# A Different Kind of Fatigue: A Cross-cultural Analysis of the Etiology of Burnout in Medical Literature

by
Jessica Tran

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Honors Baccalaureate of Science in Microbiology
(Honors Scholar)

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# AN ABSTRACT OF THE THESIS OF

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Raymond Malewitz

The rate of physician dissatisfaction is steadily rising. Between 2011 and 2012, the number of physicians that would not choose a career in medicine if given the opportunity to decide again increased by 15% (Adams). This discontentment has major repercussions in the midst of the rising need for physicians: it is estimated that by 2025, there will be a physician deficit of 90,000 (Bernstein). One reason for the increasing dissatisfaction is burnout, which physician Richard Gunderman defines as "emotional exhaustion, depersonalization, and a diminished sense of accomplishment." Although Gunderman identifies the etiology of dissatisfaction, he fails to characterize burnout and explain where and why this phenomenon occurs. In this paper, I use Raymond Williams' theory on "structures of feeling" as a lens to identify the characteristics and etiology of burnout. Williams proposes emotions serve as a "cultural hypothesis, actually derived from attempts to understand such elements and their connections in a generation or period" that should be explored as they are lived and felt instead of being converted into finished products (1289). Using his arguments to navigate Sandeep Jauhar's memoirs *Intern: A Doctor's Initiation* and *Doctored: The Disillusionment of an American Physician*, I conclude that writing helps doctors articulate and confront their anxieties when coping mechanisms prescribed by the dominant culture fail. Using Abraham Verghese's *Cutting for Stone* to renegotiate the geographic borders of this study to encompass eastern and western medicine, I conclude that although stress may be inherent to the profession, the environment physicians are placed in heavily contributes to whether or not they become burnt out.

Key Words: burnout, etiology of burnout, medical hegemony, physician dissatisfaction, Hippocratic oath

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I understand that my project will become part of the permanent collection of Oregon State University, University Honors College. My signature below authorizes release of my project to any reader upon request.

Jessica Tran, Author

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# INTRODUCTION

Upon matriculation into medical school, physicians take the Hippocratic oath, pledging to do no harm to their patients and to care for their patients to the best of their abilities (*Intern: A Doctor's Initiation* 8). For most doctors, this oath is unnecessary because their desire to help others influenced their decision to enter the medical field. However, changes in the healthcare infrastructure of the United States are creating obstacles that interfere with physicians' ability to uphold their promise: mountains of paperwork confront physicians, the threat of low grades cause surgeons to refuse operations, and strict guidelines force doctors to practice cookbook medicine when encountering certain symptoms in order to receive maximum compensation, such as administering antibiotics within a certain number of hours for patients who present with pneumonia-like symptoms (*Code Black*; Jauhar; *Intern* 101).

The obstacles physicians face in treating patients is explored in the documentary *Code Black*, which chronicles the lives of emergency medicine physicians at Los Angeles (L.A.) County Hospital. In one scene, the camera pans to a sick patient lying on a gurney and then cuts to senior resident Ryan McGarry, who looks at the camera and confesses:

> This patient needs a lumbar puncture. I have to put a needle in her spine and get fluid out of it. To do that, I have to fill out a form and eight other forms. And I have to fill them out, and chart. It's going to take me almost 25 minutes of prep just to get the procedure to happen. And so it's funny that in that moment, I'm looking for reasons to not do it. Not because I don't want to take care of the patient, because I just don't want to do the crap. But that's fucked up, because I

should want to take care of her. I should want to do that LP now. But that's the system.

McGarry's frustration originates from the amount of paperwork he must fill out, which interferes with his efficiency and erodes his passion for treating his patients. He is not alone in experiencing his annoyance. In the same documentary another senior resident, Jamie Eng, laments, "it took me four times as long to document as it took for me to talk to her [the patient] and do the exam" (*Code Black*). The policies dictated by hospital administration makes seeing patients difficult and the effect of these obstacles is demonstrated in the documentary because the hospital is constantly in a state of code black, which is defined as "patient over-crowding to potentially unsafe levels; technically internal disaster" (McGarry).

Besides documentaries, the struggles physicians face and their responses to these problems can also be seen in medical television shows. These programs almost always include an archetype of the cold, distant doctor. Examples of these physicians include Gregory House from *House*, Perry Cox from *Scrubs*, and Christina Yang from *Grey's Anatomy*. House creates an emotional barrier and distances himself from his patients by refusing to trust them. He constantly proclaims, "everybody lies" to justify his behavior (Jensen); Cox demeans his colleagues and emasculates his intern John Dorian by addressing him with female names rather than his real name (*Scrubs Wikia*); Yang intimidates her colleagues with her intensity and even tells one of them, "I'd rip your face off if it meant I got to scrub in" (*Grey's Anatomy:* "The First Cut is the Deepest"). However, as each television series progresses, viewers become intimately acquainted with these doctors and learn they are actually hiding their vulnerabilities: acting cold is a

coping mechanism developed to survive the pressures of practicing medicine. By the end of the series, House gives up medicine so he can spend time with his terminally ill friend (*House* "Everybody Dies"). Although Cox acts tough, he genuinely cares about his patients and colleagues. His guilt with the role he played in a patient's death paralyzes him but inspires Dorian, who explains, "after twenty years of being a doctor, when things go badly you still take it this hard" (*Scrubs* "My Fallen Idol"). Yang confides to a new colleague that her competitiveness comes from her desire to succeed after feeling her father's heart stop beating (*Grey's Anatomy* "Rise Up"). The intense scrutiny these physicians face makes it difficult for them to expose their vulnerability so that they instead prefer to emulate the image of an emotionally distant and hardened individual.

Callousness is just one of many ways physicians react to the rules governing the practice of medicine. Burnout, defined as "emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment," is another way doctors react to pressures created by the system (Gunderman). The prevalence of burnout is increasing. According to *Forbes*, the number of physicians who would choose a career in medicine if given the chance to do it again decreased by 15% between 2011 and 2012 (Adams). In his memoir *Doctored: The Disillusionment of an American Physician*, cardiologist Sandeep Jauhar points to a survey that showed 58% out of 2,000 doctors surveyed felt their passion for medicine diminished over the past five years while 87% confessed that their morale had depreciated (11).

The responses doctors have to the system and the threat of burnout can be examined through the lens of the hegemony. This analysis is important because it provides answers to why physicians often condone strict guidelines that increase the

pressures already placed on them rather than combat these policies. Theorist Raymond Williams defines hegemony as a "complex interlocking of political, social and cultural forces" that integrates ideals and beliefs into society so seamlessly that citizens believe the values instilled by cultural institutions are synonymous with their own worldviews (1277). Besides weaving ideals into the dominant culture, hegemony thrives because it anticipates change by identifying potential opposition and absorbing these changes to fit within the paradigms of the institution before it can fully actualize itself as a threat. This acclimation creates the illusion that the hegemonic culture is constantly progressing. The appropriation of tradition is one method the dominant culture uses to maintain its power. Williams defines tradition as a "deliberately selective and connecting process which offers a historical and cultural ratification of contemporary order" that draws its power from its connection to "many practical continuities – families, places, institutions, a language" (1281). The traditions commandeered by the dominant culture have a specific purpose and often reinforce the hegemony's values. Hegemony is integrated so closely with the ideals that citizens value that it becomes difficult to identify negative aspects of the dominant culture. Citizens are also less likely to combat the culture's paradigms because that would require them to fight against their own reality.

Although the hegemonic culture is the reality of many individuals, it can still be challenged by practices Williams classifies into two categories: residual and oppositional. The first, residual practices, are "formed in the past, but is still active in the cultural process" (1284). Residual practices can be further defined as alternative or emergent. Alternative practices are relatively passive because although they involve creating new or repurposing old ways to live, they do not challenge the system in a threatening way.

Williams gives the example of rural communities as something that is alternative and residual because the community is archaic and functions outside traditional society. Within the context of medicine, the Hippocratic oath would also be considered an alternative residual practice. Although physicians currently take the oath, many feel it is "inadequate to address the realities of a medical world that has witnessed huge scientific, economic, political, and social changes" (Tyson). We also see a shift in values in the practice of modern medicine: patient needs are placed secondary or even tertiary in relation to the needs of the hospital and even doctor. Physicians in today's culture will order unnecessary tests to protect themselves from potential lawsuits or to ensure profit (Pines and Meisel).

The changes and advances in medicine have transformed many traditional medical practices besides the Hippocratic oath into alternative residual practices. Another example of such an alteration is the physical exam. Since its origins in the 18$^{th}$ century, physicals were used as "an indication of disease that can be detected during examination of a patient by visual inspection, palpation, auscultation, percussion, etc." (*Oxford English Dictionary*). Although performing an exam can tell a physician much about the patient's condition, many doctors forgo the physical in favor of pursuing diagnostic studies that are often wasteful. In his memoir, *Doctored: The Disillusionment of an American Physician*, Jauhar recalls how a $20,000 work up to rule out stroke on his father could have been avoided if the doctor had performed a physical exam: the attending would have noticed that the symptoms were reproducible on exam because they were caused by a pinched cervical nerve (53). Despite the financial and emotional costs of disregarding the physical exam, the current culture of medicine continually relies on

technology. In response to this value shift, Stanford medical professor Abraham Verghese quips, "if you come to one of our hospitals missing a limb, no one will believe you till they get a CAT scan, MRI or orthopedic consult" (Verghese 2011).

While residual practices create a new way to live without making dramatic changes to the system, oppositional practices challenge the hegemony. Bedside manner is an example of a residual oppositional practice. In the 19th century, bedside manner was described as "the deportment of a doctor man towards his or her patients" (*OED*). Physicians were traditionally expected to provide comfort to the patient, but in today's medical culture, the pressures induced by increasing patient volumes and emphasizing profit has forced bedside manner to take a backseat because taking the time to get to know the patient could potentially make doctors fall behind with their busy schedules. The effect of the decreased focus on patients is that the patient/physician relationship suffers. In his TED Talk, Abraham Verghese notes that doctors interrupt their patient in fourteen seconds on average. In an effort to rectify this predicament, Verghese gives his patients forty-five minutes to tell him their history and complaint(s) during their initial encounter and then schedules their physical exam as a follow up appointment. This method allows him to focus solely on performing the physical exam. A routine like this is uncommon in today's medical culture, but Verghese is attempting to revive the art of the physical exam and has even created the "Stanford 25," a list of physical exam skills physicians must know. In interviews, Verghese explains his interest in the physical exam is his response to how "technology has turned the physical exam into a dying art" (Cary). By bringing these techniques back into the dominant practice of medicine, Verghese

wants to restore the patient as the focal point of medicine, which opposes the current litigious and technology culture.

While the residual is grounded through its relationship with the past, emergent practices are radical in comparison because the emergent is something that must be created and is for that reason relatively unknown. Williams explains emergent cultures are developed with "new meanings and values, new practices, new relationships and kinds of relationships are continually being created" (1284). The emergent challenges the dominant culture and like the residual, emergent cultures can also be classified as alternative or oppositional. An example of an alternative emergent practice is the use medical scribes in response to the transition from paper records to an electronic medical records system. Some physicians are unable to cope with the change to a paperless system and employ a scribe to chart for them. Scribes "enable physicians to see more patients; generate more revenue; and improve productivity, efficiency, accuracy of clinical documentation and billing, and patient satisfaction" (Gellert, Ramirez, and Webster). The use of scribes are a seeming necessity within contemporary medical practice because they help physicians adhere to guidelines and alleviate anxiety by allowing these physicians to focus on their encounter with patients instead of charting. However, scribes do not oppose the hegemony because not all physicians use the service and the scribes merely increase physician efficiency by allowing them to focus on aspects of their job other than charting. Each scribe must undergo several hours of formal classroom instruction before they continue their training in a clinical setting under the supervision of another formally trained scribed. These scribes perpetuate the current

practice of medicine and are prohibited from acting independently: at all times their work is dictated by the physician they work with.

Similar to alternative emergent cultures, oppositional emergent practices are also new customs but they differ because they challenge the dominant culture. An example of an oppositional emergent practice within medicine is a solo clinic model created by Pamela Wible, MD. She criticizes the current practice of healthcare for being "assembly-line medicine" and calls herself "America's leading voice for ideal medical care" (Wible). She attempts to mobilize physicians, medical students and other healthcare professions against the system by filling her website with testimonials and offering services such as retreats, private coaching and individualized marketing strategies for providers. Her model of medicine opposes the current hegemonic system because she practices her own values while openly criticizing the dominant culture and tries to get other healthcare professionals to follow her system.

New emergent practices such as the use of scribes and new clinics models are often incorporated by the hegemony before they can be fully actualized as a threat. Although the emergent culture creates something new, it never spontaneously appears; its origins can be identified as a type of "*pre-emergence*" where it is active but not completely defined (Williams 1286). The hegemony's control extends into defining the feelings individuals experience. As Williams explains, society interacts with feelings through an "immediate and regular conversion of experience into finished products" (1286). Rather than analyze emotions as they are being actively experienced, people hurry to classify their emotions using the terms created by the dominant culture because they assume their feelings fit within society's parameters. Hegemony therefore removes

the freedom individuals have to think and feel for themselves. Analysis of current emotions and experiences are challenging to process because it is difficult for people to distance themselves from the situation and reflect objectively. However, relegating facts and experiences to the past is detrimental because it encourages passivity. Suicide statistics are an example of this passive attitude. It is estimated that 400 doctors kill themselves annually and the likelihood of medical professionals committing suicide is twice as high as other professions (McPartland). Rather than confronting the issue of suicide by exploring what drives physicians to kill themselves and discussing these reasons, statistics such as this one allow us to avoid actively engaging with the issue because the numbers suggest that suicide is inevitable and nothing can be done to change the rate.

The rush to convert uncertain experiences into finished products removes the potential to explore new feelings. Williams describes feelings as embryonic (1288). By ignoring these new experiences, the dominant culture removes the ability for these new feelings to grow and be experienced because they are immediately categorized into defined feelings instead of explored. Williams proposes the concept of "structures of feeling" and defines this idea as a "cultural hypothesis, actually derived from attempts to understand such elements and their connections in a generation or period" (1289). Structures of feeling are actively lived and felt and are at the stage prior to becoming finalized products that have been integrated into the hegemony. Identifying and exploring these experiences can therefore illuminate the thoughts of individuals because emotions are an active process that should be experienced and explored as they are happening

instead of waiting until they have been categorized after the fact, which lessens their poignancy and increases the potential of incorrectly defining the feeling.

Besides defining structures of feeling, Raymond Williams also explains how these structures can be identified as they are lived and felt through fiction. He argues that the works of Charles Dickens and Emily Brontë (among others) exposed the conditions created by poverty and debt before social change came about by exploring these conditions in an environment with "reduced tension." (1290). I propose that analyzing fiction through the lens of Raymond Williams' theories acts as a gateway that allows us to explore how physicians respond to pressure, characterize burnout and identify what coping mechanisms physicians use and why they often fail. By analyzing literature, we are actively seeking a solution by trying to understand how and why burnout manifests itself instead of passively accepting problems as inevitable. This study uses New York cardiologist Sandeep Jauhar's memoirs *Intern: A Doctor's Initiation*, which recounts his medical training, and *Doctored: The Disillusionment of an American Physician*, which Jauhar uses to relates his experiences as an attending physician, to analyze how physicians struggle with articulating their anxieties and why they often fail to cope with coping with their emotions. The attributes of burnout in the United States are further defined by using Stanford University Medical School professor Abraham Verghese's *Cutting for Stone* as a lens to compare and contrast healthcare in the east and west. Verghese's novel indicates that burnout is a symptom of western healthcare because the condition is attenuated in the east. Through characterizing burnout, we can better understand the obstacles physicians confront and explore the issues in medicine in an effort to usher in social change by increasing physician satisfaction and improving care.

## THE WEIGHT ON THEIR SHOULDERS: THE STRUGGLE OF ARTICULATING ANXIETIES

While completing his Ph.D. in physics, Sandeep Jauhar decided to pursue a career in medicine after his then girlfriend was diagnosed with lupus (*Intern* 17). However, while training he lost his initial enthusiasm and found himself experiencing burnout, a state of "emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment" (Gunderman). While on call one night, he felt an exhaustion that he described as, "a different kind of fatigue than I had ever experienced, a tiredness mixed with unnatural excitation that went straight into the bones" (*Intern* 58). He struggled to explain exactly how he felt and could only compare his weariness using terms that he was familiar with, such as "fatigue" and "excitation." His description grounds his malaise to the realm of the physical because he only focuses on how his body felt and does not describe his emotional experiences.

Jauhar's burnout is not unusual within his specialty or his geographical location. A documentary published in 2013 called *Code Black* follows the lives of emergency medicine residents at the L.A. County Hospital in California and shows the pressures these providers are confronted with daily. One resident confides: "I don't know much about politics or the economy but I think I worry most about our spirit. All that divide – it makes us feel empty, lost, abandoned" (*Code Black*). While Jauhar focused on his physiological needs, this resident emphasizes the negative psychological effects and isolation that doctors experience. Another doctor in the documentary describes how the frustration of not being able to see all the patients in the waiting room makes him feel like "losing before you've started" (*Code Black*). While these doctors are able to

articulate their emotions, they lack the tools and resources to confront and resolve their anxieties.

Although the emergency medicine residents were able to explain their concerns in *Code Black*, Jauhar was unable to articulate his anxieties and continued believing his feelings were physiological in etiology. He attempted to cope with his stress with exercise:

> I was running a lot that winter, fighting an enveloping gloom. After exercise I felt different: more confident, relaxed, alive. In physics, kinetic energy must be added to get a particle out of a potential energy well, and so it was with me and running. In my office I'd sometimes run furtively in place with the door closed before making rounds. (*Doctored* 125)

Jauhar acknowledged that running was not a proper solution for his angst and his action of running in place symbolizes his stasis because no matter what he tried, he always ended up in the same place. By attributing his emotions to his body, Jauhar isolated himself by blaming himself for having these feelings. This blame increased the pressure on Jauhar because it forced him to explore and resolve his anxieties independently rather than asking for help. He even left his office door closed, which physically separated him from others. Jauhar's word choice of "furtive" indicates he wanted his anxieties to remain hidden and suggests he felt ashamed of his emotions. Because Jauhar had to rely on himself, he analyzed the situation by framing it as a type of problem he was comfortable with: physics. He emphasized his stasis by comparing his situation to a potential energy well: the well just needed enough kinetic energy, which suggested his anxieties could be resolved with time.

Although Jauhar attributed his emotions to a physiological problem, he eventually realized that his conflict was internal and attempted to articulate his feelings by writing in a journal so he could make the problem tangible and solvable. He wrote:

> Something is wrong – something. My mind is sluggish; I cannot focus. My mood is low; perhaps I am depressed; or perhaps this is just the way it is. I have felt for months that I am fighting something; I am fighting to stay up. I feel like a marble rolling around a bowl: back and forth, back and forth, speeding up as it gets to the bottom, desperately trying to avoid what will happen if I stop. How low can I descend? There is a pit visible and perhaps I am bound to fall into it. (161)

Jauhar's use of qualifiers such as "perhaps" illustrates he struggled to express his emotions; he kept trying to describe his feelings so he could have something to grasp but failed. Jauhar struggled to find an appropriate way to articulate his emotions because what he felt did not fit into any of the traditional categories of emotions society had created. As Raymond Williams explains, "practical consciousness is almost always different from official consciousness and this is not only a matter of relative freedom or control. For practical consciousness is what is actually being lived, and not only what is thought is being lived" (1288). Williams' theories suggest Jauhar's anxieties are a form of practical consciousness because it is actively being lived: his angst is not a finished product yet and therefore cannot be classified using society's language because even the hegemonic culture does not know how to quantify these emotions. Jauhar talked about how his mind was "sluggish" and how he felt "depressed", which shows that although he kept his thoughts private in his diary, he recognized that although he felt physically affected, his problems were not physiological in etiology. Lacking the tools to process his

feelings, Jauhar again relied on his background in physics as a coping mechanism: he compared himself to a marble rolling around in a bowl, which justified his descent as reasonable and natural. This logic released Jauhar from any blame because there was nothing he could do to prevent his fall and therefore excused him from finding a solution because the consequences were "inevitable."

Jauhar did not know how to express his emotions and tried resolving his anxieties with a typical dominant culture tradition: marriage. While training as an intern, Jauhar dated a medical student named Sonia. He initially hesitated to marry her because he did not want his wife to be a doctor. When he asked his colleagues for advice, the majority of them advised him to marry a fellow physician. One mentor justified his counsel by telling Jauhar, "when you get paged away during your anniversary dinner, only another doctor will understand" (*Intern* 98). Another doctor echoed this suggestion and told Jauhar that communication would be easier because he and his wife would speak the same language: "'I don't have to come home and say, I started a dopamine drop on a patient today. Oh, and by the way, dopamine is a drug we use to…'" (98). The advice Jauhar received from his colleagues suggests the experiences and stress doctors experience is so exclusive to the field that marrying someone with the medical profession is the only way to find someone who can sympathize with their situation. Jauhar's colleagues are not the only physicians who agree with this advice: according to American Medical Association (AMA) Wire, almost 40% of married physicians wed someone from the healthcare profession (Vassar). Jauhar eventually married Sonia, but rather than finding comfort, his fears intensified. He found himself comparing his learning style to hers: "what I was content to memorize, she wanted to dig into more deeply. I was afraid she and her family

would eventually see through my facade" (*Intern* 98). Jauhar did not identify his wife as someone who empathized with his situation. Instead, she was the ideal physician Jauhar believed he should be but failed to become. Instead of verbalizing his feelings and confronting them, Jauhar continued his isolation by internalizing his emotions again and blaming his feelings of inadequacy on himself.

When Jauhar failed to discover the solace he desired through marriage, he turned towards another aspect of dominant culture for comfort: family. However, Jauhar's family also did not commiserate with him. After Jauhar confided his fears to his father, he was told:

> Take care of your health, too. Eat fruits. Exercise regularly. If you are healthy, you can face problems much better. Save money, too, as much as you possibly can. You will need money for good times and for bad. And make some friends, Sandeep. You have no friends. (*Doctored* 136)

Jauhar's father, who is also a scientist with a Ph.D., took an approach similar to the one his son initially took and recommended Jauhar treat his stress as physical symptoms that can be fixed with diet and exercise. He also advised Jauhar to improve his life in terms of societal standards by obtaining financial stability and friendship. His father's reaction isolated Jauhar further because it suggested that Jauher's angst was his fault and placed the burden of resolving his anxieties on him. Jauhar's father-in-law, who is also a medical doctor, took a similar approach when he proposed a solution. On a car ride, he told Sandeep, "the water is the same, whether it splashes you in the summer […] it is your sensation that changes" and "we have control over our responses […] we can choose to be happy or not" (174). While his father-in-law acknowledged Jauhar's anxieties were

psychological in nature, his tone was accusatory because he implied Jauhar had control over his emotions. This blame put guilt on Jauhar for experiencing his emotions because he suggested Jauhar could control his anxieties by altering how he perceived his feelings.

Although Jauhar's fathers were unable to provide him with the emotional support he needed, he was able to find comfort with his son, Mohan. While on vacation, Sandeep enjoyed a moment with him:

> Resting on my shoulder, his big head was a weight of stability and contentment. At that moment, nothing else seemed to matter. All the sacrifices in my life seemed worthwhile. I nuzzled him, smudging the lenses of my spectacles. I rubbed my stubbly cheek on his neck and shoulders. (192)

While it may appear that Mohan comforted him, he actually encouraged Jauhar's stasis because he justified the anxieties Jauhar felt and encouraged him to continue internalizing his emotions. Jauher's focus on the weight of his son's head on his shoulders shows his reversion to using physics as a lens to comprehend his anxieties. The contentment Jauhar felt with Mohan was dangerous because it did not provide Jauhar with the motivation to resolve his issues, which allowed his angst to exacerbate.

Unable to find solace or sympathy from his wife and family, Sandeep attempted to explore his feelings with the help of a psychiatrist. During a session, he tried to articulate his emotions: "'it's like butterflies in my belly […] it isn't anger. Perhaps it's anxiety that I cannot express the anger'" (191). Jauhar acknowledged that he did know how to convey his emotions and again used qualifiers such as "perhaps." He also tried using a simile to explain himself, which illustrates his struggle to verbalize his feelings. Jauhar's difficulty suggests that the anger he described was merely an emotion he latched

onto because it was a tangible emotion that had been defined and accepted by society. However, by describing his feelings as anger when it was not, Jauhar avoided confronting and exploring his emotions because he never actually explained what he experienced. As Raymond Williams explains, feelings are often "more recognizable at a later stage, when they have been (as often happens) formalized, classified, and in many cases built into institutions and formations" (1289). Jauhar could not articulate his anxieties because his feelings had not been formalized and integrated into society. Therefore, he had to use a psychiatrist for assistance because the psychiatrist helped him sort out and define his feelings based on what was socially appropriate and fell within the parameters defined by the dominant culture.

Jauhar's psychiatrist could not help him understand and resolve his feelings under the definitions prescribed by the dominant culture, so he attempted to treat his angst with an alternative to the hegemonic culture: religion. Jauhar accepted his in-law's invitation to a gathering with a renowned guru in the hopes of finding an answer to his angst. Jauhar described his encounter:

> He was talking like one of these crackpots who attended the Berkeley physics colloquiums on Wednesday afternoons, spewing theories about things they did not understand. (*Doctored* 179)

Jauhar's movement towards religions shows he acknowledged his anxieties were psychological and illustrates his desperation because he meets the guru despite his skepticism. His comparison of the guru to a crackpot shows that although Jauhar tried to listen to the guru's teachings, he dismissed the counsel because he believed the guru could not comprehend his experiences and therefore was unqualified to help him make

sense of his anxieties. His recollection of the session is placed in context of his past experiences at Berkley, which suggests that Jauhar still struggled to process his emotions and felt he had to again regress to something familiar and comfortable: physics.

Unable to cope with his emotions using methods from the dominant culture or from residual practices, Jauhar tried confronting his anxieties by using journalism as a space where he could investigate and formalize his feelings. Jauhar explained that writing made him feel safe because, "'I hate feeling stupid; I clam up and doubt myself. It's one thing in a field where ignorance is sanctioned, like journalism; quite another in a field where ignorance is vilified, like medicine'" (164). Jauhar feels too much pressure from medicine to be perfect and needs a place where he can reveal his insecurities and flaws without fear of judgment or retribution. Journalism provides a safe environment for Jauhar to actively engage with what Williams would call a "structure of feeling," which he defines as "social experiences *in solution*, as distinct from other social semantic formations which have been *precipitated* and more evidently and more immediately available". These structures of feeling are prevalent in literature and art, which are "the very first indications that a new structure is forming" (Williams 1289). Williams' theory shows that Jauhar's journalism indicates a new structure of feeling is emerging and Jauhar needs to grapple with the emotion in order to articulate and resolve his angst.

Although Jauhar struggled with his feelings and dreamed of a reprieve from medicine, he finally broke his pattern of relying on physics by addressing his anxieties in an article he wrote for *The New York Times*, where he questioned the use of night float interns for patient care. Jauhar argued that placing these interns in charge of a large number of critically ill patients they did not know was just as dangerous, if not more

perilous than having tired residents treat patients. Jauhar described his emotions when his first piece was published:

> Most mornings now I was waking up fantasizing an escape. That I had somehow found the energy while on leave to write the piece and get it published in the most important newspaper in the country only heightened my ambivalence about medicine (164)

Journalism galvanized Jauhar out of his stagnancy and gave him an authoritative voice within an oppressive community. He called *The New York Times* the "most important newspaper in the country" but did not explain why the periodical is so esteemed. Theorist Richard Ohmann explains this newspaper is important because the periodical acts as one of "the main gatekeepers of new talent and new ideas" (*The Shaping of a Canon* 208). *The New York Times* circulates amongst intellectuals and the upper class and provokes discussions about the topics covered in its pieces. By writing an article in this publication, Jauhar created a space where his anxiety could be discussed, analyzed and integrated into society. His journalism would fall into Williams' definition of an oppositional emergent practice because Jauhar's writing criticized traditional medical practices and advocated for change. Members of the medical hegemony such as Jauhar's peers reacted negatively to his article and the piece even provoked a response from Dr. Bertrand Bell, one of the practice's pioneers (*Intern* 164). Although his article did not result in administrative changes, it did promote discussion within the medical community. Jauhar continued writing and many of his articles threatened the future of his career because his criticism of the dominant culture exposed the vulnerabilities and weaknesses of healthcare. For example, after he wrote an article that revealed the complications that occur in Intensive

Care Units (ICU), his superior threatened his future opportunities at the hospital and tried to coerce him into writing an apology (*Intern* 193). However, Jauhar's writing injected him with confidence and he refused to detract his comments. He thought, "*screw it; I don't owe them anything*" and justified his decision by telling himself, "writing was too important to me to allow it to get corrupted like that" (194). Jauhar recognized the important of his journalism because it gave him a sense of purpose and allowed him to explore his ideas; writing allowed him to direct his attention to the structure of medicine rather than to his physiology, family, or religion.

While Jauhar's writing was beneficial to him personally, it was also advantageous to the public because it expanded the discussion about the practice of medicine. A fellow physician wrote a review on Amazon about *Intern* titled, "What it's REALLY like to become a doctor" and explained:

> This book is brutally honest. Jauhar tells it like it is and I got the sense he was not attempting to sugar-coat any of his narrative. As well, I totally believe that others being initiated into medicine go through the same struggles, questions, and observations as Jauhar (but for some reason are afraid to admit them). (Stephen Pletko)

Reading Jauhar's work became a way for these physicians to reflect on their own experiences and explore their feelings because they realized that they were not alone in feeling anxiety and insecurity. Jauhar's memoirs also provided insight for people not in the medical field. Another reviewer wrote:

> Seeing the "initiation" through Jauhar's eyes forces one to wonder, "Is this really any way to train physicians?" The process seems designed to grind them down to

> the point where patients are obstacles to "get through," in order to get to sleep or on to the next step. Medicine becomes a matter of checking off the boxes and covering your ass in case you are sued for medical malpractice. The process almost seems designed to callous doctors [sic] and inure them to empathic impulses. (Kevin Quinley)

The reviewer noted that the system was responsible for the angst that Jauhar and other physicians experience. This acknowledgement makes it more acceptable for physicians to feels these anxieties because these emotions are not individualized, but rather collective because they are felt in response to obstacles that are commonly encountered in the medical field. Although Jauhar's memoirs allowed him to define his feelings and promoted discussion, the books failed to offer an action plan or suggestions for resolving burnout. Jauhar's seeming acceptance of his situation creates a pessimistic outlook for the future of medical care as another physician reviewer reflects:

> In general, much of the author's experience parallels that of all doctors of our generation. You start a career wanting to help people and have a great professional career. As the years have gone by, the treadmill seems to get a little faster every year, the administrative hassles grow, and the paycheck gets a little smaller. Obviously, the doctor is the loser in this game, but the patient is also the loser. He or she gets a physician who is stressed out, hassled from very direction, frustrated, and has less time than ever to dwell on the encounter. Regrettably, I do not see the situation changing anytime soon, and I also see, on the horizon, a large egress from the profession of mid and late career docs, the ones who cared, worked early and late, and understood and possessed the best attributes of the

> culture of medicine of a bygone era. Things will get worse, maybe much worse, before they get better. (SageRad)

The appraisal highlights issues that plague the life cycle of physicians: they begin their careers optimistically but are worn down by the system through heavy workloads, pressure created by bureaucratic policies, and decreased pay which in turn affects the doctor/patient relationship in a negative downward spiral. No matter what the changes are in healthcare, physicians always comes out as the loser.

Now that we have identified the issue (burnout) and defined what it is (emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment) and some of the factors that are causing it (medical infrastructure and the increasing pressures placed on physicians), we need to help support the physicians that save us by identifying and enacting solutions.

As the reviews of Jauhar's memoirs indicate, the effect his works have in promoting awareness about the obstacles physicians face and how these obstacles lead to burnout is not exclusive to cardiology but extends across medical disciplines. *Code Black*, a documentary following emergency medicine physicians, is another example of how doctors are trying to express their vulnerabilities and concerns through the medium of literature and art. The film opens with the scenes of patients being treated at the hospital and is intercut with a resident saying, "We were going to be doctors. We were going to help people. But what if those ideals can die? I mean what if those hopes can fade into the failure of the system?" (*Code Black*) Resident physicians are close to finishing their training to become attending physicians. However, this resident physician says, "we were going to." The use of past tense instead of present tense and passive voice

suggests that despite holding the title of medical doctor, they have failed in essence and ideology to become doctors because their top priority is not the patient. The documentary acts as a vehicle to explore the effects bureaucracy has on the mentality of physicians and the frustrations that doctors confront. *Code Black* shows that when physicians are burnt out, it is not just they who suffer: their colleagues and patients also bear the brunt of the consequences. While Jauhar's memoirs focus on his own experiences as a cardiologist in New York, *Code Black* follows multiple physicians, from residents to attendings, within the emergency medicine specialty on the other side of the nation in California and illustrates that the diminishing gratification and increasing anxiety physicians feel is part of a larger phenomenon.

Another similarity the documentary shares with Jauhar's work is the film also creates a space for exploring anxieties and promoting discussion because it questions the status quo and illustrates the necessity of change. *Code Black* was so successful that it was picked up and developed into a series that premiered on CBS in 2015 (Andreeva). Although the television show fictionalizes the documentary, it had the potential to educate the public about the realities of healthcare. However, the television series fails to rise to the challenge and instead falls into the typical medical melodrama trope. Reviewers believe *Code Black* the show is a "manufactured and emotionally manipulative drama" and it is even compared to "a bag of Cheetos from a hospital waiting room vending machine" because the show is so packaged and uniform (Thomas). One review even celebrates the "overdramatic" dialogue of the show, which includes, "Your finger is now the only thing keeping that man alive" and "You're the doctor they want. I'm the doctor they *need*" (*Code Black* "Pilot"). The over-the-top dialogue and the

show is an an example of how the shows becomes a parody of what doctors face on a daily basis, creating an inaccurate portrayal of the medical field. As Kaplan Testing comments, "you'd think that working at a hospital basically means you'll have the most dramatic life, complete with whirlwind romances and exciting surgeries (oh, and of course, everybody will be good-looking)" (Goodwin). The continual glamorous portrayal of physicians hardens the public against the true nature and hardship of medicine: people think medicine is such a wonderful, sexy profession and fail to acknowledge the many obstacles associated with the field. Rather than taking advantage of the interest the public has on the profession as a platform to raise awareness about burnout and other barriers, the need to entertain and increase ratings takes precedence over finding a solution for the anxieties that plague physicians. The refusal of the public to confront and even believe medicine is something other than glamorous suggests that the first step to finding a solution to burnout is through shattering the illusions the public holds and raising awareness about the issue.

## A MENU WITHOUT PRICES: THE COST OF BURNOUT

In chapter one, we explored how burnout manifests itself in the United States by using Sandeep Jauhar's memoirs *Intern: A Doctor's Initiation* and *Doctored: The Disillusionment of an American Physician.* Jauhar struggled to articulate his emotions and initially exacerbated his anxieties because he blamed himself for his feelings. He attempted to resolve his issues with solitary activities such as running and journaling. When those failed, he turned to dominant hegemonic practices such as religion, marriage and family. However, these coping mechanisms were also unsuccessful. Jauhar only found solace after he wrote articles for *The New York Times* because his writing gave him a space to safely explore his feelings and removed him from isolation. His writing raised awareness about the anxieties physicians experience and the challenges in healthcare. Jauhar's journey and struggles illustrate that burnout can be difficult to identify because physicians are so isolated that they are unable to express their emotions and lack the proper resources to confront their angst. Although Jauhar shows the difficulty of identifying burnout and illuminates how coping mechanisms prescribed by the dominant culture fail, his experiences fail to address how burnout manifests itself and whether or not it is a tendency that is common in the United States. Using Abraham Verghese's novel *Cutting for Stone* to renegotiate the geographic borders of this study to encompass eastern and western medicine, I conclude that although stress may be inherent to the profession, the environment physicians are placed in heavily contributes to whether or not they become burnt out. Comparing and contrasting the eastern and western medical cultures shows that burnout is a recurrent phenomenon in the United States because it is a response to the hegemony's medical infrastructure.

The similarities of training requirements between Ethiopia and the United States shows how the west sets the standards for medical education. In the United States, prospective medical students must take prerequisite courses that include but are not limited to English, mathematics, chemistry, physics, and biology before applying to the program (UCLA Undergraduate Catalog 1980-81). Potential medical students in Ethiopia are expected to fulfill similar requirements: in *Cutting for Stone*, impending student doctor Marion Praise Stone describes his experience as an undergraduate student with his friend in Addis Ababa, Ethiopia: "we entered university together for our premedical course, and the following year we entered medical school" (Verghese 338). Rather than follow a model that allows students to instantaneously matriculate into medical school from high school such as the system used in Japan (Kozu), Ethiopia shares the same requirements as the west requires its potential physicians to complete prerequisites. The ability of the west to set the precedence for training illustrates its dominance because Ethiopia follows these standards and mimics another system, which increases the prevalence of western influence.

The west's influence extends beyond prerequisites and bleeds into the medical instruction because the west establishes the standards for what is considered adequate education. While studying at the Haile Selassie the First School of Medicine, Marion notes:

> Our basic science teachers were very good, a mix of British and Swiss professors and a few Ethiopian physicians who graduated from the American University of Beirut and then took postgraduate training in England or America. (339)

The faculty selection suggests there is a hierarchy within global medicine, where the west rests at the top and the other cultures can only attempt to emulate it. The medical faculty is saturated with foreign influence because only those who have directly been educated or trained in the United States, Britain or other colonies are permitted to teach. Even the most basic science courses must be taught by these professors because these classes are the foundation for the medical students and shape their careers as practitioners of western medicine.

Besides defining the parameters of medical education, the United States and United Kingdom also set the paradigms for medical procedures. When Missing Hospital's only surgeon Thomas Stone abruptly departs from Addis Ababa, the facility's internist Ghosh must assume Stone's role and repair an emergent bowel obstruction. Unfamiliar with the field of surgery, Ghosh recalls a mnemonic he learned while training in India:

> *A very large incision should be made*
>
> *– of small ones in such cases be afraid –*
>
> *The coil brought out, untwisted by a turn*
>
> *– a clockwise turn as you will quite soon learn–*
>
> *And then a rectal tube is upward passed–*
>
> *Thereon there issues forth a gaseous blast…*(144)

Ghosh follows these instructions religiously during the procedure and the operation unfolds exactly as the direction say they will: he makes an incision, removes twisted bowel and observes: "the spot where the twist had occurred, deep in the belly. Gently manipulating the two limbs of the loops, he untwisted, clockwise, just as Cope said"

(144). By following these instructions, Ghosh practices cookbook medicine because he adheres to the procedure rules, thereby intensifying the influence of the established dominant culture. The rhyming couplets also reinforce the authority of western healthcare because the rhyme scheme only works in English. The presence of the rhymes in a formal medical setting is also unexpected because rhyming couplets are more common in poems and children's nursery rhymes. The use of rhymes in the context of medical training suggests that the west takes on the role of a parent and must educate its eastern counterparts, whom are the children in the dynamic. These children of eastern medical practices eventually grow up to disseminate the ideals taught by their western influenced parents.

When Ghosh repairs the bowel obstruction, he follows the instructions verbatim and when he becomes comfortable with his role, he begins disseminating novel western medical procedures. He is the only surgeon in the area who performs vasectomies, which establishes Ethiopia as the epicenter of cutting edge techniques. Ghosh also teaches the method to other doctors. While serving as Ghosh's assistant, Marion notes:

> Ghosh had learned the technique of vasectomy as an intern, and he's learned directly from Jhaver in India […] The operation was a novelty in Ethiopia, and now expatriate men, particularly Catholics, came to Ghosh in increasing numbers for an operation that was uncommon or unavailable in their countries. (298)

Teaching this operation allows Ghosh to spread the influence of western medical practices. Ethiopia becomes the surrogate for the west and spreads the influence of the dominant culture by bringing the culture to those living outside the hegemony, such as the expatriates and Catholics mentioned.

While Ghosh promulgates western medical procedures, obstetrician and gynecologist (OB/GYN) Hema and her adoptive son Shiva Praise Stone use their knowledge of United States medical practices as a springboard to develop new procedures. Initially, when Hema treats patients diagnosed with vesiculovaginal fistula (or fistula for short) she uses the techniques outlined by Dr. Marion Sims, the father of OB/GYN and the first physician to successfully repair the complaint:

> Hema operated vaginally, using the bent pewter spoon the Alabama surgeon had fashioned – the Sims speculum, we now call it – which allowed for good exposure and made vaginal surgery possible. (348)

Although the procedure is over a century old, Hema uses the same approach as Sims because it is an established western practice and still works. By using Sims' procedure, Hema passively practices medicine because instead of trying to tailor treatments to her patients, she perpetuates the guidelines instilled by the dominant culture. Using Sims' operation is dangerous because he created the surgery for use in patients from the west, where the socioeconomic status of patients is different from the east. Hema even admits a patient may have to undergo the procedure multiple times before the operation is successful (346). When Shiva begins working with Hema, he keeps the surgery the same but alters the preoperative measures to address the predominant issues that are associated with Ethiopian culture: the patients are dewormed, their anemia is treated and they undergo physical therapy prior to the surgery (348). These changes to the regiment increase clinical outcomes and decrease postoperative recovery time while maintaining the integrity of Sims' work.

Despite the precedence established by the west and its influence on Ethiopian medicine, the practice of medicine is held at a lower standard than its western counterpart. When Ghosh contemplates moving to the United States, he "quietly mailed out applicants for an internship in America. Granted, he was thirty-two years old, but it wasn't too late to start again" (115). Despite being an attending in Addis Ababa and having a plethora of experience compared to newly graduated medical students, Ghosh must begin his training from the beginning if he immigrates because he must be initiated into the culture by fulfilling the same requirements as the other healthcare providers. Similarly, prior to his immigration to the United States, Marion must pass his medical equivalency boards before he can begin his internship program (372). A majority of physicians who practice in the United States must undergo the same training program (internship, then residency, which is followed by the option of a fellowship), which illustrates the relative uniformity of the medicine they practice. The consistency of this training suggests that doctors are products of the hegemonic culture because they all practice medicine under the dominant culture's paradigms.

The discrepancy of the medical training between America and Ethiopia creates a fantasy of western medicine despite the novel procedures created and practiced in the east. Towards the end of his life, Ghosh reminisces about his dream of going to the United States:

> I wanted to go to America so badly. All these years I've read *Harrison's* and other textbooks…the things they do, the tests they order…it's like reading fiction, you know? Money's no object. A menu without prices. But if you go there, it won't be fiction. (353)

Ghosh is unable to travel to the United States, so he mollifies his desire by consuming textbooks manufactured by that hegemonic culture and nurses a fantasy. In his illusion, Ghosh optimistically imagines a place where resources are endless, which reflects the prestigious image of American medicine: its reputation is so lucrative that Ghosh cannot even fathom it and must reduce it to "fiction." The myths surrounding western healthcare allow it to maintain its prestige and creates a vestige of hope for Ghosh because although the resources he has are minimal, he wants to believe there is a place where patient care is not inhibited by finite resources.

In spite of the awe created by the west, eastern doctors are willing to disregard the policies instilled by the dominant medical culture because although they are influenced by western healthcare, they have the mobility and ability to practice their own values. Besides dictating the standards for medical education, the hegemony also commands the criteria for publishing research papers. Ghosh is poised to publish an article about relapsing fevers in the respected science periodical *The New England Journal of Medicine*, but is stopped by the publication's editor, who demands Ghosh alter the name of the diagnostic marker he coins as "Adam's sign," after his compounder. Ghosh refuses and vehemently defends his decision in a letter:

> *...there is a Chovestek's sign, a Boas's sign, a Courvoisier's sign, a Quincke's sign – no limit it seems to white men naming things after themselves. Surely the world is ready for an eponym honoring a humble compounder who has seen more relapsing fever with one eye then you or I will ever see with two.* (341)

Ghosh reprimands the journal and the culture it promotes: the community is only willing to celebrate white men, which breeds a culture of prejudice and discriminatory privilege.

In his rebuttal, Ghosh highlights Adam's merits and reaffirms his decision. The journal's hesitation is ironic because although the compounder is a foreigner, his name "Adam" is relatively common in comparison to the other existing eponyms of "Chovestek", "Boas", and "Quincke", which sound exotic and are difficult to remember. The editor's hesitation reflects the uniformity the hegemony demands because Ghosh's publication, whose findings would be beneficial to the medical community, is not questioned on the basis of merit, but rather something as superficial as a name merely because Adam does not assimilate into the culture. The editor eventually concedes and Ghosh's article is published according to his own terms. Ghosh's willingness to fight for his ideals allows him to avoid burnout because he constantly advocates for his values and beliefs rather than conforming to the dominant culture.

Eastern countries often fall under the influence of the western hegemonic ideals of medicine, but the people operating within eastern medical structures resist burnout because they are not imprisoned by the values of the dominant culture. Ghosh's divergence from the west's paradigms is not an anomaly in eastern medical culture, but rather an example as the physicians at Missing Hospital exhibit qualities that fall outside the dominant culture's expectations.

Although we focused primarily on Ghosh's experiences thus far in this study, we will now investigate how his contemporaries resist burnout in Ethiopia. Upon arriving to Ethiopia, Sister Mary Joseph Praise reflects on her encounter with Dr. Thomas Stone during their voyage:

> His fierce passion had been a revelation to her. At the medical college hospital in Madras where she trained as a nurse, the civil surgeons (who at the time were

> mostly Englishmen) had floated around serene and removed from patients, with the assistant civil surgeons and junior and senior surgeons (who were all Indian) trailing behind like little ducklings. At times it seemed to her they were so focused on disease that patients and suffering were incidental to their work. (24)

Stone's "fierce passion" shocks Sister Mary Joseph Praise because it juxtaposes the lethargy of the medicine practiced in India; the country is still colonized by Britain and its healthcare is a carbon copy of Britain's standards because the attending surgeons are British while the junior and senior Indian physicians are training to conform to the paradigms of the British establishment. The comparison of the Indian healthcare professionals to "little ducklings" suggests the act of following western physicians is natural because ducks imprint, which is the act of recognizing someone or something as a parent. Imprinting is critical for ducks because they have a "need to follow something for their own safety is vital to their early survival" ("My Life as"). The simile suggests that conforming to the west's standards is necessary to thrive in the medical world. However, imprinting is also dangerous because it can prevent ducks from socializing appropriately with their own kind. Likewise, the British influence inhibits these Indian physicians from developing their own medical culture. This focus on hegemonic medicine establishes a dichotomy between standardized medicine and individualized medicine. Having all trained at the same hospital in Madras, India the Missing Hospital physicians recognize these tensions and restrictions, which influences their decision to leave India. Hema explains why she emigrates from her home country:

> She left because gynecology, at least in Madras, remained a man's domain, and, even on the eve of independence, a British domain, and she had no chance at all for a civil service appointment to the government teaching hospital. (49)

Hema highlights the sexism within Indian medicine, which is an issue that is also prevalent in the west. In the 1980s, only about 10% of physicians in the United States were female (U.S. Department 87). Even with the demise of colonialism, India's medical culture remains male dominated and Hema is only able to experience growth when she moves to Ethiopia, where she is recognized for her merit instead of being judged by her sex.

Ethiopia's enthusiasm for professional mobility prevents its physicians from experiencing burnout because the culture provides opportunities for promotion and celebrates individuality. When Ghosh assumes the role of Missing Hospital's resident surgeon, he dictates how he practices and decides he will be, "operating electively three days a week and doing the emergency cases as needed. But, as he often said at dinner, he was still an internist at heart and couldn't resist coming down to Casualty to see certain patients" (221). In contrast to the cemented healthcare roles that are common in the United States and Britain, Ghosh enjoys flexibility and moves fluidly across the medical disciplines according to what interests him. Ghosh's mobility within medicine also allows him to pursue his passions outside of patient care: he is able to explore his love for teaching when he accepts a faculty position at the medical school. Although the institution is predominantly staffed by faculty from the United States and Britain, "there was one Indian: our own Ghosh. Ghosh had a title: not Assistant Professor, or Associate Professor, or *Clinical* Associate Professor (implying an honorary, unpaid designation),

but Professor of Medicine and Adjunct Professor of Surgery" (339). Although Ghosh was trained in Madras, he does not allow the influence of the dominant culture to define him and instead uses his training as a tool to accomplish his goals. Ghosh's work is so individualized that no title exists that can encompass what he does and a new title must be created to define his position because his work falls outside the hegemony's paradigms.

The mobility that Missing Hospital physicians experience allows them to disregard the values of Western medicine and create their own values and traditions. When Ghosh entreats Hema for help with a patient by citing the Hippocratic oath Hema tells him, "the Hippocratic oath is if you are sitting in London and drinking tea. No such oaths here in the jungle" (143). Hema's skeptical tone implies medicine is something that is leisurely practiced because these physicians have enough time to sit and drink tea. Her tone reflects her derision of western doctors and their ideals because there is less emphasis on the welfare of the patients; western physicians must take an oath to ensure they will treat their patients whereas a pledge is not necessary in the east because it is inherent that doctors will treat their patients to the best of their abilities. Hema's attitude emphasizes Addis Ababa's isolation from the dominant culture because the country has separate traditions. Hema's description of Ethiopia as a "jungle" draws on the west's perception of Africa as uncivilized and savage, which is ironic because the country's healthcare is on par with that of the west because the physicians are also able to publish articles in prestigious journals and provide novel operations.

Hema attitude characterizes the dichotomy of eastern and western medical culture and these distinctions are clarified and explained when examined through the lens of Gish

Jen's theory on culture. Jen proposes that there are two types of cultures that define a person's perceived role in society: interdependent and independent. She explains that an interdependent culture is associated with the "collectivist self – stresses commonality, defines itself via its place, roles, loyalties, and duties, and tends to see things in context" whereas the independent culture is linked to the "individualistic self – stresses uniqueness, defines itself via inherent attributes such as traits, abilities, values and preferences, and tends to see things in isolation" (Jen 7). Jen argues that western cultures, such as the United States, are examples of an independent culture because they emphasize individual autonomy whereas eastern cultures, such as China, follow the model of the interdependent culture because individuals each have a social role that impacts the larger collective (Yang). However, I argue that these paradigms are inverted in medical culture: the western practice of medicine identifies with the interdependent because the physicians are defined by where they work and how they were trained. While the eastern practice of medicine is associated with independent culture because the physicians have autonomy and are encouraged to practice medicine in a way that brings them satisfaction.

Hema's specialty clinic illustrates how Ethiopia allows her to practice medicine based on her interests and abilities because of its nature as an independent medical culture. Each month she hosts Version Clinic, where she corrects the position of babies in the mother's womb so they can be delivered vaginally with reduced complications. Hema brings Shiva and Marion to the clinic one day and confides, "'for all I know, this clinic could be the biggest waste of time. Ghosh wants me to do a study to see how many babies float back to where they were after version'" (Verghese 241). Hema disregards the

opportunity to put her novel technique into the dominant culture and increase the prestige of eastern medicine because she is happy with her life and does not want her lifestyle threatened. She keeps her skills isolated and integrity intact by refusing to succumb to the pressure of generating research and producing publications. Hema explains, "'I have no desire to publish a paper that might put me out of business. I *enjoy* Version Clinic'" (241). Hema favors the intimacy the clinic affords her with her patients and her decision not to publish shows she is the master of her own career because she is allowed to focus on what she values and is not influenced by fame and the ideals of the dominant culture.

Although Hema does not want to publish her findings, she does not impose her ideals of how to practice medicine on her colleagues. Shiva's ability to create a clinic based on his values further illustrates why Ethiopian healthcare is an independent culture. Shiva never attends medical school and instead relies on Hema and medical textbooks for his education. His interest in medicine originates from his encounter with a girl with an infected fistula. The odor from her condition is putrid, but "worse than the odor (since she must have lived with it for more than a few days) was to see in her face the knowledge of how it repulsed and revolted others" (228). The girl is cast aside by her husband and community, who prefer to shun her instead of trying to understand why she is ill and help her seek treatment. In contrast to the typical societal reaction, Shiva has a visceral response to his encounter and devotes his life to developing effective fistula treatments because he understands it is unfair that women must suffer the consequences of a disease they cannot prevent (part of the reason fistulas are so prevalent in his society is because of the young age women are expected to marry). Shiva's dedication and passion allow him to live in the moment and focus on himself instead of being distracted

by a western fantasy. While Shiva disregards western influence, he does not actively hide his ideas from the west like Hema does. His adroitness with treating fistulas garners the attention of *The New York Times*, who publishes an article about Shiva. In the piece, "the writer's unabashed admiration for Shiva came through, and one sensed she had abandoned her reserve, her usual dispassionate tone" (468). Shiva uses the west as a way to increase awareness about fistulas and his clinic. His facility eventually gains financial stability from an investor in the United States because rather than keeping his ideas to himself, Shiva openly discusses what he does and seeks help to accomplish his goals.

The dynamics of eastern healthcare indicate medicine is a coping mechanism to environmental and emotional distress; while Shiva uses medicine as a response to correct a stigma placed on women, his brother Marion uses medicine as a method of finding and creating his identity. When Marion feels isolated from his family, he finds solace and purpose from medicine:

> I loved those Latin words for their dignity, their foreignness, and the way my tongue had to wrap around them. I felt that in learning the special language of a scholarly order, I was amassing a kind of force. This was the pure and noble side of the world, uncorrupted by secrets and trickery. (222)

The "foreignness" and "special language" of medicine initiates him into a world that allows him to safely explore his identity with its innocence and potential. Medicine gives Marion a sense of belonging by initiating him into an exclusive culture. He explains his passion for medicine: "my notebook was chock-full of drawings and new worlds. I found use at last for my penmanship: each figure was carefully labeled." (223) By placing the information he acquires into his notebook and supplementing it with his own figures and

writing, Marion actively plays with medicine in a way that makes sense for him. He reworks information to fit his own needs, which allows him to shape his identity rather than passively accept his role in society. Marion's appropriation eventually extends beyond hoarding his ideas in a journal and moves into the actual practice of medicine. As Marion's training progresses, Ghosh takes measures to assist him: "Ghosh handed Farinachi [the toolmaker] two old stethoscopes and a drawing of his idea for a teaching stethoscope" (223) In using the old stethoscopes to create something new, Ghosh and Marion show that the current structure of medicine is unable to fulfill their desires and still requires change for improvement. Marion manipulates medicine to suit his needs, which prevents him from experiencing burnout because he controls medicine rather than having medicine dictate the rules and roles of his life.

The ability of these physicians to avoid burnout allows them to find satisfaction with dominant culture traditions such as family. When Marion discovers that Ghosh has been hiding his cancer prognosis, Ghosh explains he wanted the routine of his life to remain unperturbed:

> You know what's given me the greatest pleasure in my life? It's been our bungalow, the normalcy of it, the ordinariness of my waking, Almaz rattling in the kitchen, my work. My classes, my rounds with the senior students. Seeing you and Shiva at dinner, then going to sleep with my wife. (345)

Without the pressure to constantly produce prestigious articles and develop new techniques, Ghosh is able to find deep satisfaction with his career, which melts into contentment with his personal life. He emphasizes the normalcy and routine of his life, taking pleasure in everyday occurrences such as eating dinner with his children. Ghosh

reminisces about moments in his professional and family life, which suggest that the two are equally important to him and he is able to devote time to both aspects of his life rather than having to pick and focus on one.

Besides finding contentment with family, physicians in Ethiopia also find satisfaction with alternatives to the hegemonic cultures such as religion. After the difficult delivery of male conjoined twins, Hema commemorates their survival by naming the eldest boy Shiva because he was "a child all but dead until she had invoked Lord Shiva's name" (109). Despite being a practitioner of science, Hema holds on to her religious beliefs, which give her solace when she is confronted with distress. Her faith even takes precedence over her medical background at times. After the twins are born, Hema's household performs religious rituals to ward off evil, which includes pseudo spitting. Ghosh objects to the rite: "'Remind me never to invite you into the operating theater […] antisepsis? Lister? Pasteur? Are you no longer a believer?'" to which Hema replies, "'You forget I am postpartum man […] warding off spirits is much more important'" (164). Ghosh appeals to Hema's logic by listing out the pioneers of medicine and disease but Hema disregards his concern because her religion and emotions are more important. Ghosh's question suggests religion and science cannot exist in tandem because they contradict each other. However, Hema's security and confidence with her career allows her to find a balance between her career and religion. She even names the second twin Marion after Dr. Marion Sims. Hema's choice in names straddles the dichotomy of religion and science but shows that the two are capable of existing in equilibrium.

Besides finding gratification with family and religion, the physicians of Ethiopia are also satisfied with their patient relationships and the bond between a doctor and

patient transgresses geographic boundaries. After passing his boards in America, Marion sees Tsige, the mother of a deceased Missing Hospital patient. She reminisces about the comfort Marion gave her while she grieved to the customers at her restaurant: "'Who was it who stayed with me as my baby fought for life? No one but him. He was the only one by my side when my little baby died. No one else was there for me'" (473). Despite not seeing Marion for years and being in a different country, Tsige never forgets his kindness and the comfort he gives her creates a sense of community and connection for both the patient and the physician. The repetition of "no one" and "him" makes Marion the focal point and illustrates the depth of Tsige's regard for him. The personalized care Marion provides shows how important the patient is holistically and his connection with patients and their families hinders feelings of depersonalization.

Besides benefiting the patient/physician relationship, medicine heals the mental and emotional pain eastern doctors experience in their lives. Marion chooses a medical career because it gives him direction when he feels lost. He reflects on his decision to become a physician:

> My intent wasn't to save the world as much as to heal myself. Few doctors will admit this, certainly not young ones, but subconsciously, in entering the profession, we believe that ministering to others will heal woundedness. And it can. But it can also deepen the wound. (6).

Medicine fills a void in Marion's life and gives him a sense of purpose. He admits that medicine is inherently selfish because most doctors want to use medicine as a coping mechanism for the pain they feel. However, these intentions do not translate into the actual practice of medicine: Marion acknowledges that medicine has the potential to

intensify his pain and one reason for this negative effect is that doctors are seemingly predisposed to burnout as part of the profession. However, during his training in Ethiopia, there is no evidence of burnout as Marion uses medicine to navigate obstacles, create his identity, and develop meaningful relationships.

While Marion's interactions with healthcare in the east shows no symptoms of burnout, his dynamic with medicine changes when he moves to the United States to continue his training. His relationship with medicine contorts and Marion loses his camaraderie with medicine. He begins experiencing the burnout he had avoided earlier, which suggests that the environment these physicians are placed in heavily contributes to whether or not they encounter burnout.

The dynamics of Marion's relationship with medicine changes once he arrives in New York because the paradigms of medicine change when he moves from east to west. Once he starts training in America, Marion begins feeling burnt out. However, stress for physicians in the United States is inherently associated with the profession. Marion acknowledges this intensity but explains, "I welcomed my slavish existence as a surgical resident, the never-ending blood, pus, and tears – the fluids in which one dissolved all traces of self" (466). The word choice of "blood, pus, and tears" in Marion's description illustrates how his life has been consumed by healthcare. Medicine consumes his lexicon and he does not have the opportunity or time to focus on his own desires. Marion believes his experiences are expected because burnout in the United States is viewed as a rite of passage, which reduces his likelihood of confronting his anxieties despite calling residency "brutal, dehumanizing, exhausting" (390). Marion explains this intensity allows him to feel: "integrated, I felt *American*" (466). His identity and acclimation to the new

culture becomes dependent on his residency. As Williams would explain, Marion relishes his new lifestyle because "the true condition of hegemony is effective *self-identification* with the hegemonic forms" (Williams 1282). Marion feels assimilated into the culture because he associates the demands of his job as part of a tradition. His acceptance signifies his transition from practicing medicine in an independent culture into working in an interdependent culture where he is a product of the hegemonic culture.

As his identity becomes increasingly dependent on medicine, Marion experiences stagnancy because he is in an environment that does not celebrate individuality. The mobility he formerly experienced in Ethiopia dissipates because his identity is no longer created by his merit, but instead by the hospital he works for because a facility reflects a physician's prestige. When Marion tours his internship site at Our Lady of Perpetual Succour in New York, he immediately notices:

> The tiled roof of the older section sagged between the chimneys while the middle floors pushed out gently like love handles. The decorative grille under the eaves had oxidized to a bile green, old corrosion ran down the brick like mascara, parallel to the drainpipes. (385)

The word choice of "oxidized", "bile green" and "corrosion" illustrates the decay and neglect of the hospital while the description of "love handles" and running "mascara" paints a portrait of a dilapidated person. The sagging of the roof reflects the response physicians have to the demands of their occupation because they succumb to the burdens of healthcare. The emphasis placed on the description of the facility shows that the hospital's reputation is more important than a doctor's individual accomplishment. As physicians become defined by where they work, the homogeny they experience with their

identity contributes to burnout because it removes the potential for personal accomplishment since the emphasis is on maintaining the status quo of the culture rather than on achieving personal desires.

Western physicians are held to high standards and constantly chase prestige rather than focusing on patient care, which leads to burnout because they lose sight of what initially attracted them to medicine. In the novel, Boston General Hospital is nicknamed "mecca" because it has the newest technology and all the resources physicians can dream of at their disposal. The facility attracts the best physician in the nation with its reputation as the ideal hospital. Marion describes his first impression of the establishment:

> "Mecca" consisted of a spanking-new hospital tower weirdly shaped and shining as if it were made of platinum. It was the kind of structure architects compete to build. From a patient's perspective, it didn't look welcoming. The tower hid the older brick section of the hospital, whose architecture felt authentic and aligned with the neighborhood. (420)

Marion's depiction establishes a dichotomy between the hospital's image and its history because the there is a tension between the authentic with its "older brick section" and the superficial from its "weirdly shaped and shining" structure. The clinic's focus on its image and the change between how it previously appeared and how it currently looks illustrates the shift in values from treating patients to viewing patients as a commodity as the building loses its warm and comforting attributes. The hospital obscures its older sections, which suggests it is hiding what it truly is, in favor of emitting an illusion: the facility reflects the medical culture because its physicians present an image of prestige and honor when that is not what they actually are.

The image created by healthcare facilities perpetuates the fantasy of western physicians as ideal professionals when in reality they are often tired and overworked. Our Lady of Perpetual Succour treats a high volume of low-income patients. Unfamiliar with western healthcare, Marion does not realize this is atypical for an American hospital. However, his chief resident, Deepak Jesudass enlightens him that their facility is an anomaly because:

> All medical students and interns are in super white coats with badges that say SUPER MAYFLOWER DOCTOR. Even if they care for the poor, it's honorable, like being in the Peace Corps, you know? Every American medical student dreams of an internship in a Mayflower hospital. (411)

The dreams of American physicians highlights the distinction between the practice of medicine in the United States and Ethiopia because in Addis Ababa, the physician's focus is on medicine and the socioeconomic status of patients is irrelevant: citizens and the royal family are all seen by the same doctors (238). In contrast, rather than treating the poor with the respect and compassion they deserve, these western physicians are afflicted by the allure of prestige. The image of the "super white coats" suggests these doctors do not get their hands dirty while the reference to the "Mayflower" alludes to a history of classism and privilege, which pervades into the current culture because a patient hierarchy exists that places poor patients at the bottom and frames physicians as saviors to poorer communities. This attitude prevents physicians from treating all their patients equally and contributes to depersonalization by removing the empathy doctors have. The focus of medical students on pursuing internships at privileged hospitals encourages stagnancy and establishes a homogeny because all these students are pursuing the same

goals. These objectives set physicians up for burnout because their success becomes measured by their workplace and accolades rather than their individual ability to treat patients. This precedence sets doctors up for burnout because they lose confidence when they do not meet these goals and creates a conflict between ideals and the practice of medicine as the Hippocratic oath becomes secondary to profit and fame.

As the focus of doctors shift from patient care to prestige, the solemnity of the Hippocratic oath diminishes because the pledge because empty words that initiate physicians into the field instead of establishing a standard of quality care. The oath becomes what Raymond Williams would classify as a selective tradition, which is "an intentionally selective version of a shaped past and a pre-shaped present, which is then powerfully operative in the process of social and culture definition and identification" (Williams 1280). As Williams explains, the Hippocratic oath is a tradition that merely initiates doctors into the medical field. The focus on a past tradition locks physicians and contributes to their stagnancy by preventing them from progressing. The oath standardizes their training instead of becoming the values physicians live by because rather than treating the patients, physicians are distracted by the need to publish papers, generate profit and discover novel procedures. This competitive attitude ultimately harms patients because they are no longer the focal point of medicine.

When patients are no longer the focus of healthcare, physicians allow their fear of ridicule influence what treatment they provide. This anxiety immobilizes doctors and harms patients. When Marion unexpectedly contracts Hepatitis B and his condition deteriorates to a critical level, Shiva proposes that surgeons Stone and Jesudass perform a

procedure that has never been attempted before: a liver transplant with Shiva as a living donor. His proposition is met with hesitation from the doctors, who argue:

> If we fail [….] we lose you who walked in here healthy *and* we lose Marion. Not to mention that we won't have a leg to stand on *or* that our careers could be over. Even if we succeed, we will be heavily criticized. (502)

Stone and Jesudass are pessimistic of proceeding with such an operation and justify putting their own needs before the patient's by listing out the negative aspects. Both surgeons are focused on the effect the procedure will have on their reputation because western medicine is so focused on status. Their reluctance illustrates the power of the hegemonic culture because these physicians fear the retribution they will face for opposing the uniformity established by the dominant culture more than the welfare of Marion, who is Stone's son and Jesudass' confidant. Ironically, opposing the dominant culture is actually beneficial for the culture because as Williams explains, the hegemony "does not just passively exist as a form of dominance. It has continually to be renewed, recreated, defended, and modified. It is also continually resisted, limited, altered, challenged by pressures not at all its own" (1279). The dominant culture needs to be challenged because it asserts its control through giving the illusion of constant improvement and progression. Jesudass and Stone eventually relent and agree to perform the operation, but the focus is always on the dominant culture instead of the individuals. Rather than supporting advancements in medicine, the dominant culture controls medical practitioners by instilling them with fear, which illustrates how insecure the culture is. This rigidity puts practitioners in a difficult position because it creates a conflict between

what doctors think they should do to appease the medical culture versus what they want to do.

Besides coercing physicians into practicing hegemonic medicine, the dominant culture also diffuses potential threats to its authority by controlling how citizens perceive emerging practices. When an article is published in *The New York Times* about Shiva's fistula clinic, the journalist is quick to point out that Shiva is "not a physician, 'but a skilled layperson, initiated into this field by his gynecologist mother,'" which erodes his credibility. However, the article also praises his novel work and draws attention to the clinic's "fund-raising efforts and the desperate needs, and the article brought donations pouring in" (Verghese 468). The story's assistance in securing funding ensures the clinic's success is tied to the dominant culture. As Raymond Williams explains, any hegemonic process must be especially alert and responsible to the alternative and opposition which question or threaten its dominance" (1279). The hegemony's success relies on its dynamism – it must constantly evolve and change in response to potential threats, which creates an illusion of constant progress. Williams elaborates, "to the degree that is *emerges*, and especially to the degree that it is oppositional rather than alternative, the process of attempted incorporation significantly begins" (1285). *The New York Times* feature is published before Marion even knows about his brother's fistula work, which illustrates how rapidly the dominant culture moves to integrate Shiva's work to its system in order to neutralize its danger (467). The west attempts to appropriate the success of the clinic because it perceives Shiva as a threat: rather than conforming to the standards of western medicine, Shiva creates his own rules and follows his own ideals instead of

conforming to the dominant culture. The constraints placed on western physicians create frustration. Marion reflects on his anxiety to reading the article:

> I'd followed all the rules, and tried to do the right thing while he [Shiva] ignored all the rules, and here we were. Could an equitable God have allowed such a thing? I confess, it was a while before I could read the article. (Verghese 467)

Ironically, those that do not follow the rules of the dominant culture are recognized for their work whereas those do adhere to protocol are not acclaimed because they are merely doing what is expected and are not producing anything novel. Marion does not share the enthusiasm of the journalist and his bitter attitude illustrates his dissatisfaction with his career because he feels that despite performing the duties of his job to the best of his abilities, his work is not good enough to merit recognition. Marion delays in reading the article because he prefers avoiding the issue rather than confronting his dissatisfaction and insecurity.

Instead of encouraging the mobility and promotion of its physicians, the western medical culture expects its doctors to fall into their positions within a hierarchy. Marion recounts his encounter with the tier of medical professions when visiting Boston General Hospital:

> A gaggle of medical students in short white coats filed in and joined us in the back. I'd forgotten about the existence of medical students. How nice it would be at Our Lady of Perpetual Succour to have someone below me on the food chain. The residents wore longer coats, and their expressions were not as carefree as the students'. The attending physicians wore the longest coats and were the last to

come in. We interviewees in our dark suits stood out like penguins at a polar bear convention. (421)

The medical professionals are discerned based on the clothing they wear, which denotes their duties. The hierarchy is established by where these professions are in their training, starting with medical students at the bottom and then ascending from intern, resident, fellow, and attending physician. This establishment of roles shows that western medicine falls into the interdependent culture that Gish Jen defines because of the commonality amongst physicians. Marion even admits he wants to have someone below him because he is working in a culture of isolation and rank rather than an environment that encourages camaraderie. The interviewees are described as "penguins at a polar bear convention" because these animals live on opposite poles and these interviewees are removed from the culture of the hospital. This detachment suggests a culture in which physicians are isolated from each other because they are in competition with each other. Even the interviewees antagonize and judge each other based on where they received their primary medical education. When Marion tells an interviewee he went to medical school in Ethiopia, he notices, "if she could have moved one seat over, she probably would have" (422). The interviewee's dismissive attitude towards Marion perpetuates a culture where a doctor's identity is contingent on where they train and practice medicine at. Their attitude destroys any potential for collaboration, intensifies isolation and increases the potential for anxiety, which leads to burnout.

Beyond immobilizing physicians by placing them into roles within a hierarchy, the isolation of doctors also detrimentally affects their relationship with patients. A

mother of Thomas Stone's deceased patient writes him a letter expressing her disappointment with her son's end of life care:

> It would have been merciful if he had been unconscious. They had important things to do. They cared only about his chest and belly. Not about the little boy who was in fear. Yes, he was a man, but at such a moment, he was reduced to a little boy. I saw no sign of the slightest bit of human kindness. My son and I were irritants. (423)

Instead of treating the patient with dignity and respect, the care team treats the patient as a commodity. Objectifying the patient replaces the physician/patient relationship with a hierarchy that places more emphasis on doctors and their work. This disconnect creates a toxic atmosphere between patients, their family, and the care team despite wanting to achieve the same goal: healing the patient. Instead, the patient's family becomes another obstacle to overcome while the physician increases the anxiety of the patient's family. This tension is illustrated by the way the mother addresses the care team as "they", which isolates her from the doctors and establishes them as the other. This depersonalization of doctors increases the potential for burnout because they lose the ability to connect with others and lose their sense of personal identity as they become pawns of the hegemonic culture.

The burnout physicians experience limits their ability to treat patients and ultimately affects societal culture because it contributes to keeping patients within their socioeconomic rank: a patient's status dictates the care they receive and the physicians they can see. Jesudass explains the patient demographic treated at Our Lady of Perpetual Succour:

> The poorest in America are the sickest. Poor people can't afford preventive care or insurance. The poor don't see doctors. They show up at our doorstep when things are advanced. (390)

Patients are segregated based on their class and these patients suffer because they are forced to wait until their condition deteriorates before they seek treatment. Even then, the choices these patients have are limited because they can only go to certain hospitals, such as Our Lady of Perpetual Succour. Physicians therefore become tools within a profit-focused hegemony because the patients they see are dictated by the dominant culture. Jesudass elaborates on his frustration when he tells Marion about how Boston General Hospital comes to their facility to take organs from deceased patients for their transplant patients because these operations make a profit of several hundred thousand to half a million dollars. However, Our Lady of Perpetual Succour does not see any of that revenue: "*Us?* They don't pay us a fucking cent! That's how much *they* make. They come, cut, and take, show us the middle finger, and ride off in their whirlybird leaving us on our camels" (391). Jesudass' bitter attitude shows that even if physicians know they are used to generate money for the dominant culture, they are essentially helpless because there is nothing they can do to combat the hegemony. The juxtaposition of "camels" with the "whirlybird" emphasizes the economic discrepancy between the various hospitals in the United States and establishes the competitive nature that is encouraged in the west. Although stress is inherently associated with a medical profession, the infrastructure of the west exacerbates that anxiety until it evolves into burnout. Physicians lose their individuality as they become an aggregate of white coats that are emotionally exhausted.

The focus on the western dominant culture's success instead of physicians' desires contributes to burnout because physicians must relinquish their ability to practice individualized medicine because they are being pulled in so many conflicted directions by society's demands. Physician Abraham Verghese uses fiction as a vehicle to examine his journey of transitioning from eastern medicine into western medicine and explore his anxieties; critics argue that *Cutting for Stone* is semi-autobiographical as Verghese shares many similarities with Marion Stone. The parents of both men were raised in Madras, both men studied medicine in Ethiopia and then eventually ended up practicing medicine in the United States after completing their residencies in America (Grady). Verghese even explains his inspiration for writing the novel on his website:

> I wanted the reader to see how entering medicine was a passionate quest, a romantic pursuit, a spiritual calling, a privileged yet hazardous undertaking […] It's a view of medicine I don't think many young people see in the West because, frankly, in the sterile hallways of modern medical-industrial complexes, where physicians and nurses are hunkered down behind computer monitors, and patients are whisked off here and there for all manners of tests, that side of medicine gets lost. (Verghese)

Verghese uses the novel as a mechanism to address his anxieties and the ramifications he sees for the current medical culture because the romance of medicine becomes lost in translation as medicine becomes increasingly regulated and muddled down by guidelines and physicians are the ones that will experience the brunt of the consequences. Verghese's concerns have been echoed by many healthcare professionals whom have explored these issues in outlets such as newspaper articles and blogs. For example,

Verghese mentions computers are overrunning healthcare. Registered nurse Theresa Brown reverberates these same concerns in an article written for *The New York Times*, where she highlights the inefficiency of electronic documentation: "All the attention given to our paperwork is taking us further and further away from the difficult truth that meeting very ill patients' needs occur in real time with real people, not in the paperwork about them" (Brown). She explains that medical professionals are often encouraged to chart excessive assessments on patients to present them as higher medical risks in a process known as "upcoding", which increases the reimbursement that hospitals receive. This article, one of many written by medical professionals, illustrates that Verghese's apprehensions are legitimate and the nation is beginning to take notice. Verghese has disseminated his concerns to multiple iconic cultural outlets, which include giving a TED Talk and being interviewed by the National Public Radio (NPR). The nation's increasing interest in his work turns a critical eye to the current practice of healthcare and its future. This attention also illustrates the legitimacy of using fiction and literature as a medium to explore and analyze ideas, which will continue to be critical as physicians struggle to articulate their feelings when confronted with the increasing pressures presented by the dynamics of healthcare and the dominant culture.

## RESTORING THE PASSION AND ROMANCE OF MEDICINE

Physicians in the United States have difficulty articulating their emotions and confronting their anxieties because they either believe their apprehensions are a natural facet of the medical culture or they fear repercussion. These physicians cannot cope using methods prescribed by the dominant culture. Writing and reading literature are viable vehicles for exploring and confronting emotions because they offer a safe space and encourage discussion. Cardiologist Sandeep Jauhar's memoirs showed how burnout manifests itself and promoted conversations about the current state of the medical hegemony while Abraham Verghese's novel allowed us to examine the practice of medicine cross-culturally by comparing the United States and Ethiopia, which allows us to conclude that burnout is distinctive to the west because it is a response to the infrastructure of healthcare.

The effect of burnout illustrates it is critical to continue breaking down the barriers that isolate physicians by disseminating the truth about medical culture. While this thesis used memoirs and a novel as a lens to examine burnout, there are other viable mediums that can be used. In 1998 chemist and novelist Carl Djerassi published an article in *Nature*, a prestigious multidisciplinary science journal that typically publishes research papers. In his piece, Djerassi argues fiction is a space that promotes the "discussion of ethical dilemmas that are frequently not raised for reasons of discretion, embarrassment, or fear of retribution" (511). At the end of the article, he encloses a renga (a writing style in which two or more authors take turns writing a story all while their identities remain anonymous to each other). The particular story Djerassi includes is written by experts in various field, which ranges from disease neuroscience to physics to journalism to

computer science. Despite the divergent disciplines, the story seamlessly encapsulates the dichotomy between academic and financially driven industrial science, which suggests the pressure and disillusionment the characters experience is universal. The renga provides a safe space for these authors to explore their anxieties without fear of being reprimanded.

While it has always been critical to explore anxieties, the importance of being transparent about the anxieties physicians experience is even greater now due to the numerous changes in healthcare. Healthcare in the United States is currently undergoing alterations in response to the Affordable Care Act (ACA). Implemented in 2014, the law prevents insurance companies from increasing patients' fees based on their medical history, limits the fees charged to elderly patients, and extends the coverage young adults. After the introduction of the act, over eight million citizens enrolled in healthcare. However, while the number of insured patients increased, the number of physicians choosing to participate in the law decreased. Over 214,524 doctors opted out of the program for various reasons such as decreased reimbursement rates: while ACA plans pay approximately $0.60 for a service, Medicare compensates $0.80 and private plans pay $1.00 for the same service (La Couture). In response to this reduction, physicians are forced to accept a decrease in pay or take on more patients, which would increase their workload and augment the potential for burnout (Fodeman). Even without the decreased reimbursement rates, the threat of burnout would still hover over the heads of physicians because there are always obstacles waiting to confront doctors. One such barrier is that the demand for physicians outweighs the supply. *The Washington Post* estimates that by 2025, there will be a physician deficit of 90,000 (Bernstein). If this deficiency is not

addressed, doctors will be forced to increase their patient volume, which will increase patient dissatisfaction and physician burnout.

As a doctor's burden intensifies in response to the changes in healthcare infrastructure and augmenting patient needs, the threat of burnout also increases because no significant action has been taken to address the declining satisfaction and morale of physicians as current bureaucratic policies are focused on profit. The attention on revenue was felt when 30% of residents in the Columbia University/New York Presbyterian Family Residency Program were fired when the program was unexpectedly shut down on October 12, 2015. Despite the rising needs of patients and generating a profit of over 365 million dollars in 2014, the administrators wanted to focus on fortifying their specialty care programs because specialists typically make 45% more than primary care providers (Berke). The program was eventually reinstated after a harsh outcry from the public and the incident shows how physicians are used as a vehicle for profit and also illustrates the powerful effects of public awareness and intervention.

While writing openly and promulgating awareness is important to creating a solution, it is also critical to analyze the strengths and weaknesses of other medical cultures to further characterize burnout and discern possible panaceas. For example, in Singapore, 81% of physicians are satisfied with their careers while 92% are happy with the amount of autonomy granted to them (Qian and Lim 367-368). Singaporean doctors have more choices and healthcare policy is structured in a manner where each healthcare provider has a clear and collaborative role in a culture centered on the patient: general practitioners (GPs) take the time to listen to their patients and they act as a liaison between the patient and the community by connecting patients to other healthcare

facilities as needed and specialists handle specific and limited diseases within hospitals (369). I believe the distinction between the roles of the providers places the emphasis of patient care on teamwork and reduces the burdens placed on physicians.

Besides Singapore, many other countries also have a relatively high degree of physician autonomy, which contributes to lower burnout rates in comparison to the United States. In Denmark, all GPs are independent contractors and the only government requirements are to open their facility from 8 a.m. until 4 p.m., see all patients with acute complaints in the same day, and evaluate all other patients within five business days. As a result of this flexibility and independence, Denmark had a burnout rate of 28% between May 2004 and January 2012 (Pedersen, Andersen, Olesen, and Vedsted).

While increasing the amount of physician autonomy in the United States is a possible solution for addressing the burnout looming over physicians, it is not the solution that will end all problems. It might not even improve career satisfaction. However, it is critical to take action because while engaging in discussion about issues is important, especially while trying to articulate emotions and identify what the problem is, it is also important to resist the temptation to remain passive. We must actively address these anxieties because it is only by exploring emotions that we can create an environment that is safe for physicians to voice their feelings because doctors should not be forced to internalize their feelings nor should there be repercussions for being vocal. One day, we must be able to take their emotions from the page and translate them into reality because confronting burnout is not just beneficial for physicians: it is also advantageous for patients and hospitals. Studies show the satisfaction of patients is directly correlated with the happiness of their physicians: patients with doctors who are

highly satisfied with their job are more likely to leave their encounter with their physician happier than those who receive care from a burnt out doctor (Qian and Lim 364). Patient and physician satisfaction will generate more revenue for hospitals due to increased patient numbers and more productive physicians. As we work towards reducing burnout, perhaps the words of the Hippocratic oath will regain its credence and we can restore the sacred bond between physicians and patients. Until then, we must continue examining burnout, from the way it manifests itself to its effects, using as many methods as possible, whether that is through analyzing the Singaporean or Danish healthcare systems further, questioning the lack of resources available for physicians, or examining more novels that explore the anxieties physicians feel. Regardless of the method, we must never stop talking about burnout because to silence anxiety and fear is to silence physicians and plunge them back into isolation.

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