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Re-Visioning Medicine

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Abstract Studies suggest that medical students and physicians have higher rates of anxiety, depression, and suicidal ideation than their peers in the general population. Some authors have suggested that medical culture perpetuates these problems by erecting "barriers to treatment," preventing students and physicians from getting the help they need. Here, the author begins a broader examination of the potential role of culture by examining the myths and symbols that form the basis for medical culture and the medical self-image. The author argues that a medical self-image based on a de-contextualized medical mythology, the Asclepius myth, results in a sense of professional identity that is unbalanced, dehumanized, and characterized by unattainable expectations. The outward expression of this medical self-image, the medical culture, is often a-relational, unhealthy, stressed, or even toxic. The author suggests some ways of re-modeling medical culture, including its rituals and symbols, and medical education in ways that incorporate what is currently kept in its shadow.

Keywords Medical culture · Medical self-image · Medical mythology · Medical symbols · Medical education

In their discussion of the culture of medicine, Boutin-Foster, Foster, and Konopasek (2008) define culture as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups" (108). They extrapolate from this that the culture of medicine, more specifically, can be understood as "the language, thought processes, styles of communication, customs, and beliefs that often characterize the profession of medicine." Boutin-Foster et al. (2008) state that the concept of a culture of medicine may be difficult for those within the profession to grasp, as it is not formally taught (or even spoken of) but rather is learned through role-modeling. In other words, the medical culture is something that is passed down from one generation to the next through a process of tacit social conditioning (Pololi et al. 2009, 106–14).

Hafferty and Franks (1994) and others (e.g., Kirmayer 2003, 248–77) also argue that medical education is a process of socialization or enculturation as much as it is a process of learning information and techniques. One of their central theses is that medical education does not occur within a cultural vacuum:

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> Medical training is not just learning about becoming a physician, it involves learning how to "cease" being a lay person. Medical training is not just about the acquisition of new knowledge and skills, it is about the acquisition of a *physician identity and character*. Initiates arrive at the gates with established values. They do not, however, leave medical training with those values intact or unmodified (italics added, 865).

The idea of the "medical self-image" is central to the concept of a medical culture or "world-view"—defined as the group-learned definitions and interpretations of phenomena as well as the attitudes, values, prejudices, and fears of doctors (Egan 1990, 175–81). The medical self-image is the view one has of oneself *simply by virtue of the fact that one is a doctor*, which implies certain characteristics based on the common (medical and larger cultural) understanding of what a doctor is. Egan argues that this medical self-image took shape early in the profession when doctors developed a sense of group identity through opportunities to self-reflect in medical journals, at conferences, and through professional associations. While he suggests that the medical self-image was initially largely transmitted by medical educators, his ethnographic research indicates that there were many public opinions about physicians in the non-medical realm of society that also fed the image. Today, as was the case then, the medical self-image is also perpetuated through established medical culture (i.e., rituals, tradition, and lore) as well as popular culture (e.g., the images of physicians portrayed in the popular media).

In this paper, I argue that there are problems with the current medical self-image, as it is rooted in a medical mythology that has been decontextualized. It is my position that the current Western medical self-image, born of this truncated mythology, is at the heart of current problems in Western medical culture—the problems professionals and students report when asked about their experiences (Pololi et al. 2009, 106–14; Gaufberg et al. 2010, 1709–16). Though they necessarily feed upon and inform one another, as suggested by Egan (1990, 175–81), and in some ways are indistinguishable, the differentiation between self-image and culture is important for the sake of this argument. Here, culture refers to the *outward* expression of common *internal* experiences (the medical self-image). I will argue that the medical self-image based on the current medical myth results in sense of identity that is out of balance, characterized by unattainable expectations and plagued with conflict and that the outward expression of this is an often a-relational, unhealthy, stressed, or even toxic medical environment.

As a caveat, any time one speaks of culture, one speaks in generalities. The same is the case here. I acknowledge in laying out this argument that it is not specific or applicable to the individual experience of every physician—in fact it may not even completely accurately describe the individual experience of any one physician. Rather, this is an argument about the collective, an amalgamation or an average. As the saying goes, the whole is not equal to the sum of its parts. In this case, understanding a culture involves focus on similarities (the whole) versus individual differences (the parts). It is when looking at how to change a culture, how to disrupt the status quo, that a focus on individual differences becomes quite important. The focus of this paper is not on change, though some avenues for change are suggested, but on exploration and understanding of the status quo. I will begin with an examination of medical mythology and symbols.

The role of mythology in medical culture

> *It is in and through symbols that man, consciously or unconsciously, lives, works, and has his being.*
>
> —Thomas Carlyle, *Sartor Resartus*, 1836

The medical profession is rooted in mythology and steeped in tradition based on myth. The staff and the serpent, the white coat, the black bag and stethoscope, the Hippocratic Oath: these are the symbols of physicians, and they carry significant cultural meanings, both within the profession and outside of it, that operate as the backdrop for the everyday practice of medicine. For example, when a doctor dons the white coat each day, he or she may think of it only as a uniform, a work coat, akin to the suit coat of the business person. However, whether its wearer is conscious of this or not, this simple article of clothing is a symbol imbued with specific meanings for both doctor and patient, and these specific meanings have their basis in myth.

Asclepius

The image of the physician in the Western world traces back to the skilled Greek physician Asclepius (Asklepios) who was eventually elevated to the status of a god through lore and legend. As the myth (Jayne 1925; Stanton 1999, 476–77; Blayney 2005; Lyons 2012) goes, Asclepius was the son of Apollo and his mortal nymph mistress, Coronis. Upon learning of her infidelity, Apollo killed Coronis in a jealous rage, only discovering that she carried his son as she lay burning on the funeral pyre. Apollo rescued his son, Asclepius, from his dead mother's womb and gave him to Chrion (a centaur who was a healer and teacher) to be raised and trained as a healer. Like his mentor, Asclepius was a kind, gentle, and very skilled healer who became widely revered.

The earliest medical schools were connected to the shrines or temples devoted to the worship of Asclepius (Blayney 2005; Lyons 2012). Patients journeyed to these hospital-shrines to be healed by priest healers who were thought to be the keepers of the sacred secrets of healing that were passed through oral tradition from father to son (Blayney 2005). These hospital-shrines also housed (harmless) Asclepian snakes in honor of the great healer. Asclepius is most often depicted as a bearded, bared-chested man holding a staff made of knotty wood with his sacred single serpent coiled around it. He was ultimately deified as the Greek god of healing not only because he could heal the ill, thus preventing death, but also because he learned to raise the dead (Stanton 1999, 476–77). Zeus, the Greek god of gods, was angered by this, however, as the possibility of human immortality represented by Asclepius was a threat to the power and status of the gods. In his rage over Asclepius's power, Zeus struck him dead with a thunderbolt (Stantin 1999, 476–77). Prior to his death, Asclepius had children, including two daughters: Hygeia, goddess of health, cleanliness, and sanitation (Jayne 1925) and Panacea, or Panakeia, goddess of healing (Jayne 1925). Apollo, Asclepius, Hygeia, and Panacea are the gods to whom the Hippocratic Oath for the ethical practice of medicine was historically pledged by physicians (Jayne 1925).

This myth carries a deeper meaning when seen in the context of the culture and identity of the profession and those within it. King and Hoffman (2000) point out that, "Myth does its work in the heart and can therefore be more powerful than the logic to which it has always been opposed" (208). There is a pull to myth and truth about myth that is deeply felt and valued apart from any basis in objective reality. Myths represent an emotional, poetic, felt experience—a personal or cultural truth (Stein 1980, 379–401). King and Hoffman (2000) describe myths as shared stories that respond to profound human needs for a sense of community, legitimacy, social control, and justification of power dynamics. I would add that myths are also a response to a profound human need for identity or self-understanding and self-definition. For an individual or group, they provide something to hold on to, something with which to identify, a way of labeling a subjective reality, a felt experience, a deep sense of tradition or history, roots and groundedness, a frame for understanding oneself and the world. Furthermore, they have the power to do so, to shape identity and culture, even when outside of conscious awareness.

Medicine as a culture, and medical professionals individually, have a need for legitimacy, a sense of community, social control, and sense of identity and therefore, are not immune to the appeal of myth. In fact, the medical myth described above that serves to ground the medical culture is *particularly* appealing because it meets these needs *and* because it has inherent appeal as it is tied to Apollo, one of the great gods of the Greek pantheon (Jayne 1925). Apollo, full name Phoebus Apollo, is the son of Zeus, the most powerful of all of the Greek gods. Apollo has been described as "the most Greek of all the gods" and as having "good and lovely endowments" (Hamilton 1942). He is the god of light, who contains no darkness, and the god of truth, who speaks no falsities. As his full name suggests, he is brilliant (Phoebus means brilliant), and he represented mental enlightenment to the Greeks (Jayne 1925). He was believed to be pure and beneficent, serving as a direct link between gods and men, showing men how to know and make peace with the gods (Hamilton 1942). He was the healer who first taught men the healing art. Apollo's importance in Greek mythology is evident in his parentage and also in his qualities, thus communicating the very importance and power of his descendents including Asclepius and all physicians since (King and Hoffman 2000, 208).

One of the most powerful messages carried through the myth of Asclepius is that there is something godly about being a healer—of course, in the myth, as myths do, this quality or experience is literalized such that Asclepius *actually* is a god—in fact "the most worshipped god in Greece" whose status in the pagan religion was akin to that of Jesus in Christianity (Stanton 1999, 477). The sense of godliness captured in this myth likely speaks to the felt experience of many physicians who appreciate and wonder at the miracles they create and witness daily. To bring someone on the brink of death back to life or health is indeed god-like, definitionally belonging more to the realm of the immortal deity than that of the mortal human.

The medical myth also communicates another message, which often seems lost or unspoken, or is more unconscious both within the culture of medicine and in popular culture generally. Stanton (1999) captures it beautifully: the medical myth communicates that not only is the god-like healer capable of defying death and expected to do so, but he or she is also resented for doing so, thus putting physicians in a double-bind. In the medical myth, this is illustrated by Zeus striking Asclepius dead, the ultimate punishment for answering his calling and using his god-like powers to bring the dead to life. When he got too good at what was doing (too close to godly), Asclepius lost his life. Today, as in the myth, physicians are also often accused of "playing god" when they use scientific and technological advances to transform "the traditional art of healing and palliation into an unnatural extension of life" (476). Stanton (1999) further describes the impossible position of physicians:

> As humans, we want to defy mortality. In the face of death, we seek miraculous cures and unlimited hope. At the same time, we fear and resent the mortal who can achieve these goals. Such abilities challenge our innate belief in the sanctity of the human soul, imagined to be beyond the control of man. The mythical status of [Asclepius], as a demigod, represents the inherent contradictory expectations that we have of physicians. (477)

As half-mortal, half-divine, Asclepius is set up from the start for failure; he is expected to be both human and divine but, given their contradictory nature, cannot truly, fully be either. Asclepius fails at being a god because, though he can bring others back from the dead, he is himself mortal and ultimately cannot save his own life. At the same time, by using his godly gift to save others already destined to death, he fails at being a mortal because he clearly defies the laws of mortality (Stanton 1999, 476–77).

Consistent with the first message of the medical myth, the image of the physician that is commonly portrayed is as one who is heroic, glorious, skilled, "a great source of delight" who

"charms away pain" as was described by early Greek poets (King and Hoffman 2000, 208), or, as Egan notes, "the only perfect man mentally" or "nobler than missionaries, and greater even than those [sic] who occupy our pulpits" (Egan 1990, 178). This popular image certainly does not capture the much more conflicted message contained in the medical myth about the difficulty the physician has balancing the power he or she holds within the limits he or she has. G.T. Howard, quoted in Egan, more accurately portrayed the reality of the situation:

> We have so long been, nolens volens, placed on pedestals of more or less altitude, and made to appear almost supernatural persons who never dream of troubling about mundane things, and we have been more or less attentive listeners to such a torrent of platitudes about the glory of our noble profession, that one feels rather reluctant to hint that there is another side to the picture; that we sometimes wonder where the glory and nobility are, and that there is, after all, a lot of human nature in our ranks. (Egan 1990, 180)

In sum, the problem inherent in the messages contained within the medical myth from which public and personal conceptions and expectations of modern Western physicians are born is that they result in a self-image that is quite unbalanced and at odds with the realities of medical practice. This self-image calls for power and perfection yet at the same time is a set-up for failure. The reality of medical practice is that mistakes are made, physicians are human, and people die.

A closer study of mythology surrounding medicine reveals that the current myth upon which Western medicine is based is only a piece of the story. As tends to happen when old meanings no longer fit experience, other pieces are lopped off at one point—in particular, when medicine became secularized and physicians, Hippocrates for example, began to value rationalism over faith and scientific method over shamanism (Paris 1990). It is this truncated, de-contextualized version of Western medical mythology that results in the current medical self-image, as it is this version that is reified through ritual and rite of passage. In order to understand and perhaps reinvigorate Western medical mythology in its more complete and contextualized form, I turn to an exploration of the rest of the story.

The "prequel" to the Asclepius myth

Before Asclepius was deified as the Greek god of healing, another mythological figure held the caduceus staff, a symbol also tied to Apollo that is often used to represent (or misrepresent, some argue) medicine (Klinge 2008, 84–5; Wilcox and Whitham 2003, 673–77). The caduceus staff is a golden wand on which two serpents are intertwined and at the top of which is a pair of wings. According to myth, Hermes, another son of Zeus, stole Apollo's prized cattle and hid them in a cave. When Apollo came to claim them, he was enchanted by the music of a golden lyre that Hermes had constructed from two of the cattle and a tortoise shell, and Apollo gave Hermes the remaining cattle in exchange for the lyre. Apollo was also amazed by the music from a shepherd's pipe that Hermes played. In exchange for the pipe, he gave Hermes a golden wand; the kerykeion (caduceus) was said to be a magic wand that could turn everything it touched to gold. The serpents came to be entwined around this magic wand when Hermes drove it into the ground between them in a peace-making effort, and they wrapped around the wand in friendship. The wings are said to have been added in approximately 250 BC to represent the winged traveling hat and sandals of Hermes (Wilcox and Whitham 2003, 673–77).

Hermes is known as the messenger, or the god of communication and magicians, but he is also associated with alchemy and was known as a "guardian of health" (Jayne 1925). He was a personification of ambiguity and adaptability, and his caduceus staff represented health as a

constantly shifting state of "balance amidst contrary forces" (Paris 1990, 98) versus a fixed state of being. Hermes's medicine was shamanistic medicine. He was thought to be especially suited to his role in healing because he had "metis," the Greek word for female intelligence or intuition personified by Metis, the Greek goddess of wisdom said to have known more than all gods and men together. As the myth goes, Metis was Zeus's first wife. When Zeus realized that his wife's wisdom may be passed on to their children, thus creating offspring who could be a threat to his power, he swallowed her before she could give birth to Athena, thus trapping intuition or "feminine intelligence" in his own belly, thought to be one root of the phrase "gut" feeling (Paris 1990). More than mere intuition, metis is the basis of creativity, inventiveness, and ingenuity. It is opportunistic, open to discovery of any sort through any form of knowing (scientific or not); it is the ability to see in any object what it has to reveal (Paris 1990). In this way, a medicine based in metis, Hermes medicine, is based more in intuition, art, and faith than in science—a more "feminine" medicine.

Several have argued that a mistake made by the U.S. Army Medical Corps along with the misinterpretation of printers' marks in medical textbooks led to the current misuse of the caduceus as a symbol of medicine (e.g., Klinge 2008, 84–5). Beyond being a mere mistake, Wilcox and Whitham (2003) argue that this is a wholly inappropriate symbol for medicine because what Hermes represents is "at odds with the practice of medicine" (676). They see Hermes as "unethical" and excessively corrupt given his "overly shrewd" ways, acts of deception, and association with commerce. They consider Hermes's role as "the guide of souls along the pathways to the underworld" to be particularly problematic as an image with which physicians, "with the possible exception of palliative care specialists," identify. Instead, these authors argue that, "the symbol of the '*blameless physician*' Asklepios, and not the caduceus of Hermes (Latin, Mercury), is an appropriate emblem for the ideals of modern medicine" (italics added, 675). This symbol is the rod of Asclepius, a knotty, wooden staff on which a single serpent is entwined. The myth says that Asclepius chose this symbol after he was surprised by a snake that had entered the room while he was examining a patient and subsequently killed it with his staff. Asclepius watched in awe as a second serpent arrived and placed herbs in the mouth of the first serpent to bring it back to life. Asclepius then used the same herbs to bring his patient back to life (Wilcox and Whitham 2003, 673–77) and chose his symbol as a demonstration of respect for the snake.

This symbol seems quite appropriate for Asclepian as snakes were seen as representative of wisdom and associated with health and life. In addition, snakes figured prominently into treatment of patients at the Asclepian temples; patients would spend the night in the temple surrounded by snakes thought to bring dreams to the patients that, once interpreted by a priest/healer, would reveal the appropriate treatment. I argue that the "mistaken" or "inappropriate" symbol of Hermes may be an equally appropriate symbol of medicine because it captures more accurately the realities of the practice of medicine; the caduceus, versus the rod of Asclepius, represents more than the virtuous, infallible, or life-giving, aspects of healing and healers by taking on a slightly darker tone (of an imperfect healer) and incorporates the creative and feminine (Hermetic) aspects of medicine that are not represented by other symbols.

Another part of the larger context of the Asclepius myth on which Western medicine is based also relates to Apollo. Included in the myth is the fact that Apollo, the father of Asclepius, was himself a god of healing. In fact, in representations of Apollo that revealed him as less than completely beneficent, he was responsible for both curing *and* inflicting disease—it was from him that Asclepius inherited his healing powers. What is not included in the medical myth is that Apollo had a twin sister, Artemis, a moon goddess who was also a healing divinity (Jayne 1925; Hamilton 1942). In fact, Apollo and Artemis are only two of the many Greek gods *and goddesses* associated with Western medicine and healing (Jayne 1925).

Remembering Artemis and the other gods and goddesses of healing re-contextualizes the popular medical myth and may help to re-define and expand modern notions of medicine such that "feminine" ways of knowing and healing are recaptured as part of medical training and practice. Furthermore, such a remembering restores a more balanced and realistic image of physicians and approach to health care, thus creating a potentially different atmosphere for future medical training and practice. A balanced and realistic approach acknowledges varied ways of knowing, accepts and embraces the humanness (mortality and fallibility) of medical practitioners, and makes room for the not so sunny Apollonian aspects of the healing professions including error, pain, suffering, and death. Currently, these less noble sides of medicine are expressed mainly in popular culture through television shows like *Scrubs*, *House*, and *Gray's Anatomy*, all television programs for which there is wide appeal, especially to physicians in training. Perhaps this appeal is due to recognition on some level that there is more to being a physician than the professional traditions and lore would suggest. Perhaps the appeal is also due to a desire for validation of the sillier, darker, or more dramatic aspects of medicine and validation of the sense that doctors, even very good ones, are people—or more aptly, *characters* with all of their idiosyncrasies, quirks, and flaws.

The fact that the myth on which the current, more specifically academic, medical culture is based is decontextualized, is problematic because it suggests that the medical self-image, upheld by professionals and the public alike, is distorted. From a position viewing health as balance, openness to all experience, and the ability to create and modify our understandings of the world such that we can live more meaningfully within it, the current medical myth is not healthy. It is unhealthy because it excludes important ways of being and knowing and is, therefore, unbalanced and at odds with reality, resulting in physicians trying to exist within a self-image based in myth that does not fit with actual experience. This discrepancy can be "crazy-making." At the least, it can leave physicians without a coherent narrative and unable to make sense of large parts of their actual experience, which can lead to anxiety and depression, a very common experience of physicians and trainees (Dyrbye, Thomas, and Shanafelt 2006, 354–73; Dyrbye et al. 2000, 334–41).

The white coat

As opposed to resulting from a decontextualized myth, some of the problems in modern (particularly academic) medical culture seem symptomatic of buy-in of one part of the medical myth while simultaneously denying or ignoring another part: namely buy-in of the god-like nature of medical practice and the profession coupled with the denial of the human existential realities of imperfection, decay and, ultimately, inevitable death, which are also realities of medicine.

The white coat, another medical icon and the most common symbol used in the media to represent physicians, (Jones 1999, 478) represents a conscious (at least at one time) denial of this aspect of the existing myth. Physicians adopted the white laboratory coat in the mid-19th century at a time when the reputation of medicine was poor, as it was associated with quackery and mysticism versus true science (Jones 1999, 478). In order to change this image of medicine and connect it directly with the scientific approach medicine was trying to adopt, physicians began wearing the same kind of laboratory coats worn by the scientists of the day (Jones 1999, 478). At the time, traditional scientific lab coats were actually beige, but white was chosen when the attire was adopted by the medical profession. The choice to wear white coats (versus another color) represented a deliberate effort to change the public image (and likely the self-image) of medicine to something more pure and hopeful (Jones 1999, 478). The new white coats stood in direct contrast to the black robes (conveying a sense of mourning and

death) worn earlier by hospital caretakers when hospitals were seen as "houses of dying" versus the "institutions of healing" they later became with scientific advances in medicine (Jones 1999, 478).

The choice of white for the iconographic physician's coat, whether conscious or not, is significant, as the color carries many meanings that communicate something specific about the culture of medicine. As every symbol is at once an explicit representation of something and at the same time an implicit representation of its opposite, inherent in the symbol of the white coat then is the suggestion that medicine is all things "white" (pure, clean, light, living, scientific, noble, godly, etc.). In other words, all things Apollonian. At the same time the white coat suggests that medicine *is not* anything "black" (impure, dirty, bad, evil, dying, mystical, etc.). In other words, feminine or Hermetic. Likewise, the medical myth when acted out in a way that fails to recognize or denies the humanity of Asclepius, suggests that medicine is all things godly, heroic, virtuous, laudable, and noble, and *is not*, therefore, selfish, unethical, shameful, imperfect, or human. The donning of the white coat then signifies that the wearer is virtuous, one of pure or good intent, someone with lofty ideals and pure practices, someone who is clean, thus healthy, in mind, body, and soul, perfect or striving to be, and godly, like Apollo or Jesus, Moses or the Saints who are often depicted in white robes (Jones 1999, 478).

As Mark Twain stated in a now common turn of phrase, "The clothes make the man." Along these lines, what one wears both reflects and informs one's self-image. The white coat is something that distinguishes doctor from patient, lay person from doctor—as it is ritualized in medical training through the white coat ceremony rite of passage for medical students. From a patient perspective, the white coat is useful, a symbol of professionalism, authority, and (scientific) knowledge that can provide comfort and reassurance in a time of need (Boutin-Foster, et al. 2008, 106–11; Douse et al. 2004, 284–86). Less usefully, this symbol coupled with the myth communicates that the one wearing the white coat is, in some powerful way, very different from the one without and elevates the status of and expectations for the physician to unrealistic heights. The physician, who is idealized, is also dehumanized through the common acceptance of one aspect of the myth (godliness) and the denial of the other (humanness).

Dehumanizing medicine

The dehumanization of the physician is a common theme in the work of various researchers and authors describing the ills of the medical culture—for the sake of this argument, those things that are outward expressions or consequences of the current medical self-image. In a recent study, Pololi et al. (2009) conducted open-ended interviews with faculty from five different United Stated medical schools about their experiences of the medical culture. Their primary conclusion was that there are serious problems in the *relational* culture of medicine. Though positive relationships with students, residents, and patients were noted, very few of the faculty described positive relationships with their colleagues. Study participants expressed that the medical culture does not seem to support or value relationships and that faculty feel disconnected and isolated at best and disrespected, overworked, and dehumanized at worst. They depicted academic medicine as a culture of intense competition and individualism, finger-pointing and fault-finding, disloyalty, dishonesty, retaliation, penalization, and dissatisfaction.

Furthermore, these authors suggest that these aspects of the culture are not restricted to faculty. Rather, as students in effect "learn" the culture through their experience in medical school, they quickly become indoctrinated into these ways of being. Students may not always be able to articulate the process by which this occurred during their medical education,

especially as much of this learning seems to occur through the "hidden curriculum," (Pololi et al. 2009, 106–14; Hafferty and Franks 1994, 861–71) which includes what students learn through observation of peers and mentors. This method of sharing information is certainly unofficial, often completely unspoken, and can even be unconscious. The "hidden curriculum" can be deleterious, often in direct contrast to the content of formal courses on medical ethics (Gaufberg et al. 2010, 1709–16). Jorm and Kam (2004) suggest that it is at this very point—where actual practice does not match an organization's values or ethics—that underlying (often unconscious or unspoken) cultural assumptions (i.e., the medical self-image) are revealed. I suggest that the messages communicated through the "hidden curriculum" (the culture of medicine) is, at least in part, the result of (and contributor to) a problematic medical self-image based in a decontextualized and distorted medical mythology.

Myers and Gabbard (2008) illustrate this process of latent learning when they describe the implicit ("hidden") and sometimes explicit messages communicated to medical students and young physicians that "time devoted to oneself and pleasurable pursuits may be regarded as selfish and neglectful of one's duty to patients and the profession" (10). They describe the "workaholic" nature of medical culture as one of self-sacrifice, specifically sacrifice of time, enjoyment, and self-care. As an example of this, a medical student in treatment with me for extreme anxiety made it a point to schedule a therapy session during the hour allotted for lunch on his clerkship schedule. However, when the attending physician began lecturing into the lunch hour and the student asked about the break, not wanting to admit he had a therapy appointment, he was told, "Doctors don't get to take lunch." Consistent with this attitude, Myers and Gabbard (2008) suggest that students quickly learn that in order to gain the approval of attending physicians they must "run the extra mile and strive toward perfection" (11). This is a concrete example of how an image of physician as god-like, perfect, not human (thus not having needs) can be played out in day-to-day practice as well as how the problematic medical self-image can be propagated to future physicians who internalize these kinds of statements/learnings.

As Myers and Gabbard (2008) also suggest, the propagation of problematic aspects of the medical self-image is not hidden or "latent" but rather is openly conveyed through the actual curriculum. For example, there has been a recent re-birth of teaching "professionalism" in current medical education, and formal coursework is offered on the topic. A student who had just completed his professionalism training was in therapy in part to address long-standing anxiety and depression resulting from the lack of meaningful connections in his life—driven by his tendency to heal old wounds by playing the role of rescuer or savior to others no matter what the cost to himself. In therapy, he had been struggling for years to understand the connection between his problems with depression and anxiety and his approach toward relationships, which was based in his deeply entrenched belief that goodness is based in selflessness. This was the foundation of a self-image, formed through his life circumstances, that was very consistent with the medical self-image that drew him to the profession to begin with. This student's progress in therapy was hindered by the explicit messages he received in his professionalism training, such as "professionalism means doing what you least want to do when you least want to do it" and the highest form of professional development is "a complete lack of selfishness" (i.e., *always* putting the needs of others first—especially patients). This kind of teaching, one that furthers the implicit image of physician as godly, perfect, or without human flaws or needs, facilitates the systematic development of physicians who lack work-life balance, who feel depressed and burned out, who lack empathy and compassion, and who may even come to resent their patients.

Myers and Gabbard (2008) highlight some of the ugliest aspects of the medical culture when they talk about the experiences of shame and humiliation sometimes associated with

medical training. Sadly, this shame and humiliation are frequently the direct results of abusive and dehumanizing practices in medical training discussed elsewhere in the literature (Elnicki et al. 1999, S99-101; Kassebaum and Cutler 1998, 1149–58; Recupero et al. 2004, 817–24). At other times, they result from a more private experience of intense self-criticism, which tends to result from a combination of personal perfectionism and crippling self-doubt, both of which are prominent characteristics of those drawn to the profession (Myers and Gabbard 2008).

One student, a very competent and bright budding professional, was overcome with anxiety when beginning her acting internship (AI) in the field of choice during her third year of medical school. She expected that as an acting intern she should be performing at the level of an actual intern, which in her mind meant that she should "know everything" about the field—and by this she literally meant *everything*. Since she was still learning, she constantly felt like a fraud and spent hours crying in the bathroom during the first week of the AI. When she was called upon and did not know an answer, she felt ashamed, embarrassed, and incompetent. She felt as if she was under a spotlight, where everyone was watching her and waiting for her to fail. The shame and self-doubt eventually reached a level where she was unable to function on the rotation at all, and she had to withdraw, furthering her sense of being a fraud and a failure. As Myers and Gabbard (2008) suggest, this was a student who came to school already struggling with perfectionism, self-criticism, and self-doubt. However, the implicit expectation learned through her experiences in the medical culture that physicians (and, by extension, medical students) should be perfect and "know everything" proved incapacitating for her. Though she recovered from this experience, she carried this expectation forward through the remainder of medical school. She struggled again with intense anxiety when she graduated and began her actual internship, still feeling like a fraud because she did not yet "know everything."

Gianakos (1999) takes a more indirect approach to describing the problems within the medical culture by focusing on what it is not. In constructing an "ideal" version of medical culture, Gianakos suggests that the current medical culture is not one that truly puts patients first. For example, students within the present culture do not learn that competence and compassion are equally important, and they are often not taught how to truly listen and communicate with their patients. Gianakos further insinuates that in the current climate of medical education, students and physicians are not taught how to care for themselves and lead the kind of balanced lives that will benefit both them and their patients. Furthermore, the medical culture, Gianakos suggests, is not emotionally safe. It is not an environment where one feels able to ask questions, to share when one does not know something, or to express fear and concern. Gianakos states that the ideal medical culture, would be one in which collaboration supersedes hierarchy, where people treat one another with respect, where people truly strive for excellence and take responsibility for their mistakes, and is one in which self-reflection and self-awareness are both appreciated and encouraged in the process of helping medical professionals grow to lead meaningful lives (207–09).

In sum, both authors and real-life stories illustrate the ways in which the current medical myth is lived out, creating and fostering a culture that can be quite damaging. The central theme is in the dehumanized medical self-image and the often dehumanizing day-to-day practices that result from this way of viewing the role and nature of the medical professional. Both authors and examples also illustrate the need for a more human medical self-image in which physicians are free to be imperfect and are seen as people who also need to be cared for (by self or others) as part of leading a balanced and meaningful life. In daily practice, Pololi et al. (2009) call for a more relational medicine based on dignity, trust, and respect of patients and colleagues. I argue that these kinds of changes in the day-to-day practice of medicine and medical education are more likely to occur through a re-visioning of the medical self-image

through re-contextualizing and re-humanizing the myth upon which the culture of modern medicine is based.

Embracing the shadow: re-modeling medicine

The "shadow" is a term used by Jung (Campbell 1971) that describes the dark aspects or inferiorities of the self or a culture that are largely unconscious but are nevertheless real and present. For the self and culture, whether we are actively ignoring these darker characteristics or are simply "pleasantly" unaware of them, they still have an impact on how we think, feel, and behave. With some considerable effort, a person or a group can become aware of the shadow and work to assimilate it into conscious being. In fact, this is necessary if a person or culture is to change in positive and lasting ways. It is only by seeing, understanding, and embracing the shadow that a person or culture can find a sense of congruence, control, or agency—can be less an unwitting victim of confusing forces and more an agent of choice, action, and change.

The shadow in this case is the humanity of all physicians, the part of the myth that is often denied, and the "feminine" (artistic, creative, intuitive, and *relational*) aspects of healing that are part of the larger mythological context. The troubles of students and professionals within this medical culture (e.g., disillusionment, dissatisfaction, burnout, anxiety, depression, and suicide) can be seen as signals of a very long-standing denial or repression of this shadow—a denial of imperfection and a shutting off of the creative, intuitive, and relational aspects of medicine.

Re-symbolizing medicine

What might an embracing of the shadow look like in the medical self-image and the culture of medicine? First, as Stein (1980) states, "the myth cannot exist apart from its recitation" (381). Myths are perpetuated by rituals, which were originally born of the myth. Thus, in order to change the myths, and thus the medical self-image, some changes in medical rituals and traditions may be important. On the surface, making changes to rituals may seem like a small gesture, but even seemingly small things (like a white coat) carry huge significance (Jones 1999, 478) and, given time, seemingly small changes can produce major shifts in cultural consciousness.

One possible concrete change to medical ritual would be a change in attire. Studies have suggested that patients like that their doctors wear white coats, (Boutin-Foster et. al. 2008, 106–11; Douse et al. 2004, 284–86) as its symbolic function is clearly useful for some patients, but does this mean another symbol might not be more accurate and also useful? Perhaps physicians should go back to wearing black coats. Consider how different it would be to see a physician in black, what a different meaning the coats would carry. Actually, though different, this would likely be an equally problematic symbol as the white coat, as it too would represent only a partial picture of the reality of medicine. So, perhaps physician's coats should be black *and* white. If we all (physicians and patients) were symbolically confronted every day with a visual representation of the fact that with light comes dark—that one cannot have something without also having its opposite at the same time, it might be harder for the public and medical professionals to deny the realities of death and disease and to participate in the dehumanization those who both suffer and heal.

Perhaps more realistically, the profession might consider the elimination of the white coat. Some physicians already advocate this for hygienic or relational reasons. This change might

begin with students by eliminating the traditional white coat ceremony that occurs at the transition into medical school (an early indoctrination into the medical self-image) and then continue on a larger scale by altogether eliminating the white coat worn by students, residents, and attending physicians.

Similar small but important changes have been made in the more distant past. For example, it was typical for the classic version of the Hippocratic Oath (Jayne 1925) to be recited by medical graduates as part of the graduation ceremony—another rite of passage into the profession that reified the medical self-image born of the myth of Asclepius. The language in this oath heavily conveyed themes of godliness and perfection using terms and phrases like "purity and holiness" and "being honored with fame among all men for all time to come" (Edelstein 1943). The modern version of the Oath commonly recited at graduation ceremonies today takes a drastic turn from the classic version and is more akin to what I advocate for in this paper—focusing on the art as well as the science of medicine and the fallibility and humanity of physicians. For example, this oath reads, "If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God" (Lasagna 1964, 11). While it is encouraging to see that this revision was made some time ago, it is also somewhat disconcerting to realize that even with this modern version graduates find themselves reciting something that may be quite uncharacteristic of or even foreign to their experience of medical education, medicine, or their identity as a physician (e.g., "I will not be ashamed to say 'I know not,'" and, "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being…"; Lasagna 1964,11). Perhaps the oath (in its modern version) is something that needs to be spoken from the first day of medical school and then consciously embraced in recitation and practice throughout medical education rather than as a footnote to the experience.

Re-modeling medicine

In addition to changes in symbol or ritual, medicine and the medical self-image could perhaps benefit from re-modeling practice, and thus practitioners, in ways that might be more in line with a different mythological character: Asclepius's mentor, Chrion, the wounded healer (Crystal 2012). Chrion, half-man, half-horse, is a mythological representation of two realms of experience. The human realm is that of Apollo (lucid, logical, light, and reasoned); the animal realm is that of the underworld, complementing light, reason, and clarity with the darker, earthy, murky aspects of experience (Kirmayer 2003, 248–77). In this way, Chrion is an embodiment of opposites: the apollonian and the hermetic; scientist and shaman; masculine and feminine; intellect and intuition; suffering and healing. He is far from perfect, godly, or pure. Though skilled and intelligent, the wounded healer remains humble in his knowledge that he is no different than his patients in his suffering and his ability to heal. The myth of Chrion is about acknowledging one's own imperfections, wounds, pain, and capacity for suffering in such a way that allows a physician to empathically and compassionately help others—something current medical education seems to "erode" rather than foster (Hojat et al. 2009, 1182–91). Chrion is also a personification of teaching and mentoring, an aspect of medical practice that is very important, especially as this is how culture is transmitted but is currently not the focus of training or practice.

The picture Gianakos (1999) paints of an ideal medical culture is very much in keeping with Chrionic myth, as it is one in which students and physicians would be encouraged to ask questions without fear of humiliation or feelings of shame; help-seeking behaviors (academically or otherwise) and self-care would also be encouraged; students and physicians could

openly talk about how it feels to lose a patient and express any emotions they have about any aspect of their work without concern about ridicule or negative evaluation; the environment would promote connection rather than competition because shared feelings, pains, and experience create a feeling of community. In this "ideal" medical culture, students and physicians would be able to strive for their best, for success and excellence, without undue anxiety about failure (imperfection) because perfection would no longer be the unspoken expectation. Students and physicians would be and feel valued for their uniqueness and for what they have to offer the profession rather than feeling dehumanized or devalued. Furthermore, given this shift, medicine might attract a different kind of future physician—one who is not already burdened with the impossible expectation of perfection but rather one whose calling to heal is born of empathy (207–9).

In order to create this kind of environment (fitting with Chrionic mythology), certain practices in medical education would become obsolete. "Pimping," for example, where students are grilled for information by an attending physician in front of their peers under fear of shame and ridicule would not be part of this new medical education. Although this often cruel practice is certainly an expression of the human imperfection of some physicians, which is a reality to be embraced, it lacks the compassion required of the medical educator and creates an educational environment that is not ideal for learning for most students. In the "ideal," medical education would be about propping up versus tearing down. Where is it not already happening, traditional lectures might be replaced with more discussion or action-based learning that allows for questioning, critical examining, and trial and error. Collaborative learning (versus competitive learning) would be encouraged through group assignments, study groups, discussions, and the use of only Pass/Fail grading, for example. Empathy and relationships with patients would be central to the teachings of the clinical training years—addressing the concerns of current research suggesting that medical students become *less* empathic during those years (Hojat et al. 2009, 1182–91). Current reasons for a loss of empathy, including compassion fatigue due to extended hours under high stress with little control and a lack of self-care may be less prevalent in an "ideal" kind of medical education. Furthermore, lack of empathy resulting from compassion fatigue may be addressed in medical education by providing students with more support and opportunity to process their reactions to the tragedies they often witness and by helping students develop better skills for coping with the inherent difficulties of being a physician.

Re-humanizing medicine

Re-modeling the medical self-image and practice of medicine and medical education in ways that end up being more consistent with Chrion (versus Asclepius) might be one way of addressing some of the current ills of the medical culture and those within it. Another option would make some changes in medicine and medical education that are reflective of a re-contextualized medical myth, changes that re-humanize and re-feminize medicine. These changes would allow room for other ways of knowing and being as a physician—valuing art and intuition along with science—and focusing on relationship including a more nurturing relationship with the self. It seems that there is a long history of a partnership between art and medicine in at least one sense: art in the service of healing. As the Cleveland Clinic Arts and Medicine Institute Website states: "Fine art is good medicine. It comforts, elevates the spirit, and affirms life and hope. Art in the healthcare setting, combined with outstanding care and service, creates an ambience that encourages healing and supports the work of medical professionals" (Cleveland Clinic 2011). Fine art has "long hung on [the] walls" there as a means for promoting health. Dr. Satre Stuelke's Radiology Art project is another example of

art in the service of healing, (Stuelke 2011) as it was designed to help patients better understand or relate to the radiology procedures they experience during treatment by depicting common objects using radiology.

A truly re-humanized medicine must go beyond using art in this way—as an adjunct to treatment and in the service of healing the ill. In a new culture of medicine, art would be in the service of knowing and relating with as much benefit for the physician as for the patient. This kind of merging of art and medicine is already being done on an individual level all over the country (New York University 2010). For example, the work of Dr. John Saito, a pediatric pulmonologist, depicts the "very deep emotions and experiences shared by doctors and patients" through his painting. He states:

> Painting keeps me attuned to my emotions, my humanity, and my compassion. Medicine allows me to view events with a scientific and clinical eye and provides beautiful visuals to recreate on canvas. Although very different in many ways, art and medicine have found a balance for me that is filled with beauty, humanity, and warmth. (2009)

There are also examples of this on an institutional level, at Columbia University, for instance, with its the Program in Narrative Medicine. The Master's of Science Degree Program announcement clearly connects the impetus for this program with the lost relational aspects of medicine:

> In embracing the revolutionary advances in health care technologies, our modern medical system has all but forgotten the critical importance of stories: stories of suffering, stories of healing, stories of the relationships that tie patients to their clinicians. Not only does this failure affect the quality of patient care, but it contributes to an ailing health care system, with dissatisfaction and frustration felt by health care consumers and those who care for them. (http://www.narrativemedicine.org/index.html).

The mission statement of the program makes clear the idea that it is through a creative or intuitive way of seeing and relating (i.e. "metis") that the field can re-connect with the human, relational aspects of medicine:

> Narrative Medicine fortifies clinical practice with the narrative competence to recognize, absorb, metabolize, interpret, and be moved by the stories of illness. Through narrative training, the Program in Narrative Medicine helps doctors, nurses, social workers, and therapists to improve the effectiveness of care by developing the capacity for attention, reflection, representation, and *affiliation* with patients and colleagues. (italics added)

The idea behind this program is that relationships between self and self, physician and physician, physician and patient, and physician and society begin with a moment of narrative reflection. This deeper reading of the self and other (the same kind of deeper reading required in poetry) allows for better self-understanding and an ability to better recognize and compassionately respond to distress in others, which in turn results in a better understanding of larger cultural issues in medicine and avenues for change.

A similar effort is taking place at the University of Florida College of Medicine. Here, a focus on medical humanities, "help[s] us understand that medical practice is a human- and a humane endeavor. The humanities help us recognize past mistakes- and their mirrors in the present-, to see biases and celebrate triumphs, and they provide a window into human nature. Through this understanding, the humanities help to develop better relationships with patients" (http://medinfo.ufl.edu/~Emedhum). The New York University School of Medicine also emphasizes the importance of medical humanities and defines it as

> an interdisciplinary field of humanities (literature, philosophy, ethics, history and religion), social science (anthropology, cultural studies, psychology, sociology), and the arts (literature, theater, film, and visual arts) and their application to medical education and practice. The humanities and arts provide insight into the human condition, suffering, personhood, our responsibility to each other, and offer a historical perspective on medical practice. *Attention to literature and the arts helps to develop and nurture skills of observation, analysis, empathy, and self-reflection—skills that are essential for humane medical care.* The social sciences help us to understand how bioscience and medicine take place within cultural and social contexts and how culture interacts with the individual experience of illness and the way medicine is practiced. (http://medhum.med.nyu.edu/directory.html, italics added)

Other efforts consistent with re-humanizing medicine involve the teaching and practice of mindfulness as part of medicine and medical training. Mindfulness is a practice (or way of being) that comes from the Buddhist tradition and involves complete and purposeful attention to the present moment along with acceptance and non-judgment about what that moment is offering. In the late 1970s after Dr. Jon Kabat-Zinn introduced a Mindfulness-Based Stress Reduction program to help chronic pain patients at the University of Massachusetts, the medical field as a whole began to take more interest in this practice (Irving, Dobkin, and Park 2009, 61–66; Ludwig and Kabat-Zinn 2008, 1350–52). As with the arts, mindfulness can be thought of and used as an intervention designed to enhance healing—a means to an end. However, more in keeping with the spirit of the practice, mindfulness is a way of being that can beneficial to all—sick or well, patient or physician—an end in itself. To be mindful is to be aware (including self-aware) and thus, facilitates connection to the self (to better know thy self) and to others. Mindfulness is inherently relational and intuitive—knowing through participation and through experience (versus logic or cognition).

Several medical schools have courses or programs involving mindfulness. Georgetown University School of Medicine, for example, offers mind-body skills course that includes experiential teaching of breathing techniques, meditation, guided imagery, art, music, movement, and writing (Saunders et al. 2007, 778–84). Graduates of the course and quantitative outcome measures indicate that the course meets its goals of better self-understanding, improved connections with others, stress relief, and increased mindfulness. Other institutions—Vanderbilt School of Medicine and the University of Rochester School of Medicine and Dentistry—have built comprehensive and longitudinal student wellness programs that incorporate mindfulness teaching and practices (https://medschool.vanderbilt.edu/student-wellness/about, http://www.urmc.rochester.edu/news/story/index.cfm?id=1626). Other medical schools have utilized and benefitted from workshops offered by Jack Kornfield, one of the leading Buddhist teachers in the United States, which include experiential exercises for medical students and residents during which one person is asked to face another and look into the other person's eyes in silence for an extended period of time. During that time, Jack recites a Buddhist principle and instructs: "As you look, know that the person before you is someone who has known both deep sadness and great joy." The experience of knowing another in this way, even without words, can result in quite a powerful emotional connection with the other, which can be personally transformative as well (Knudson, pers. comm., 2010).

Although all of these efforts ultimately result in better patient care, such practices have the power to make some real shifts in the ways medical professionals view themselves and the image through which they act, and thus, are in the service of something more global. Unfortunately, the kinds of practices described above are the exception rather than the rule, and their effects have not yet become part of mainstream medical culture.

Final thoughts

Through my experience counseling medical students, I have developed an immense respect for medical professionals and the difficulties of training and practice. As an inside witness to the process of medical education with an outsider's perspective, I have also been quite saddened by the burden medical students and professionals bear—some of which seems driven not by the nature of the work but by the culture of the profession. This is a culture that was defined by and now defines the common or shared ways in which physicians, medical students, patients, and the general public view the physician. Shared meanings (culture), like personal meanings, are developed because they are useful at some time for some reason—they make our experiences make sense. Also like personal meanings, shared meanings can eventually cease to be a useful way of understanding and approaching the world and, when they are not abandoned or adapted to make new sense out of experience, they can cause great distress.

There is no doubt that physicians and medical students are experiencing great distress. Several studies show that medical students have higher rates of anxiety, depression, and suicidal ideation than their peers in the general population (Dyrbye et al. 2008, 334–41; Dyrbye, Thomas, and Shanafelt 2006, 354–73; Shapiro, Shapiro, and Schwartz 2000, 748–59). Furthermore, approximately 12.8 % of male physicians and 19.5 % of female physicians self-report clinical depression (Center et al. 2003, 3161–66). The suicide rate amongst male physicians is more than 40 % higher than for men in the general population and for female physicians is more than 130 % higher than for women in the general population (Dyrbye et al. 2008, 334–41; Dyrbye, Thomas, and Shanafelt 2006, 354–73; Center et al. 2003, 3161–66). It is estimated that 400 physicians commit suicide each year, and suicide is the second leading cause of death for medical trainees (Nuzzarello and Goldberg 2004, 876–81; Rogers 2008, 16–21). It is my experience as well as the consensus of other authors (Center et al. 2003, 3161–66) that the culture of medicine, rooted in and informed by the medical self-image, quite often creates or contributes to the distress of health professionals.

Culture is often difficult to examine from within, as it is the lens through which one sees, and thus, a culture examined from within is one examined through its own perspective, making it blind to its own blind spots. Less difficult is an examination of a culture from an outsider's perspective though that examination is also colored by its own lens. This paper has offered an outsider's understanding of often unspoken aspects of medical culture through humanistic and archetypal (mythological) lenses. This understanding is offered in an effort to lay bare some of the potentially unhelpful and possibly destructive underpinnings of the culture of contemporary Western medicine. The goal is to open a dialogue about potential changes that might address the distress and dis-ease that in many ways plague medicine and medical education today.

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