comment. The articles were of course from Japanese newspapers for the Japanese participants and from Swiss newspapers for the Swiss participants.

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Here are some examples of how Swiss physicians reacted :

I think our profession has changed …There are more and more demands put on the physician … We are loosing our identity …We are not anymore infallible (allusions to change of identity, status and roles)

The human side is put between parentheses … (allusion to cognitive dissonance)

The public is fascinated and on the same time fearful of medicine… (allusion to the ambivalence of society towards medicine)

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Second, we investigated the influence of the institutional context and the work environment on the physicians.

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We showed them pictures of a physician's working day and asked them to tell us what they see and to comment.

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Here are some examples of comments made by Japanese physicians :

This physician seem to fill in forms, he is forced to do this, he seems bored ...he looks at the PC for a holiday location… (allusions to institutional constraints)

The people seem to be alone, everyone is in his bubble… (allusion to lack of relationships)

In the meeting, they all look up to the boss… (allusion to hierarchy)

He is happy that work is done, he will now have a drink… (allusion to stress-related behviour)

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Third, we investigated the physicians socialization and how the relate to peers.

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We used quotes; in Japan quotes form physicians which we collected from pubslished qualitative studies, and in Switzerland from books written by physicians. The quotes adressed issues, such as the way clinical work is conceived, hierarchy, gender differences, medical knowledge and attitudes, or the issue of role models and relationships with peers. And again, we asked them to react and elaborate on the quotes.

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Here are some examples of reactions from Swiss physicians:

A physician has to do everything and to know everything… (allusion to physician-hood)

I think it's essential to have some distance towards the patients… (allusion to rules)

I've got used to things, I even consider that I lack compassion… (allusion to physician fatigue)

I have the impression physicians have difficulties to talk about themselves … (allusion to a lack of communication).

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And finally, we wanted to access their « inner » world, their emotions and psychological health, by

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Showing them four short sequneces, soundless and blurred, of a physician at work, a physician encountering a patient, of physicians together as a group of peers, and of a physician alone turning in circles; I will show this last sequence in the next slide. As we have described in our paper cited below, clinicians show not only conscious reactions but often unconscious reactions towards patients - which can lead to strong emotions and sometimes unreflected behaviour - but also towards elements of the context, be it persons or discourses.

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(No comment necessary)

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Again a few examples of what Japanese physicians saw in the sequences :

Ahh, professor's round, all are following him blindly…(allusion to comformism)

This physican turns in circles, he has to announce bad news to his patient … (allusion to anxiety) or he is afraid to has to go see his boss… (allusion to hierarchy-related anxieties)

He is not in a good condition, I would like to ask him what's the matter … (allusion to physician's suffering).

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The data can and will be analysed from different perspectives and by means of different methods,

such as thematic analysis of the narratives; thematic analysis identifies what content have been voiced. But we will also analyze the reactions towards the narrative facilitators: for example, physicians did not react much towards architectural elements of the institution (hospital), as if they are completely used to

them and perceive them as « natural », which does not mean that architectural elements do not have an effect on them.

One can analyse the directions the whole of the narratives take, that's what I will present to conclude (as preliminary results), or one can analyse individual narratives and create a typology of physicians, for example, the optimistic physician, putting much hope in technical progress and evidence-based medicine, or the sceptical physician who regrets past times. Or one can isolate the minority discourses, voiced only by a few physicians. I can not go into details, and would thus just like to show you just some results of the thematic analysis.

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Japanese physicians' narratives were rather homogeneous, and painted the following picture:

A physician with a tough and stressfull job, a kind of « lonely fighter », who feels torn between his ideal of patient-centered care and a harsh clinical reality with time and other pressures.

Patients were generally considered as preoccupied « consumers » and physicians fear to deceive them. In addition, physicians deplore a lack of understanding of and communication with patients, but also with peers.

The health care system is perceived as excellent for the patients, but less for physicians.

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And :

Despite the harsh reality, no complaints were voiced and rules of conduct considered to help to find a way in a somehow constraining and not supportive environment and within a society which delegates some of its problems to medicine …

While difficulties with communication runs like a red thread throughout the narratives and the joyful sides of the profession remain unvoiced, no indication at all existed of what has been called the collapse of morale among hospital physicians by the researcher Yasunaga. However, the specific setting of the study may explain partly this results.

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The Swiss physicians showed a more heterogeneous picture, with different narrative, sometimes co-existing in the same participant. In Switzerland many phsysicians are from various European coumtries, but also from the middle East. For example more than half of the resident working in my service are not Swiss, and persons from 112 different nations work in the hospital.

Swiss physicians painted the following picture:

A nostalgic physician who face a practise under transformation, which is increasingly dominated by technics, a physician who is affected by a identity crisis and a loss of prestige in an environment, which shows considerable ambivalence towards medicine.

A physician who has a positive outlook on the developments, fascinated by medical progress and increased diagnostic and therapeutic possibilities.

A lonely fighter, as in Japan, who feels - and that is different - only understood by peers, and who‘s work and life collapses together.

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One last general comment:

A hundered years ago, at least in Switzerland the themes « health » and « medicine » have played a limited role within society and physicians were often entirely devoted to their profession, and highly respected. While today health and medicine have become very important issue within society - quoting Foucault:

health has replaced salvation -, ironically physicians seem to feel less valued, some disengage from their professions and emmigrate into an inner insulation.

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To conclude: physicians somehow endure their destiny, and some of them reported difficulties to « see the whole picture » in which medicine in practiced. As one participant stated:

I hardly ever use this part of my brain !

We therefore will continue to conduct physician-centered research; we already use some of the narrative facilitators and some of the results to discuss with medical students, but also in postgraduate education; with the goal that physicians are not only accumulating and applicating knowledge, but (i) that they are aware by what forces affect them (conscientization), (ii) that they think about their « outer » world (refexivity) and (iii) their inner world (introspection), so they can position themselves in a changing field. We hope that our research contributes to stimulate this part of the clinicians' brains.

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A final word