Introduction and Overview

We no longer have doctors in America; we have *healthcare providers.* We aren't patients; we're *consumers.* The healthcare system has turned the art and science of healing into big business, and many doctors can no longer devote the greater part of their working hours directly to patient care, faced as they are with reams of insurance- and legal-related paperwork, the constant threat of malpractice, and a burgeoning patient population. Despite this, some physicians still enter the profession with deeply held convictions, hopes, and idealism, and go on to excel not just as medical doctors, but as human beings. Some volunteer their time and expertise mentoring others or volunteering their services. Some found or fund organizations devoted to good works. Some spend their off hours lost in research or tinkering with tools and ideas for theories or devices whose only profits may be measured in lives saved. Many do this on a volunteer basis and some in addition to their very full-time jobs as medical doctors.

Why? Let us consider two fictional doctors—Dr. Smith and Dr. Jones. Why does Dr. Smith go to the office, treat patients, and go home in time for dinner, while Dr. Jones goes to the office early, plugs away at some pet research project, treats patients, stops at the hospital to check a patient's progress, goes to the board meeting of a charitable group, types up extensive notes about each patient of the day, and picks up take-out on the way home to a dark house? Why are some people just so . . . *good*?

This is no small question. It is universally acknowledged that the healthcare system in the United States is ailing. What is less clear is what is causing the problems and how to effect a cure. As the life expectancy and overall health of Americans have increased, patients' levels of respect and trust for the doctors sworn to prevent, diagnose, and treat illness have decreased. People question the quality and course of their care, suspicious that the doctors' tests and treatments are based less on what is best for the patient than on what is allowed by the insurance companies. Most of the suggested cures for the healthcare system focus on finance, as though the medical expenditures growing uncontrollably and metastasizing at every level of the system are the cause of the ills. But what if the cause goes deeper than that? What if there's something much more basic we need to make healthy before we can hope to take care of the upward-spiraling costs?

In 1996, one doctor suggested a different root cause of our healthcare system's ailing state. "Medicine's profound crisis," he wrote in *The Lost Art of Healing*, "is only partially related to ballooning costs, for the problem is far deeper than economics. In my view, the basic reason is that medicine has lost its way, if not its soul. An unwritten covenant between doctor and patient, hallowed over several millennia, is being broken" (Lown, 1996, p. xi). Who is this doctor to be suggesting that there might be something not quite right at the human level? Surely he must be some obscure, radical scientist to put forth a view so contrary to common wisdom. No, this doctor is none other than renowned cardiologist and Harvard Medical School professor Dr. Bernard Lown—the man who developed a version of the defibrillator that resuscitated hundreds of thousands of patients. He is also one of the founders of Physicians for Social Responsibility, and cofounder of the International Physicians for the Prevention of Nuclear War. Doctor Lown was a recipient of the 1985 Nobel Peace Prize because of his work to prevent nuclear war. More recently, Lown and his colleagues founded the Alliance to Defend Health Care, a physicians' group dedicated to the patient advocacy and reform of the U.S. healthcare system. Clearly he has spent considerable time taking the pulse of the system, so his words deserve close attention.

What does he mean, "Medicine has lost its way, if not its soul?" Lown's essential message is that the vital connection of trust between doctor and patient—a bond that held fast through 3000 years of medical tradition—has broken. In other words, there is not enough caring in health care.

"Healing is replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technological procedures. Doctors no longer minister to a distinctive person but concern themselves with fragmented, malfunctioning biologic parts," he wrote. "The distressed human being is frequently absent from the transaction" (Lown, 1996, p. xii).

As I pondered Lown's words in view of my own question of why there were so many Dr. Smiths (good, possibly even great doctors) and so few Dr. Joneses (exemplary physicians *and* praiseworthy people), it struck me that if I were to examine the lives of a sampling of Dr. Joneses, I might be able to identify some common denominators that led them to excel, and perhaps this information could be used to lend insight into our current healthcare system.

So I decided to interview Pride in the Profession Award Honorees, and I proceeded to think about what I would like to ask these doctors. I found that my interview questions fell into three general areas. I am reluctant to reduce these areas as some bulletized list of catchphrases with somewhat similar meanings but perhaps different connotations (e.g., goals, dreams, milestones, plans). Inevitably the themes would overlap as well; since the original purpose of categorizing the types of information was to facilitate my own analysis after the fact. I decided to forgo any organizational labeling until after I had completed all the interviews and begun to study them in earnest, and only then determine whether the results themselves suggested logical groupings. I approached the interviews with three broad descriptions of information I wanted to gather; these can best be relayed as questions.

The first general area of questioning explored those things that led each interviewee toward a medical profession. This encompassed a range of topics—everything from parental guidance and childhood heroes to pivotal moments and synchronistic events. I asked such questions as these: Do you recall any single moment or event, or several related incidences, when as a child or adolescent you consciously decided to become a doctor? Were you encouraged or discouraged by anyone such as family, friends, counselors, or others, and did this have any effect at all on your decision or specific plans?

The second general area of questioning concerned the actual experience of being a doctor and what part that played in the interviewee's sense of self. My intention was to find out, if at all possible, to what degree the role of physician informed the individual's personal credo and identity—and vice versa. These questions were less dependent on memory and more

dependent on reflection, as these sample questions suggest: In what ways does your current medical practice differ from what you once imagined it might be? Have you accomplished any or all of your major life goals, and if not, what have been the obstacles? Have you experienced burnout? If not, how have you prevented it, and if so, how have you dealt with it?

The third general area of questioning was an attempt to assess the interviewee's inner strengths (and perhaps weaknesses) in terms of such abstract constructs as character, principles, and motivation or inspiration. My purpose in delving into these topics was to analyze in which ways, if any, the interviewees shared characteristics in common and identify any possible correlation between these and the doctors' acknowledged outstanding achievements. To this end, I asked such questions as these: Have you ever found yourself in a situation as a doctor where the correct course of action concerning a patient conflicted with your sense of what was the right thing to do? What is the most important reason you get out of bed each morning? What enables you to persevere in the face of resistance?

Choosing the Profession

The initial questions were designed to tease out any and all of the details of what might have contributed to an interviewee's pursuing a life in the medical profession. A natural starting point seemed to be the traditional life story, with an emphasis on anything that contributed to the doctors' choice of career and to the achievement of that goal. "Life stories—our chosen form of narrative—tell us much about individual and collective, private and public, structural and agentic and real and fictional worlds. Stories occupy a central place in the knowledge generated by societies" (Goodley, Lawthom, Clough, & Moore, 2004, p. ix). Notwithstanding the vagaries of memory, any milestones or turning points in the physicians' lives would very likely emerge from such biographical narratives.

The process of collecting and analyzing life stories sounds deceptively simple, but in fact that very process could affect the quality, quantity, and interpretation of the findings that result. Foos and Clark (2003, p. 207) quote gerontologist Peter G. Coleman (1999, pp. 133–139) and his definition of four lenses that can be used to view life stories. They emphasize that the same lenses must be used for all interview data to ensure comparability—namely, *coherence* (the linking thread); *assimilation* (interpretation of events); *structure* (beginning, middle, and end); and *truth* (the reality perceived by the storyteller). Coleman noted that when telling

life stories, people with a greater sense of perceived control were more apt and better able to recollect and relate their personal histories in an orderly and meaningful narration rather than as a haphazard reporting of nonsequential and perhaps even inconsequential vignettes. Perhaps this can be attributed to the fact that, as professor of psychology Charles R. Snyder has said, a solid understanding of oneself makes goal-directed thinking an easier task, since "personal coherence serves to clarify the important goals of one's life; in turn, having specified goals increases the probability that the adolescent has the necessary will- and way-related thoughts to pursue these goals" (Snyder, 1994, p. 102).

One might expect the exemplary physicians interviewed to have this "solid foundation of self-hood" (Snyder, 1994, p. 102) and to have a proficiency, if not mastery, in the area of goal-directed thinking. Given their stellar achievements in multiple areas of their lives, and given the likelihood that they would consider themselves to have a relatively high degree of control in their lives, the interviewees seemed likely to present logically structured tales with relevant detail during their interviews. This proved, most often, to be true. Perhaps the public attention paid to their achievements contributed to their apparent ability to recollect and comment on memories from their formative years.

In 2006, National Public Radio began a show entitled *This I Believe*, a series of audio essays in which people both famous and unknown expounded on their personal belief systems and how these developed. Inspired by the original 1950s radio series of the same name and produced by Edward R. Murrow, *This I Believe* examines life lessons gleaned from both monumental and mundane events and observations, and how these shaped the present and future for the respective tellers. In the introduction to the printed book version of the 80 audio essays, Studs Terkel summed up his own thoughts in this way: "My credo consists of the pursuit and the act. One without the other is self-indulgence. This I believe" (Allison & Gediman, 2006, p. 5).

That the interviewees in this book must have followed a similar philosophy I knew by virtue of the selection process—it was their *actions*, not their *desires*, that qualified them for nomination—and it was my pleasure to be allowed to elicit from them the same sorts of memories of epiphanies, turning points, encouragements, and inspirations as those captured in the essays. To tell the full story, I had to be concerned not just with the act but with the pursuit that shaped the doctors' lives.

To that end, I approached the physicians' personal histories from two directions. First, I simply asked, with a minimum of guides and prompts, that they tell me their life stories. This allowed the respondents, rather than me, to decide what elements might or might not have been significant and thus warrant inclusion. As British biographer Gordon Bowker (1993, p. 19) said, biographies are in a "constant state of becoming," which suggests that a self-appraisal of one's achievements and circumstances in the present might have a noticeable effect on the tenor and content of a life story. We have entered the age of biography (Bowker, 1993) with our growing fascination for reality television, celebrities' behaviors, 24-hour event coverage; exposure to the barrage of information about important life stories no doubt affects people's sense of what to add, or leave out, when telling one's own personal narrative. Examining the approaches and concerns regarding the process of studying life stories, the authors of *Researching Life Stories: Method, Theory, and Analyses in a Biographical Age* (Goodley et al., 2004, p. ix) argued that "notions of identity are linked into projects by which people write their own lives in varying conditions of alienation and empowerment." That is, people tend to select narrative elements to fit a particular context—in this case, the life of an exemplary physician engaged in additional humanitarian endeavors.

To say that memory can be flawed is only to repeat what we all know to be true. Not only is selective memory a common occurrence, but it is also common for the memories themselves to be factually inaccurate—two events are conflated in recollection as one, stories we know only second-hand transform over time into memories, and contexts and continuities become muddled over time. I do not mean to suggest that life stories, including those told by the physicians interviewed here, are in any way untrue or deliberate misrepresentations of fact. My intention in raising the idea that narrators may not be 100% reliable and that every detail recounted may or may not be true in the actual, provable sense (and I as interviewer would be none the wiser) is merely to acknowledge the necessity of accepting the life stories as they are told. Ultimately, it may not matter. American scholar of autobiography Timothy Adams said, "Autobiography is the story of an attempt to reconcile one's life with one's self and is not, therefore, meant to be taken as historically accurate but as metaphorically authentic" (Adams, 1990, p. ix). Thus, while I did gather such facts as specific years and locations, it seemed more important to note whether the interviewee mentioned them at all than to determine if they were correct.

Few people have personal biographers. Since the self-narratives rely so heavily on memory, it's necessary to discuss, in brief, some of the research that had been done concerning life stories and memory. Much of it confirms what many already know, namely that it is not uncommon to retell stories in such a way as to cast a particular light on the subject, whether positive or negative. What is not so well known is that this can happen without the narrators' intent. Studies have shown that personality can affect not only what is included or excluded from a life story but also the way in which such stories are recounted. McAdams (1982, as cited in Fivush & Haden, 2003, p. 197) suggested that the brain processes motive-related events differently than it does events that do not relate to the narrators' personality motives. He also found that people with high agentic motives more often included in their life stories memories that emphasized action and choices (e.g., mastery, achievement) and told their stories in such a way that they were always central. This contrasted with people with high communion motives, who recalled events and experiences that included and featured others, and their stories often emphasized similarities and interdependence among people. More specifically, autobiographical memories are dependent on the kinds of situations that precipitate the emergence of the memory, the personality motives that are characteristic of the individuals reporting the memory, and the methods used to measure motives (p. 198). In essence, some people star in their own life stories, whereas others prefer to be part of a larger ensemble cast. Would this difference correlate with the difference between good doctors and exemplary physicians? Does it all come down to seeing oneself as part of a large, interconnected network and a bigger plan?

Other subconscious factors can affect the telling of life stories such as the circumstances that precipitate the story (e.g., a formal interview versus a first-date introduction) (Nakash & Brody, 2006). These might include unintentional conflation of separate events, selective memory, telescoping timelines, and simple faulty recall. Of course, retrospective interpretation and conscious editing can color the stories as well; as the adage says, hindsight is 20/20. As mentioned earlier, in the case of the exemplars, I had to make the conscious decision to accept what was offered as true, without any attempt to substantiate or verify the data. Nevertheless, I couldn't help wondering if our doctors found it easier to retrieve positive memories of events and circumstances or negative ones. I was also curious whether they recalled positive and negative memories with equal facility, yet chose to recount more of one than another. I wondered if the exemplars would tell

stories that did not relate one misfortune after another, but rather would string together a series of happy choices, lucky coincidences, and supportive people.

My second approach to collecting personal histories, once the interviewees had told the whole story, was direct questioning. I asked an identical set of questions of each of the physicians with the goal of establishing a framework of common denominators that I might later compare (e.g., background, family influence). I queried each about their home lives as children and adolescents, and how they were raised and who might have led them to their career choice. I asked if they had known people who inspired, encouraged, or helped them work toward their goal when they were young—and similarly, if anyone had tried to dissuade them or alter their career paths. Included would be not only real people in direct contact such as parents, extended family, peers, teachers, or other social contacts, but also media celebrities and even fictional characters from books, television, or movies.

Some developmental theories are pertinent in examining these various influences in the physicians' early lives, and I touch lightly here on the issues of nature/nurture; continuity/discontinuity (gradual versus abrupt change); self-activity/passivity (self-determination versus change through external forces) (Sigelman & Rider, 2006, p. 29). These developmental issues might conceivably affect not only the specific career choice but the level of commitment—the amount of energy devoted to and joy extracted from that profession. For example, someone who decides to become a doctor more out of some instilled sense of duty or tradition may not embrace the field with the same vivacity as one who makes the same decision based on having seen the local doctor help an ailing relative back to health. Additionally, ". . . some adolescents prefer not to work at all for a while rather than be forced into an otherwise promising career which would offer success without the satisfaction of functioning with unique excellence" (Erikson, 1968, p. 129). Would these doctors have come to their work without some type of moratorium?

Similarly, the concept of personality—traits, behaviors, ways of thinking, motives and emotions—would likely affect career choice. Weiten and Lloyd (2006, p. 34) called personality "an individual's unique constellation of consistent behavioral traits." Would consistency play a major role in choosing a profession? It would certainly be rare to make such a decision without deliberation over time.

Russell Muirhead, who writes on the moral meaning of work, has argued that while it is true that personality affects the work we choose to do, the reverse may also be true. For those who dedicate the bulk of their waking hours to their professions, the work can also affect personality, making them "more compassionate or more stern, more decisive or more resentful, more deft or more argumentative" (Muirhead, 2004, p. 28). Because of its power to communicate to others an established place in the social hierarchy, given others' preconceptions, biases, and even stereotypes, a job itself has significance beyond just a means of income. It can be, for many, an important and integral part of self-description. The most commonly asked question from strangers making small talk is, "What do you do?" In this day and age, the underlying question people really want to ask is, "Who are you?" The listeners' reactions will almost certainly vary according to the answer given: factory worker, stay-at-home mother, astronaut, or pediatrician. For people with certain personalities, the right to identify as a physician may fulfill some important need, and the anticipation of such fulfillment and the accompanying satisfaction and pride could easily drive career choice. For such people, "work cannot be merely another of life's routines but is rather a key source of their identity" (Muirhead, 2004, p. 28).

This book is not the proper forum for an in-depth examination of the nature of personality and psychoanalytic theory; it should suffice to note any personality-related similarities or differences among the interview subjects, both as observed and documented by others, and as perceived by the physicians themselves. Foos and Clark (2003, p. 179) quoted mystery writer Dame Agatha Christie: "We are the same people as we were at three, six, ten, or twenty years old. More noticeably so, perhaps, at six or seven because we were not pretending so much then." The physicians' viewpoints on Christie's belief and whether they felt that they personally have changed much or not over time drew out some useful insights, particularly with regard to such things as motivation and dedication. Foos and Clark maintained that while traits remain relatively stable as people age, their concerns do change—as do their coping strategies (Foos & Clark, 2003). Some studies have suggested that the period during which people's personalities show the greatest degree of change is during their 20s (Clausen & Jones, 1991, p. 209). This is also the age at which most students must make a commitment if they intend to pursue medical careers.

There is no consensus among personality theorists regarding the degree to which people are actively involved in their own development; some assert that individuals contribute in an active way through the natural curiosity of the species that drives people to explore and absorb cues from their environments, whereas others argue that human nature is essentially passive, and that circumstances and settings play a much larger role in personality development than an individual's innate traits (Sigelman & Rider, 2006). Either way, it appears that similar environments do not guarantee similar development. Psychologist John Chirban (2004), for example, wrote that children growing up in environments that are less than ideal often become adults who may share certain characteristics but whose outward characters vary significantly, and noted that "turbulence in the home often pushes us to extremes" (p. 35). He cites two people with similar backgrounds, noting that both "wrestled with loneliness, depression, and self-loathing while exhibiting powerful charisma" (Chirban, 2004); although both became professional actors, one constantly sought to forge strong emotional connections while the other shunned affection and personal relationships. A child growing up in a tumultuous environment may very well go on to become an exemplary physician. Would such a person have powerful charisma and—even more pertinent here—would the physician be emotionally distant or restrained, or would he or she be warm and intimate? Chirban (2004) used the term *true self* to describe what in common parlance is called the authentic person deep down and argued that "if parents or society ignore rather than celebrate the qualities of a child's true self" (p. 35) it can be difficult if not impossible for that child to reach personal fulfillment. In examining the self-narration by the exemplary physicians, it would be useful to be able to gauge whether the interviewees felt that in living their exemplary lives they were embracing their true selves.

Formal institutional settings also appear to play a role in career choice in general and might well influence the decision to pursue a career in medicine, as well as what kind of physician someone may become. Schools, for example, are just one area where the seeds of such aspirations may be sown, then nurtured or left to wither away. The United States has seen a broadening in the spectrum of school structures and teaching styles—charter, private religious, coed, home-school, magnet—in addition to the obvious differences such as class size, electives, or the availability of extracurricular activities. Of the many options, could any one of these be more apt to pro-

duce exemplary physicians? The interviews were designed to touch on details about the physicians' education. For example, did the physicians, as students, add sports, clubs, church groups, committees, and volunteer work to their busy high school and college years?

"Both organizational features within schools and differences between schools shape the distribution of educational outcomes having implications also for career outcomes (Lee, Bryk, & Smith, 1993, p. 43). Education professor Duane Brown, who specializes in career development issues, has said that the traditional U.S. educational system relies heavily on grouping, most often by perceived ability to learn, which is known as tracking. Students are funneled into distinct programs in which the content, teaching style, and ultimate educational goals differ drastically from one another. In effect, the students are labeled as one of these: vocational, general, college prep, remedial, honors, special needs, gifted, etc. (Brown, 2002, p. 44). Critics argue that tracking creates an inequitable system. I wondered if the exemplary physicians shared a common label early on.

This importance of role models in the physicians' life stories begged exploration. During the interviews, I tried to discover in each case who had the most influence on shaping their character and preparing them for life in general from birth until they entered medical school. The interviews were also designed to help paint a picture of the events and environments they encountered during that same time period—places, years, current events, significant occurrences, personal tragedies or triumphs, and other possible factors.

Among those life stories, would it be common to hear mention of a favorite relative or friend who was a healthcare professional and whom the interviewee sought to emulate, consciously or otherwise? There were also references to role models from movies or media. Since the 1950s, television has had a love affair with the medical profession, most often portraying doctors as heroic, if sometimes imperfect figures in these programs: *Ben Casey*, *Dr. Kildare* (1960s), *Medical Center*, *Marcus Welby*, *Quincy*, *M*A*S*H* (1970s), *St. Elsewhere*, *Doogie Howser, M.D.* (1980s), *Chicago Hope*, *ER* (1990s), and *Nip/Tuck*, *House*, *Grey's Anatomy* (2000s). Doctors on the big screen have been equally ubiquitous. For most people, the first sustained exposure to such often-idealized visions of doctors comes at a time of life when they are struggling to establish their own identity. They are likely moving from what Erikson called *latency* (around ages 6 to 12 years), with its conflicts between industry and inferiority, on

their way to *early adulthood* (around ages 18 to 34 years), with its conflicts between intimacy and isolation, and commitment. The interim *adolescence* (ages 12 to 18 years) is fraught with the conflicts of identity and role confusion as people explore their individuality—a key part of which is making choices in preparation for a career (Erikson, 1950). George Vaillant described a similar stage in which the conflicts are between career consolidation and self-absorption. The question of what might differentiate a job from a career, he answered with four words—commitment, compensation, contentment, and competence. This shift represents the "transformation of preoccupation with self, of commitment to an adolescent's hobby, and (as Shakespeare put it) of 'seeking the bauble reputation' into a specialized role valued by both self and society" (Vaillant, 1993, p. 149). The interviews were structured to encourage revelations on how and when the physicians recognized their career-related talents and abilities and made a conscious commitment to enter the medical profession.

Even now the majority of positive media role models of doctors are more often men. Male doctors on the small and big screen vastly outnumber female doctors, and the women who are represented often showcase the traditional working woman work/life conflicts, whereas it is exceptionally rare for a portrayal of a male doctor to question how that doctor can successfully balance family life with professional life. In light of gender stereotype differences in the era the interviewed doctors came of age, the ratio of male-to-female Pride in the Professions award winners (approximately 2:1) should not be surprising. Although the numbers have risen significantly in the past 4 decades (only 7.6 percent of physicians were female in 1970), male doctors still outnumber their female counterparts by almost three to one (American Medical Association, 2006). The importance of role models and mentors in this cannot be overstated. Successful scientists almost invariably were once chosen by esteemed researchers to be assistants or protégés (Zuckerman, 1977). The absence or presence of a strong mentor figure has a direct correlation to the attrition rate in students in the sciences, with women being especially prone to change fields if they find no such mentor (Subotnik, Stone, & Steiner, 2001). What do our good doctors say about this phenomenon?

Sigelman and Rider (2006) addressed the role of mentors in occupational development. Ideally this mentor would be part counselor, part coach, part role model. In particular, mentors should pass along invaluable tips about the unwritten rules that drive professions. Good mentors do not

feel threatened by their protégés; rather they applaud and promote them. Our doctors were asked about key lessons from relationships with mentors, the cultivation of the work together, and their separation or ongoing connection. Erik Erikson wrote frequently about the concept of generativity, "everything that is generated from generation to generation: children, products, ideas, and works of art" (Erikson & Evans, 1967, p. 51). He held that established middle-age professionals have a need to pass on their wisdom and experience to the next generation. The caveat, of course, is that the emerging generation needs to be receptive to such mentoring.

Working or studying with scientists who share one's race or gender also has a positive effect on the career goals of science students (Hill, Pettus, & Hedin, 1990). Parents in the field can provide a dual benefit, as mentors/ role models within the profession as well as the primary architects of such ethical foundations as respect for humanity, honesty, morality, commitment, and similar virtues. Irrespective of professional field, in the course of good parenting, children also learn important life lessons crucial to socialization, including conflict resolution, empathy, mutual respect, obligation fulfillment, listening skills, resilience, responsibility, and discipline, among others (Bolt, 2004; Snyder, 1994). I was interested to learn the percentage of exemplary physicians for whom one or both parents also worked in the medical profession.

Strong mentor relationships after medical school also play a positive role in professional development, with advantages to both protégé and mentor; similarly, having a poor mentor has been shown to be worse than having no mentor at all (Kail & Cavanaugh, 2007). In the interviews, the exemplary physicians are invited to speak to their experience of mentoring relationships.

Many well-known and highly respected doctors readily credit teachers, research partners, and advisors for their success. Take, for example, the aforementioned cardiologist and Harvard Medical School professor Dr. Bernard Lown. Although Lown is not among the current list of Pride in the Professions awardees, he would certainly meet the qualifications. A man of many great accomplishments, he nevertheless opens his book, *The Lost Art of Healing*, with characteristic humility. "Great teachers and extraordinary institutions enabled me to forge ahead in medicine and to evolve a philosophy of healing" (Lown, 1996, p. vi). Lown became a mentor as well; one of his children (Beth Lown) became a physician leading the movement to humanize medicine.

Professional and Personal Identity

The second series of questions sought to determine to what extent the daily reality of being a doctor informed the physicians' sense of self, and how much of a role it played in their identity. While elements of the life stories could not be completely separated from the development of the physicians' sense of self, chronologically speaking the emphasis was no longer on what they wanted to be when they grew up, but concerned essentially everything after the physicians entered medical school up to and including the present. Additionally, this series of questions added a layer of reflection as I probed beneath events and circumstances to discover the physicians' perceptions and insights.

Earlier I mentioned Lown's notion of a philosophy of healing, which is nurtured in part by the practitioners' early professional experiences, interactions, and life lessons. This suggests a fully realized personal credo that speaks directly to a physician's sense of purpose. The greatest database of literature outlining doctors' stated reasons for entering the medical field would have to be a collection of medical school applications and interview transcripts. Such a database would no doubt be filled with heartwarming and inspirational anecdotal introductions to hundreds of thousands of idealistic altruists. Most premed students declare that they want to enter medical school so that they can remain in a scientific field and help people while doing so. A relative few mention inspirational doctors they have known. Almost none cite parental pressures, prestige, or money (Coombs, May, & Small, 1986).

Once they have earned their medical degrees, however, it may be that at least part of the difference between the ordinary and the extraordinary practitioners comes from the answer to this simple question: What gets you out of bed in the morning and off to work? Regardless of the field in question, it is possible to distinguish between the concept of a job and a calling. Williams (1999, p. 99) gave these very clear, distinctive definitions. A job, he said, is "mechanical, with a job description; we are measured to see how well we have performed this function, and rewarded accordingly. . . . True work, on the other hand, comes from within us, and is about being engaged; it is where we choose to channel our life's energy." He summed up the distinction thus: "A job is a what, not a why . . . . Good work contains a *why*, not just the *what*" (Williams, 1999, p. 99). Since the exemplary physicians in question have been cited for more than simply doing their jobs, as it were, it seems likely that their

interviews would reveal a belief that medicine is more than a job but true work—a calling.

Calling in this sense has nothing to do with religious matters. It has everything to do with one's personal philosophy and self-image, or identity—a continuing and coherent sense of self over time (Foos & Clark, 2003). It also has much to do with one's major life goals. Many a young child, when asked, "What do you want to be when you grow up?" will answer, "doctor" without any thought or realization of what that truly entails, merely responding to the environmental cues from books, television, toy manufacturers, family, and peers. Most do not go on to be doctors. Erikson suggests that an adolescent's choice of a future occupation represents a key part of establishing an identity, not because of the profession itself but because of the exercise of free will, imagination and self-discovery it requires ". . . it is the ideological potential of a society which speaks most clearly to the adolescent who is so eager to be affirmed by peers, to be confirmed by teachers, and to be inspired by worthwhile 'ways of life.'" (Erikson, 1968, p. 130).

During medical school and in the early years following graduation, most physicians appear to have, for the most part, already established their identity, and while this will continue to evolve over time, their essential sense of self has settled into place. As they eased into their professional lives, the new physicians would unavoidably come to reflect on how the actual fact of being a doctor compares with their anticipatory imaginings. The prolonged training would have left them minimally familiar with the mechanics of being a doctor—for example, the basic routines of hospital rounds or private appointments, or the specific tasks of reading an X-ray or making an incision—yet as with any job, the new doctors no doubt encountered surprises. Some of these have been welcome. Others may have been rude introductions to the disparity between practicing under the aegis of the educational safety net and being the ultimate authority in what could be a life or death situation. From the moment they received their medical degrees, the physicians would have another opportunity to reflect on their decision to enter the field. Weighing their daily routines and experiences against their ideals and life goals, they might find that the greater the difference between the two, the less satisfaction they would derive from their professional lives.

Suppose that after a year or 2 or 5, a physician finds that the practice does not fulfill those life goals set down in youth, or conflicts with long-held

ideals and visions. There would seem to be three main avenues of recourse: emotional resignation, professional recalibration, or external engagement. Many healthcare professionals that I have worked with seem to typify the first response, emotional resignation. In this situation, a variety of reasons from financial constraints to personal inertia might lead to a gradual shutting down. Expectations dim, excitement fades, and the profession becomes little more than a mantle worn for 40-plus hours a week and then shrugged off at quitting time. It becomes, in short, just a job.

Job satisfaction depends in large part on how well expectations and actual conditions coincide. During the late 1990s, an extremely popular bumper sticker read, "I owe, I owe so it's off to work I go." Statistics have shown that more heart attacks occur on Monday morning—the traditional start of the workweek—than any other time in a week (Murakami et al., 2004). No one has named a restaurant chain T.G.I.M. (Thank God It's Monday). Clearly many people have a love–hate relationship with work; the questions become which outweighs the other, and how should one address the imbalance? As people age, some professional options fall by the wayside. There are plenty of starting over career stories, but the fact remains that some jobs require the energy, resilience, health, and fitness most often found in youth. In addition, as people take on families or other responsibilities and commitments, such requirements as extensive travel or relocation can seem onerous.

The anticipation of job dissatisfaction seems to be increasing; when I asked at what age they would like to be retired, almost every one of my students in an introductory psychology class pledged their intentions to try to set aside enough money so that they could retire by age 40. That's 27 years shy of the current age required to receive full Social Security benefits. It was as if they had decided in advance that whatever career they chose could not possibly hold their interest or provide longstanding satisfaction. The intrinsic motivation for the work itself seemed to be lacking, and they were looking ahead at their professional lives as merely a means to an end, as something to endure on the way to life *after* work.

Joshua Halberstam (2000) discussed this distinction in depth, and concluded that when we are lucky enough to do what we are meant to be doing, we automatically have a career, not a job. Williams (1999) used the word *engaged* to describe the determining factor, and called the feelings that pull us toward a certain rewarding profession a "calling," albeit in a secular sense. Levoy (1997, p. 137) suggested that hearing a true calling requires one to connect the dots between signals and starting points that

come through many different channels, including dreams, fantasies, cravings and ambitions, persistent symptoms, fears, and resistances—channels whose messages are related by seeming synchronicity. Recognizing and tallying these synchronistic events and coincidences requires an attitude of openness. The "union of objective needs and subjective meaning [happens] consciously for many people" (Hopcke, 1997, p. 101), allowing them to recognize when they have found the work they were meant to do, and to pursue it wholeheartedly.

Whereas the first series of interview questions were designed to capture the bare bones of a life—names, places, achievements—the second set of inquiries aimed to flesh this information out with the kind of retrospective percipience that is sometimes possible only in hindsight. It could easily happen that someone could experience what Levoy (1997) called "messages" without recognizing them at the time as part of a larger synchronistic calling, and yet still heed the call itself to become a physician. To elicit or perhaps even discover such moments required a more open-ended questions such as: How did you become aware that your interests or hobbies—e.g., biology, puzzle solving—might coalesce into a vocation? What were your life goals as a child, a teen, and as a young adult, and if they have changed, do you know why? Hopcke (1997, p. 101) has said that rigidity can blind us to synchronicities, and that the way to allow "meaningful coincidence to change the story of [one's] life [is to] wander the world randomly and be willing to listen to whatever life presents." The random wandering is not intended literally, of course, but suggests an openness to experience and possibility outside the realm of the expected. This prompted questions like: Do you recall a point in your life where things clicked, prompting you to choose a career in medicine? Now that you've practiced medicine for years, would you consider medicine your true calling? If not, what is your true calling, and is being a doctor a part of that?

The second way that a physician can react to the realization that being a doctor may not be living up to expectations is professional recalibration. By *recalibration,* I mean resetting expectations or trying to change the status quo. The latter could mean changing professions entirely, of course, or it could mean addressing the reasons that reality falls short of satisfaction, such as cutting back on hours, leaving private practice for a hospital post (or vice versa), or narrowing a specialty. To do so, the physicians would have to consciously assess the parts of their professional lives that were not satisfying and perhaps rethink certain choices. Erik Erikson

(1968) thought everyone would benefit from this type of certain self-directed therapy. As mentioned earlier, he called these earnest reflections "moratoriums," and argued that under such conditions people's sense of self emerges more fully and their identity becomes clearer. A physician who is recalibrating must make choices, including the choice to remain in the status quo.

A choice, of course, is not the same as a commitment. Character and commitment will always be measured by actions. Wanting to help people is not the same as actually stepping outside one's comfort zone to work with AIDS patients or opening a private practice. As theologian Margaret Farley (1986) pointed out, even commitment can have less-than-straightforward meaning, and it appears in many nuanced forms, including what she calls "prereflective commitments"—those commitments people make prior to any explicit recognition of them. Typically, however, we think of commitments as conscious outward actions, pledges we make to others or to ourselves—that is, giving our word about something.

Often we think of commitment as the intention to work toward a single goal, but that need not be the case. Catherine Bateson (1989, p. 9) spoke of "the creative potential of interrupted and conflicted lives, where energies are not narrowly focused or permanently pointed toward a single ambition." Not only must physicians adapt and keep current if they have made a professional commitment, but they may also have to revisit their wider visions and occasionally renew or add commitments. Farley (1986) made a distinction between intellectual, *abstract* commitments—for example, the pursuit of truth and other types of value commitments such as justice—and *action* commitments, whether specific momentary undertakings or lifelong plans. Did our exemplar physicians find the need for a major recalibration, or did they subconsciously make minor adjustments, internally and externally, to maintain job satisfaction? Are they explicitly aware and conscious of the depth of their own commitments?

A key part of satisfaction with an ongoing professional commitment is a healthy work–life balance. Psychiatrist Robert Coles (1993) argued that people who respond to a call or mission are especially susceptible to depression and burnout. In his frequent interviews with people who performed long hours of volunteer work, the word *burnout* surfaced repeatedly. People with exceptional dedication are often highly self-critical, or perhaps more likely to discuss their sense of their own impending burnout more openly. Dr. Coles recounted an exchange he shared with

Dr. Martin Luther King at a conference in the mid-1960s. Coles, King, and a handful of others were discussing burnout—having become all too aware of it both in themselves and in others—when King said, "Burnout is surrender," and then elaborated, "We have just so much strength in us. If we give and give and give, we have less and less and less—and after a while at a certain point we're so weak and worn, we hoist up the flag of surrender. We surrender to the worst side of ourselves" (Coles, 1993, p. 141). Any level of commitment to something physically and emotionally exhausting can take its toll; sustaining such a commitment can exact an exorbitant price. The question is not so much why people suffer from it as it is why some people do not, or are at least capable of overcoming it.

Halberstam (2000) reported that older workers report higher job satisfaction than younger workers, most likely because they have learned to adjust their expectations over time—to recalibrate. Yet how could our exemplary physicians truly excel if they merely adjusted—that is, *lowered*—their expectations? Such behavior might lead to minimal success—doing what needs to be done, and no more—but hardly seems likely to inspire exemplary achievement, although it may help forestall burnout. Even laboratory rats, having found a route through a maze to a pile of food, will retrace that identical route every time, never searching for any alternate—and perhaps shorter—route to their reward. Likewise, people focused on an anticipated reward will be far less likely to try out new ideas or innovative methods (Halberstam, 2000). This suggests that any of the exemplars who might have found the need to recalibrate would not have actually lowered their expectations, but would have instead aimed at changing their environment. This would be analogous to the rats sawing an opening through the wall of the maze to get directly to the food—or perhaps hopping out of the maze in search of different food entirely.

Merely living up to expectations leads to mediocrity; it also can lead to personal malaise. Robin and Dominguez (1992) noted the irony behind the phrase *making a living*, and asked how many people are more alive after work than before, refreshed and energized, ready to spend time with family. "Do we come home from our 'making a living' activity with more life? . . . For many of us, isn't the truth closer to 'making a dying'? Aren't we killing ourselves—our health, our relationships, our sense of joy and wonder—for our jobs" (Robin & Dominguez, 1992, p. 41)? Presumably, the exemplars have escaped this fate. The selection criteria for the awards as well as the actual achievements of these physicians suggests that they *do*

have more energy after work, perhaps because they do not view their pro-fessional activities as work at all but as something so enjoyable that it is more akin to play. Their varied achievements extend beyond the normal working hours of the physicians into what normally gets called personal time, and they clearly require a great deal of emotional energy and often physical energy as well.

Robert Coles recognized that while burnout can occur in any sort of job, its prevalence within the service professions is especially telling. This includes not just the obvious at-risk professionals such as those in the fields of medicine, education, and counseling, but also those people who expend enormous amounts of time and energy for remuneration that is more emotional and spiritual than financial, such as Peace Corp volun-teers, hospice workers, soldiers, and even single parents. The personality and experience people bring with them into their service roles, including their strengths, weaknesses, vulnerabilities, and abilities, must, as Coles phrased it, "yield to human particularity" (Coles, 1993, p. 142). In this view, burnout is not inevitable; the individuals most susceptible are those who have some unresolved psychic injury from early life—some internal, and very likely unrecognized, predisposition toward recreating certain behavior and response patterns from the past. If this is a given, does it dic-tate that this accomplished group of doctors is somehow better at resolv-ing these types of early life experiences?

Williams (1999) said that to persevere to our true vocation is to know a greater meaning and fullness of life that is deeply satisfying. This level of vocation will always invoke the emotional and spiritual dimensions; the concept of burnout, after all, implies that there was once a flame inside, a burning desire to make a difference. Did our physicians ever find that to keep the spark alive they needed to reinvent themselves? How did they keep nurturing a willing heart?

Gawain (1994) believes that work and play are the same. That is, when we are mindful of whatever we are engaged in at any given time, the result is a fullness and joy in the experience that will be felt by everyone around. The Greeks have the word *amartia* (to miss or fall short of the mark), which describes the loss of personal balance. Although the word is often translated into English (especially in religious works) as *sin*, its true mean-ing is the emotional state of a person who has gone to extremes and lost proper perspective, which is why Aristotle used the word to describe the character flaw that leads to the protagonist's downfall. It also fits with two

simple maxims *meden agan* (no extremes) and *pan metron ariston* (measure is always best) by which the ancient Greeks lived (Chirban, 2004, p. 253). Do our exemplars frame this issue similarly in their own lives?

It is popular to depict people in human service professions as being somehow otherworldly or more saintly than most of us. Williams (1999) debunked some of the myths surrounding such professions, many of which fall into the category of the things that everyone knows and yet turn out to be false, based on stereotypes, old information, and myriad other reasons. Chief among the myths pertinent to this book would be that those who serve must be superhuman, that service does not pay and is best left to those who are already successful and can afford to give, and that it is always better to give than to receive. It seems likely that the exemplar physicians will have seen through these myths and are already fully aware that service, especially excellence in service, does not preclude a normal life.

One attribute commonly found in high achievers that does not appear to be more myth than reality is positive thinking. As with the classic sad sack character Eeyore, the view that life's glass is perpetually half empty seems to hold back otherwise capable people. An overzealous belief that positive thinking will inevitably lead to success and that specific visualizations can actually dictate a course of events is considered a type of magical thinking that fails to differentiate between cause and mere correlation; thousands of people have become millionaires selling self-help books based on this concept, exhorting people to think themselves rich, in love, successful, and healthy. Exploring just this aspect of the exemplars' possible personality and psychological makeup would require delving more deeply into the realm of anomalistic psychology than space and time permit. Anomalistic psychology is the study of "extraordinary behavior and experience, including (but not restricted to) those which are often labeled 'paranormal' " (French, 2007, p. 4), such as placebo effects, dissociative states, hypnosis, synchronicity and the psychology of coincidences—as well as the psychology of deception and self-deception. It is worth examining, however, the role that expectations and attitude might have played in making the exemplars the exceptional people they have become.

Norman Vincent Peale codified the concept in his 1952 classic, *The Power of Positive Thinking*, followed soon after by Maslow's theories of self-actualization and the movements of human potential and self-actualization. Jung defined *guided imagery*, more often known these days as

visualization, a type of concentration on a mental picture that develops rich and detailed images. Jung believed that this active imagination enhanced the therapeutic process; decades later it has become a commonly accepted tool in preventive medicine, particularly in self-regulated stress reduction and pain management, as well as a complementary therapy in treatment of illness and disease (Jung, Jaffe, & Saint-John, 1979).

Renowned psychiatrist Karl Menninger is famous for having said, "Love cures people—both the ones who give it and the ones who receive it." In his book *The Vital Balance*, Menninger also weighed in on the power of listening, calling it a magnetic and strange thing and a creative force. The people who listen to us are the ones we move toward. When we are listened to, it helps us know who we are (Menninger, 1963).

The third and final recourse for doctors whose professional lives may not be giving them satisfaction is external engagement. By this I mean extending or going beyond the bounds of their customary role as doctors to seek satisfaction elsewhere and thus regain balance. This may happen unintentionally, for example by discovering or being recruited to a specific cause, but regardless of how physicians engage externally, doing so requires at least a minimum of soul searching lest that engagement conflict with their personal credo or ethics. This brings me to the third series of questions in the interviews.

The Wellspring

My last series of questions during the interviews was designed to answer the obvious question that the first two sets of responses would naturally prompt—namely, How do you do all that—and more? That is, given the time, energy, and emotional dedication that must be invested to be an excellent doctor, how is it that these exemplary physicians were also able to muster the internal resources to invest still more in the humanitarian undertakings that led to their nominations for the Pride in the Profession Award? There are thousands of people, maybe millions, who would love to be able to excel at their professions, raise good families, and still be able to devote themselves to one or more causes, yet most of us find that we cannot do it all. We fall prey to the if onlys—if only I had more time, energy, or money, or if only I had less stress, fewer obligations, and so on and so on—and it is most often our good intentions that fall by the wayside. So how is it that some people are able to do it all—willingly and without ever quenching the fire inside that drives them?

I entered into this project with a hypothesis that, in the end, was substantiated. As I spoke with each physician in turn, I began to realize that even though their answers to my questions seemed on the surface to have little in common, they could be distilled into a few elemental ingredients. That it took me months to perform this distillation seems, in retrospect, nearly inconceivable. I chalk it up to the natural tendency toward tunnel vision when the pursuit heats up; in our impatience to be finished with the data collection and get to the good part—measuring results against hypothesis—we often fail to reflect along the way on the significance of individual answers.

Collecting the data for the third set of queries often took more time than that required for the first two combined, largely because the open-ended questions required the interviewees to do more than recollect; they had to ponder, assess, synthesize. Most knew the answers they wanted to give right away but many were at a loss as to how to express them since they had never consciously done so before. The experience was enlightening for us both, at times, as when I asked such questions as these: What is your greatest regret concerning your life's work? Have you ever been faced with a dilemma in which your personal ethics seemed at odds with your course of action, and if so, how did you handle it? What would you like to see engraved on your tombstone?

Dr. Jerome Groopman wrote in his foreword to *The Soul of a Doctor* (2006, p. xi), "A physician's experience goes far beyond the clinical, because a person is not merely a disease, a disorder of biology. Rather, each interaction between a doctor and a patient is a story." Recognizing this is crucial for physicians, who "can notice, think about, and use what is going on inside and around them. . . . They emerge gradually, along paths marked by a sequence of stages" (Pories, Jain, & Harper, 2006, p. 1) and grow professionally when they break with the antireflective tradition that has long prejudiced medical students against self-examination and questioning the status quo. Self-awareness is a key component of a life lived in an ethical and spiritually evolved manner. Empathy makes it possible to look upon patients as people, not medical problems to be solved. Many of my questions to the exemplars concerned their philosophies of healing—i.e., the nature of their interactions with patients—and encouraged them to reflect.

I started by asking what it was, more or less, that got the physicians out of bed in the morning. The aforementioned cult classic *Your Money or*

Your Life (Robin & Dominguez, 1992) described a world where most people are more "dead" at the end of the workday than they were at the beginning. People get locked into unsatisfactory jobs purely for a paycheck, and often do so because they identify too strongly with the job itself. Presumably, the exemplars have escaped this fate. The selection criteria for the awards as well as the actual achievements of these physicians suggests that they *do* have sustained energy after work, perhaps because they do not view their professional activities as traditional work. Their varied achievements extend beyond the normal working hours of the physicians into what normally gets called personal time, and these endeavors clearly require enormous expenditures of emotional and sometimes physical energy.

How do they do it? Studies have shown that the typical American works 47 hours a week—164 more hours per year than in the 1980s (Schor, 2007). Physicians are not excluded from this phenomenon, so the answer could not lie in the exemplars having copious amounts of leisure time at their disposal. Most were neither rich nor retired. In fact, many of them scoffed at the very idea of retirement.

One possibility was that the exemplars truly enjoyed their day jobs and thought of them not as work but as a chance to spend time doing something they loved. Gawain (1994) said that when we are mindful of whatever we are engaged in at any given time, the result is a fullness and joy in the experience that will be felt by everyone around. The 13th-century theologian Thomas Aquinas said, "There can be no joy of life without joy of work" (Aquinas, 1273). Po Bronson (2002) discussed how his perception that certain jobs were cool and others were not changed when he realized that it wasn't the jobs that inspired passion but passion that inspired joy in a job. "Passion is rooted in deeply felt experiences, which can happen anywhere," he wrote (p. 365). "I used to think that life presented a five-page menu of choices. Now I think the choice is in whether to be honest, to ourselves and others, and the rest is more of an uncovering, a peeling away of layers and discovering talents we assumed we didn't have" (p. 365).

Mindfulness appears to be a key component of enjoying one's work; it would be difficult to feel bored and engaged at the same time. Of course, sometimes the greatest enjoyment can come from those periods when we are *so* fully engaged that we are barely aware of the work. This experience is nearly the opposite of self-examination. Mihaly Csikszentmihalyi (2003,

p. 39) called this "flow," the feeling we get when we are totally immersed in an experience. He chose the term because, as he said, so many people describe the feeling as "being carried away by an outside force, of moving effortlessly with a current of energy, at the moments of highest enjoyment." This mental state is hardly exclusive to physicians but is quite common and has been described by people engaged in a full spectrum of activities from mountain climbing and surgery to farming and parenting. Was the promise of flow possibly what got our physicians going each morning and sent them off to their daily practice? Had they experienced flow before, and if so, what were the circumstances (work, leisure, other)? Perhaps these flow states, like sleep, have restorative properties.

Flow is distinct from autopilot or thoughtlessness. It is not a lack of connection, but a hyperconnection. It is a way of living in the moment with an eye to the future by relying on knowledge gained in the past—the Zen moment. Janet Belsky (2007, p. 315) said that we experience flow as being "energized and alive." She argued that the main criterion that sets the experience apart from simple enjoyment is that flow is intrinsically motivated—intense absorption for its own sake and not because of some expected reward. The lists of achievements of the exemplary physicians, along with the fact that they clearly did not find their medical practices to be energy sinkholes, suggested that "flow" might be a common experience among those interviewed.

Experiencing "flow" does require knowledge gained from the past. Csikszentmihalyi (2003, p. 39) recounted a surgeon's flow experience in which the doctor said that "in good surgery everything you do is essential, every move is excellent and necessary; there is elegance, little blood loss, and a minimum of trauma. . . ." Presumably the surgeon in question must then have had the skills, the tools, the confidence, the knowledge, and the conviction to actually perform the operation at hand. In fact, in an earlier work, Csikszentmihalyi (1997) cited a study in which three generations of villagers in a remote Italian town were asked to report the frequency and timing of their "flow" experiences. The oldest generation reported the greatest number, most of which occurred during some work task; the middle generation reported that half their flow experiences occurred during work and half during leisure; the youngest generation experienced the fewest instances of flow, and these came during leisure activities.

Csikszentmihalyi called flow "a source of psychic energy, neither good nor bad, constructive nor destructive" (1997, p. 60), but said that it was

crucial to master the art of using it well. By this he meant that using flow for the sake of feeling good or establishing a good life for oneself was not a bad thing but that one should also channel it toward "goals that will reduce the sum total of entropy in the world." (Csikszentmihalyi, 1997, p. 60). Did the physicians find their work so playlike, so invigorating, that they were able to devote themselves to causes beyond their daily practice. How did they know where best to channel their energies? Did they have a set of standards they used to decide, and how did these standards arise? Just as the surgeon caught up in the flow of an operation should know how to wield a scalpel before making an incision, a good doctor ought to also have knowledge and experience in ethics, honesty, honor, morality, compassion, decency, and standards before making a decision.

The classical Greeks used the word *arête* to mean the quality of virtue that guides one to make ethical decisions. In virtue ethics, people do not make ethical decisions out of duty or even to achieve something good but because "doing the ethical thing is simply part of the most fully human way of living. One does not behave ethically in order to get the benefits of living well, but in living well one performs ethical actions" (Neher & Sandin, 2007, p. 18). In this system, character outweighs rules, and making good judgments are a key component.

If enjoying their work was a primary motivation for them to persevere, and if that enjoyment allowed them to work at making a living rather than making a dying, there remained the question of what led the exemplars to invest themselves in their various causes. Why not spend the time, money, or energy on some more self-serving pursuit like travel or collecting, and benefit those they know—family, friends, personal connections—rather than strangers?

These questions moved me to revisit the concept of character—not the outward gloss of personality but the deeper components such as values and ethics. Richmond (1999) maintained that character is not a genetic predisposition but a product of all the experiences, teachings, and choices made throughout the years. It is, he said, what we rely on in times of crisis. "Under duress, our surface personality falls away. There is no time to think 'What is the right thing to do or say'" (Richmond, 1999, p. 16)? The earliest Greek philosophers believed that practicing virtue ethics could dictate the ethical course of action in any given situation. Could it be that the character beneath the individual personalities of the exemplars had a stronger, more ethical value system that sparked an undying desire

to do good? If so, why? What wellspring could provide such abundant motivation?

Virtue ethics, first espoused by Aristotle, is a school of philosophy that focuses on the ethics of right and wrong. This approach relies on character and ethical thinking rather than fixed rules, punishments, rights, duties, or consequences. Since all physicians must demonstrate high character at the time they take their modern-day Hippocratic oath, it seems more likely that virtue ethics could have played a much more important role in making some practitioners into good doctors and others into truly exemplary physicians. The fictitious Dr. Smith, who works a regular shift and then goes home for dinner, is not inherently any less ethical or qualified to decide right from wrong than is Dr. Jones, who works a regular shift yet also devotes time, energy, and money to good causes.

Perhaps there is some element of Dr. Jones's character that cannot be satisfied with personal achievement alone, with simply meeting minimum standards on all fronts, and must always strive for a personal best, or to be part of more sweeping, even universal advancements. The following story illustrates a case presenting to a physician in the mold of Dr. Jones. Rarely do illnesses and diseases follow rules, and while there may be standard treatment protocols, physicians do not have a rule book to dictate the right course of action in any but the most simplistic of circumstances. Perhaps the best example is in the area of diagnostics. While physicians— like most people—come to certain conclusions by following a decision tree of some sort, approaching a patient's condition with a binary mind-set can have serious consequences. Groopman cites the example of a young woman who had spent 15 years visiting doctors complaining of intense pain and nausea upon eating. Her general practitioner immediately suspected an eating disorder, but sent her to a specialist to confirm. The specialist dutifully did so, and the patient was treated for anorexia nervosa through medication, therapy, and nutritional monitoring. The problem was, she continued to get sicker, despite the fact that she claimed to be following the prescribed diets and medication schedules. It wasn't until she was sent to yet another specialist to confirm an additional diagnosis, irritable bowel syndrome, that she met the doctor who saved her life. What gastroenterologist Myron Falchuk did that the other doctors did not do was quite simple; he ignored the routine concept of confirming another doctor's diagnosis. Instead he focused on listening to the patient. What he heard led him to correctly diagnose celiac disease; her

body was failing to digest the food she ate, and she was slowly starving to death. Falchuk credits his philosophy of healing to his mentor, Sir William Osler, sometimes called the Father of Modern Medicine for having developed the concept of the medical residency program. Falchuk said that it was Osler's view that "if you listen to the patient, he will give you his diagnosis," something Falchuk took to heart. While he embraced the new technology and procedures available, Falchuk believed that "technology had also taken us away from the patient's story. And once you remove yourself from the patient's story, you are no longer truly a doctor" (Groopman, 2007, p. 17).

Had Falchuk followed rules and accepted at face value the previous doctors' diagnosis despite the evidence of the patient's continued failing health, she would have gotten worse. Instead, Falchuk made the ethical decision to not to view her as a patient with anorexia nervosa and irritable bowel syndrome, but as a woman with severe gastrointestinal symptoms. Because of his long exposure to and experience with this sort of empathic approach to patients, Falchuk may even have experienced "flow" as he listened to her story and had the flashes of insight that led him to probe further. While he did not use the terms, Falchuk did report that he was "so excited by this," leading Groopman to characterize him as having "the sweet pleasure of the detective who cracks a mystery, a legitimate pride in identifying a culprit. But beyond intellectual excitement, he showed joy in saving a life" (Groopman, 2007, p. 22).

This delight in a peak experience was something that Abraham Maslow (1954) believed was the driving force of psychological development and part of self-actualization. Self-actualization is the ultimate achievement of one's personal potential, which could only be reached after the fulfillment of a larger hierarchy of needs (physiological well-being, safety, love, esteem, and self-actualization). Both Maslow and Carl Rogers (1961) further ascribed two key traits to self-actualized people. The first was authenticity, or the ability to be spontaneous, alive individuals who believed themselves and their behavior to be ethical and good. The second was empathy, and in particular an empathic interest in problem solving—helping others through emotional conflict in an engaged but nonjudgmental manner. Falchuk exhibited those two traits. Would they also form a central part of the character of the exemplary physicians? These traits would seem ideal for the exemplary physicians, particularly empathy—the ability to imagine what someone else might be feeling and to try to

see the world through another's eyes (Bolt, 2004). Kaplan and associates defined empathy as "the capacity to take in and appreciate the affective life of another while maintaining a sufficient sense of self to permit cognitive structuring of that experience" (Kaplan, Jordan, Miller, Stiver, & Surrey, 1991, p. 273). It will be interesting to see if the exemplary physicians manifest these qualities.

Too few medical schools that train doctors in traditional western medicine encourage students in and emphasize the study of empathy. In *The Empathic Practitioner,* Milligan and More (1994, p. 1) noted that many physicians express ambivalence towards the role of empathy in medicine. Western physicians are trained to approach relationships with patients with a kind of find-it-and-fix-it mentality that places the utmost value on empirical objectivity and evidence-based medicine. This approach has eclipsed the notion that interpersonal dialogue with patients could inform their treatment plans. Yet there are doctors who use empathy as a means to empower patients. Will we find a disproportionate number of them among our exemplars?

Many of the preceptors acting as role models for the next generation of practitioners systematically keep themselves detached and self-protective. In the course of my own work in medical settings I have often heard healthcare professionals admonish each other to be professional, which often seems to translate into "Don't have or show feelings about or to your patient." Yet if the aim of a medical interview is to minimize anything personal and subjective, how does the role of the physician in that instance differ from that of a dispassionate journalist pursuing a medical news story? It directs all focus toward the details of disease—on signs, symptoms, and quantifiable evidence rather than on the patients who exhibit those signs and symptoms, and on the patients' perspectives. It removes the human element. Similarly, advances in technology can increase the gulf between patients and their physicians; consider the difference between taking a patient's pulse by laying one's hands directly on a patient's body to personally count beats versus clipping a mechanical device to that same patient's finger. More transpires in this interaction than the accomplishment of a simple task. How do some physicians manage to avoid this distancing and isolation?

As noted previously, illness and disease do not follow rules. What happens when a physician, having developed a philosophy of healing to follow, is suddenly confronted with a situation in which there seems to be a

marked difference between the doctor's personal ethics and a suggested response or action? For example, in the 1990s, a directive from the federal government made it illegal for physicians at family planning centers receiving federal funding to discuss abortion with pregnant patients (Milligan & More, 1994). This ran contrary to many doctors' empathic responses and sense of responsibility. Similarly and more recently, certain drugstores came under fire when pharmacists decided not to sell over-the-counter emergency contraceptive pills despite the fact that the prescriptions were legal. I asked the exemplars to describe any similar conflicts they have encountered.

Ethical considerations need not be restricted to general principle but can enter into decisions on the smallest, most human scales (Dan, 1988, p. i). How exemplary physicians approach such instances may be highly instructive. For example, doctors must constantly be aware of more than just the medical implications of their words and actions. Fears of malpractice suits may lead to defensive medicine and may lead to a very different patient–physician relationship and communication style. Doctors are people, too, with doubts and fears that can affect not only physicians' professional lives but perhaps even their choices in extracurricular lives as well, such as where they focus their energy outside the hospital walls— where they volunteer, the causes they work toward, and the goals to which they dedicate themselves.

There are countless cases, too, where the usual course of action in a given medical situation just doesn't feel right to a physician. Groopman (2000) recounted the case of a physicist whose marrow was not producing enough blood cells. A doctor with extensive experience in transplants insisted that the patient undergo a marrow transplant immediately, despite there being no compatible donor available; if his diagnosis of myelodysplasia or aplastic anemia were correct, a transplant would be the best option, but moving forward with an incompatible donor meant that the physicist might die from the procedure or, if he survived, be permanently debilitated by graft-versus-host disease. Groopman's lab, however, found no evidence supporting the first doctor's diagnosis, and talked the patient into waiting while he performed some culturing experiments in the lab. While the cultures were growing, the severely immunocompromised patient nearly died of pneumonia. Along with the antibiotics and transfusion, Groopman suggested trying a white cell growth factor mixed with a red cell growth factor to boost marrow production. The first doctor declared that risky and pointless and was only convinced with great diffi-

culty to try the new protocol. In the end, the intuition of Groopman and his fellow hematologists was validated, and the patient was put on a regular regimen, and no transplant was necessary. Groopman credited a lesson he learned as a student from a highly respected clinician who was not afraid to admit when she did not know the answer to some medical puzzle. Her advice was that in cases where the diagnosis was unclear and the treatment options potentially dangerous, a doctor should stand down and engage in watchful waiting (Groopman, 2000).

Primum non nocere. That Latin phrase means "first, do no harm," and it is one of the first guiding principles a medical student learns. When the danger of an intervention appears to outweigh the possible benefits, the physician has a moral imperative to act in the best interests of the patient, not to do something out of a fear of looking ignorant, out of pride, out of stubbornness, out of habit and reflex, or out of the need to feel useful. During the interviews, uncovering instances in the exemplars' histories where they had to make such decisions could be most enlightening. In a related context, the questions should also elicit the physicians' greatest professional regrets.

How are physicians able to hold out hope without being dishonest at times? How do they cope with feelings of powerlessness when an infant is dying of an incurable condition? Or when—inevitably—an error in clinical judgment is made? How do they keep from reproaching themselves so much that it affects or even paralyzes their ability to care for the next patient? What do they do when patients rebuke them for errors in care? How do they keep themselves from going on the defensive and narrowing their vision for possibilities?

In any discussion of the human capacity for hope, the issue of faith and spiritual beliefs will arise. Csikszentmihalyi (2003) wrote that "flow and religion are different faces of the same quest: to find a reason, a justification for being alive . . . an intimation of what the rapture of life can be, and point toward an existence more imbued with soul" (p. 60). Paul Tillich asserted in the 1950s that faith did not have to be associated with formal religion or belief (Tillich, as cited in Fowler, 1981). Fowler calls faith "a person's or group's way of moving into the force field of life [and] finding coherence in and giving meaning to the multiple forces and relations that make up our lives" (Fowler, 1981, p. 4).

Morality, too, can exist separately from religion, but religions do not exist separately from moral codes. Richmond (1999) said "so much of

what passes for 'ordinary life' is, when seen through different eyes, not ordinary at all, but full of potential for spiritual learning" (p. 9). He spoke of questions of a spiritual nature that concern us all, and calls these "koans" after the instructional stories taught by ancient Buddhists. "To practice the koan of everyday life means to confront every situation as though it were a profound spiritual question. In that sense, every koan story is a specific instance of the koan of everyday life" (Richmond, 1999).

In the case of the exemplars, they likely have koans of their own gleaned from a multitude of sources from church, school, medical school, practical experience, and intimate social interaction. To find a set of common koans among the interviews might be tantamount to codifying exactly what it is that is the difference between a good doctor and an exemplary physician.

Colby and Damon (1992) point out that human goodness is both pervasive and fragile. Our sense that we live in an era of increasing large-scale violence might make it more difficult to trust that some professionals can continue to embody strong and genuine goodness that is not diminished or blunted by the tone of the times. In 2007, newly released letters of Mother Teresa widely reported in the news suggest that though she was admired by the outside world, she had many doubts even to the point of doubting the presence of her God. Perhaps we will find some physicians who admit to similar dark nights of the soul while the outside world continues to admire what appears to be a bottomless well of dedication. Those doubts did not cause Mother Teresa to waver in her ministrations, however; she continued her humanitarian efforts despite her temporary skepticism in the existence of her God. After her death in 1997, she was beatified by Pope John Paul II, who bestowed upon her the title of Blessed Teresa of Calcutta. We love to dramatize moral heroes in such a way that sets them apart in mythical terms. Exploring the roots of moral excellence in our physicians might inspire the possibilities for a leap forward by other healthcare professionals who haven't achieved the same public praise.

When Gregg Levoy (1997) wrote about the concept of the true calling, he said that the bewildering effort to determine whether such a calling comes from a higher power or another source is irrelevant. More important is the determination of whether the calling is truly authentic. Will this call provide a feeling of being more alive? Authenticity trumps origination. Furthermore, Levoy does not dismiss the possibility that some-

thing less than noble may also contribute energy and drive—unresolved anger at a bitter rival or a scoffing parent, for example.

Many people who belong to no formalized religion, including some who identify themselves as agnostic or atheist, nevertheless would describe themselves as spiritual. Spirituality requires only a fascination with and belief in the intangible, in such unknowns as the nature of the soul. Faith, too, exists easily without an objectified provider in the form of God, Allah, Buddha, or another omnipotent figure; faith is confidence and trust—an unshakable belief in something (or someone) despite the absence of proof. Faith and spirituality motivate us all in our life's work to a greater or lesser extent, from Mother Teresa herself right down to the farmer who plants seeds confident that crops will grow and provide food. James Fowler (1981) said our secret hopes and compelling goals are fueled by faith, and that matters of faith are the dynamic process through which we find meaning in life, which may or may not be religious in content or context. He called faith the way that people see themselves in relation to the force field of life. Dr. Groopman (2003) examined the nature of hope as well, which he defined not as blind optimism ("my cancer will be cured") but as a determination to persevere in full recognition of the odds and obstacles ("I understand that this cancer treatment might actually kill, not cure me, but I have decided that it is my best option"). Many of the physicians who identify as religious will no doubt credit God with being the wellspring of their goodness. How many of the physicians will directly ascribe their actions to a higher power? Of those who don't, how many will see the source as something apart from themselves, such as a feeling of solidarity with other human beings or as an instrument of some universal energy?

Fowler wrote that faith is a universal concern, and it is something that concerns everyone regardless of whether they are religious or not, believers or nonbelievers. His reasoning was that we strive to discover how we should live and what will make life worth living. "We look for something to love that loves us, something to value that gives us value, something to honor and respect that has the power to sustain our being" (Fowler, 1981, p. 5). It is the power to sustain our being that remains elusive—the source of the wellspring.

Fowler (1981) argued that we are all capable of faith, and that moves us to search for that something; the exemplary physicians' something may be what they choose to do beyond the bounds of typical work, and faith

that it is meaningful and has value. If we return to our hypothetical doctors, the average Dr. Smith and the exemplary Dr. Jones, the question becomes this: Is the difference between the two the something itself, or simply the faith that moves them to keep looking for it? Is this a mere chance of character—perseverance in the face of resistance, the Sisyphean effort to right wrongs—that drives the exemplars? Or do we all have the capacity to do more, to be more, if we can only divine and tap into our personal something—maybe Csikszentmilhalyi's flow?

If your heart isn't in it, any action becomes work. Mother Teresa said that true wealth is the ability to feel blessed with whatever you have and a willingness to share it. We may feel blessed and grateful, but without the desire to share what we have no matter how much or how little that may be, there is little joy to be found.

And what about people who work happily into their 80s and 90s? Life coaches and psychologists alike all say that the secret to making a living is to do what you love and love what you do. Psychology textbooks had not even included an indexed entry for the word *love* until the past 25 years. It was somehow unscientific to talk about how love underpins creativity, joy, and peace. Yet I suspect our physicians will have focused clearly on the miracles that can occur when love is present, and that if asked what makes the days fly by, a large part of the answer will most likely be a love for the work itself. Did our physicians take comfort from discovering their purpose early in life or did it take time to evolve later over the years? Other, less inspired professionals may have started with clear goals and ideals only to get discouraged or sidetracked into something that devolved into merely a job, a means to a paycheck. What is this magnetic pull? What does it sound like? What does it look like? Most importantly, how did these physicians recognize it? Did they have to go through a special process to learn to listen to their inner selves?

These reflections led to my questions for the exemplary physicians. Is the thing that makes your life worth living specific to you (e.g., your family, your job, your pet cause), or can anyone conceivably share a part of it? Does it all come down to the realization that embracing life itself is the reward, and that it is all about the journey and not the destination? I invite you to listen in with me to the voices of our dynamic doctors as they ponder these questions.