The person of the practitioner: Roy Jobson

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Editorial

I have struggled to find the 'right' topic for this edition's CPD. In the process however, I have managed to put a few possibilities for future editions at the back of my mind. In the end I have chosen to use material that I have lived with over the last ten years since returning from a year as a Humphrey Fellow in the USA. Elements of this edition concern my personal story – and so I have to state from the outset that, although there are elements of objectivity, particularly in terms of the work of people that I quote, this is essentially subjective material. I trust that some of you who read this will find a few points of identification for yourselves. I hope that if anything I say offends you, you will recognise that I am talking about my own experience, and not even attempting to state 'universal truths' on behalf of others.

One of my personal difficulties of the last decade was to live through (and survive!) an incapacitating major depression. I have always had a tendency towards depression, and this was the second prolonged period in my life. Part of the experience could well be described as *susto* which in the Aztec tradition means 'soul loss'.[1] I found that expression particularly helpful, as I experienced my own religious background (protestant Christian) as completely irrelevant – it actually contributed to the problem. I am a recovering survivor-victim of childhood spiritual abuse. [For a copy of my booklet 'Stray Thoughts Captive' of poems and writings about this and other issues:, please e-mail me at mrjobson@lantic.net.]

I also have to admit that I am killing two birds with one stone in this article, as it forms the basis of a workshop I will be presenting at the second SA National Wellness Conference in Port Elizabeth in the first week of March.

Roy Jobson

1. Avila E. *Woman who glows in the dark: A curandera reveals traditional Aztec secrets of physical and spiritual health. New York. Jeremy P. Tarcher/Putnam; 1999.*

Joseph Campbell once stated: *People say that what we're all seeking is a meaning for life. I don't think that's what we're really seeking. I think what we're seeking is an experience of being alive, so that our life experiences on the purely physical plane will have resonances within our own innermost being and reality, so that we actually feel the rapture of being alive.*[1]

When I was in the depths of depression, working out the meaning of my life was paramount – particularly because there only appeared to be a lack of meaning to everything. Campbell's words were futile and unattainable. Now that I am better, I find myself revelling in simply being alive and his words make sense. Another part of this experience has been to learn that the gloomy times (which still occur) are temporary and will end, often within a short time. I've come to realise that it's not helpful to resist these times, and somewhat like the allegorical creature in the parable at the beginning of Richard Bach's *Illusions: Adventures of a Reluctant Messiah*,[2] it's wiser and ultimately better to 'let go and go with the flow'.

In recent years society has been exposed to a profusion of motivational speakers who urge people to set (often-simplistic) goals and then strive to achieve them. We are urged to take our lives in our own hands and believe in ourselves. Some of this is accompanied with evangelical zeal not unlike the 'hellfire and brimstone' preachers of not so long ago. I particularly like the following quote by Rick Fields:

This person called up and said, 'You've got to come and take this seminar. It will completely change your life in just one weekend.' And I said, 'Well, I don't want to completely change my life this weekend. I've got a lot of things to do on Monday.'[1]

Setting goals can of course be very worthwhile, and believing in ourselves (that we're capable and worthy human beings) is vital in terms of healthy self-esteem. But I must point out that my 'goals' now – both personally and as a health professional – are quite different from 20 years ago. What has not changed quite so much are my values.

I suspect that, as the Jesuits claim, these were imprinted into my being in the first seven years of my life.

The way we live our lives, i.e. our behaviour, the actions we take, the manifestations of the driving force in our lives, can be thought of as based on 'life issues'. One way of considering various life issues is to examine some of their components. (I have extensively used and modified John Bryson's work in presenting this approach.[3])

A life issue could for example be my depression (and the consequences of a major depression); or, how I behave in my chosen profession as a doctor.

The components of a life issue could be made up of:

- Our values
- Our mandates
- The context/situation in which we exist/practise
- Our intrinsic/internal consciousness
- Other as yet unknown aspects

1. What are your values (as a person and as a doctor) and where do they come from?

My values are reflected by the kind of person that I am; what I do in and with my life; how I respond to life-situations and to other people; and what I believe in.

As Bryson (modified) states: 'If a person can be clear about her/his values, s/he will be able to say *no* more easily to any proposals or actions that are likely to damage his/her integrity and *yes* to those that maintain or enhance her/his integrity.'[3]

Integrity or the extent to which each of us lives up to our own values could also be called 'authenticity'. Bob Terry has suggested seven criteria by which to assess our authenticity.[4]

Correspondence:
Our actions/behaviours correspond with (are compatible with) our values.

Consistency:
Possibly best captured in the phrase: 'to walk your talk'.

Coherence:
Authentic action leads to other authentic actions; or, authentic action does not lead to inauthentic action.

Concealment:
Having a hidden agenda is inconsistent with being authentic. Being unwilling to address unintended consequences of a particular stance is inauthentic.

Conveyance:
Is our authenticity carried forward (conveyed) into creating relationship and dialogue as '[W]e engage in listening and understanding that cross boundaries and enter into the life, space, and experience of the other.'?[4]

Comprehensiveness:
Authenticity is 'all-embracing' – of others, and of one's own 'shadow' self.

Convergence:
Authenticity tends towards common human experience. As Terry states in more esoteric language: 'It is the search for the one and the many that transcends the many in the search for the one.'[4] This latter sentence could possibly be a summary of the whole discipline of medicine.

Having considered aspects of our values personally or professionally, let us turn to our 'mandates'.

2. What are your obligations and responsibilities (as a person and as a doctor)?

These are the 'musts' of our personal and professional lives. Some of them are clear and explicit (the date by which my HPCSA subscription is payable); others are often unspoken or implicit (phoning mum on her birthday).

Some of us have religious mandates to observe such as times to gather and pray; particular fasts or pilgrimages; or evangelical crusading.

What we often ignore is to look at those aspects of our lives **not** prohibited by our obligations and responsibilities. Are there possibilities, which I have not considered that are nevertheless compatible with my obligations and responsibilities? If I dislike being a doctor, is there another way of using my knowledge and skills and still meeting my family and financial obligations? If I love being with my children, is there a way of legitimately reducing my work hours to spend more time with them? (And will I then actually spend that extra time with them?) Do I really need to work so hard, or is it just habitual? What is preventing me from writing that book? from learning another language? or from taking that cruise? The old story about putting your hand into a bucket of water to see how indispensable you are when you remove it, remains salutary advice.

3. What is the context/situation in which you exist/practise?

This is all about our external environments. We can look at the trends occurring in our society (e.g. crime vs 'proudly South African'); we can consider those areas with where we can collaborate and co-operate; or those which are a threat to our contexts; we can consider the political, economic, social and technological aspects (PESTs).

Ilbury and Sunter's adaptation[5] of constructing scenarios is another useful way of looking at our external environments. As Bryson (modified) summarises 'Scenarios are **stories** that pose alternative futures . . . based on assumptions about trends and events. Usually a best case, a worst case and a case somewhere in between are developed to map out the range of possible futures a person may face.'[3] (my emphasis)

4. What is the influence of your intrinsic self/inner consciousness in your personal and/or professional life?

This has a lot to do with our view of ourselves and the world, and ourselves in relation to the world. I may have a defensive, closed and controlling attitude to life. I may have an open and trusting approach to other people and all the circumstances of life. I may define my worth in terms of my status/perceived importance ('being a doctor') or my possessions (the make of car I drive). I may define my worth in terms of my need (healthy or pathological) to help others.

How do I internally rationalise the injustices of society? What 'accidents of fate' have made me wealthier than some people and poorer than others? Why is it that I am more talented and

intelligent than some in certain ways, yet completely inferior in other ways? Is everything that I am 'merely' a result of my personal genetic make-up and some sort of circumstantial quirk of chance? Why is it me writing this and not you?

Our worldviews also determine the extent to which we're prepared to take certain risks or be vulnerable – when this is appropriate, of course. (Am I going to tell you about my depression or not?) Healthy boundaries and limits are important aspects of our inner consciousness too. (Am I going to end up doing that house call at an unearthly hour for some relatively minor problem because my need to be needed or liked, overwhelms my need for sleep?)

This internal consciousness is part of what motivates us in our everyday personal and professional lives. It is what may transform a religious 'mandate' from being dead collections of rules into a source of ecstasy.

Bob Terry has written about our life-motivation in terms of metaphors of life (or worldviews) and he has described six of them.[4] I have taken the liberty of adding a seventh at the end.

- *Life is a gift (existence):* [which ties in with the Campbell quote from the beginning of this article.] Many of us use this metaphor when describing life as sacrosanct, etc., and certainly this is a metaphor passionately held by persons opposed to abortion or voluntary euthanasia. Consider what the typical characteristics of a doctor who is motivated by this metaphor might be.
- *Life is a market (resources):* Capitalism, the 'free market' and privatisation are prime examples of this metaphor and the illusion (?) of individual free will, and freedom to choose can also be described here. These are highly valued aspects of modern Western life, as well as democratic systems. [Perhaps the cynic would say that the person with the most money is the one who wins the democratic election? – yet another version of the market metaphor.] Consider what the typical characteristics of a doctor who is motivated by this metaphor might be.
- *Life is a body (structure):* As doctors we probably use this metaphor more than most people do, as we're more knowledgeable about the interdependencies, complexities and hierarchies of living systems. 'Systems' is a key word, and systems theory features prominently in this worldview. The focus is often on growth and homeostasis ('balance'). We talk about the 'body corporate', 'political bodies', and a 'body of knowledge' (structure again) As doctors we have our own particular meaning for 'foreign body'. However, 'illness' descriptions sometimes make this a particularly vivid metaphor – for example 'there's a cancer in the council of the university.' Consider what the typical characteristics of a doctor who is motivated by this metaphor might be.
- *Life is Ups versus Downs (power):* We all use these metaphors extensively. I used one quite unconsciously at the beginning of this article when I talked about the '*depths* of depression'. We talk about being (or not being) *up* to something; an *elevated* post or position; or being *beneath* contempt. People who feel that they have been victimised usually experience themselves as having been at the receiving end of those 'in power' (above them). As doctors, we are most often in an *up* position compared to our patients who are, or perceive themselves to be, in a *down* (sick, miserable, *powerless*) position. It's highly likely that we all know what the characteristics of a doctor who is driven by this metaphor are, not only because we've probably personally behaved in this way towards our patients (and even our colleagues – especially nursing and more junior staff), but because we've seen doctor-colleagues behaving in this way.
- *Life is a Journey (mission):* Again a common metaphor in everyday life, journeys are often featured in the way we describe our activities. Perhaps one of the most well-known journey metaphors in this country is 'Long Walk to Freedom' – the autobiography of former president Mandela. Another book title in similar vein is 'The Road Less Travelled', by Dr M. Scott Peck. We sometimes hear that 'it's been a long haul' in terms of a major accomplishment. Journey metaphors not only focus on the destination, but on the 'process' of reaching the destination. [What *is* the destination of your life?] Meandering and going 'off the beaten track' are also valid forms of journeying. In medicine, our formalised diagnostic process could also be considered a journey with the final diagnosis as the destination. The steps along the way, however, including all the inter-personal doctor-patient interactions, often form a vital part of overall management – as family physicians know all too well.
- *Life is art (meaning):* Art has very important and distinctive components – we can be creators (and co-creators) [participants], 'appreciators' and recipients [observers] of art, or both creators and recipients [participant-observers]. We often talk about 'seeing the whole picture' in terms of this metaphor.

  Do you see your life, personal and professional, as a work of art? To what extent are you yourself the artist creating the masterpiece of your life? and/or to what extent do you possibly see yourself rather as an instrument being used by some greater purpose? (God?) How does the concept 'the art of medicine' feature in the way you practise your profession?
- *Life is a school (evolution):* I have added this mainly because it seems to be a fairly pervasive metaphor in many circles. The idea is that we have 'come to earth' in order to learn one or more lessons which our 'soul' still needs in order to 'evolve' further [perhaps that is actually a 'body' metaphor?]. In terms of medicine, illness then takes on a quasi-spiritual aspect in which it is given greater significance than we as doctors tend to recognise. This is perhaps one of those areas in which our profession is accused of not treating the 'real' ('spiritual') causes of disease.

It is quite likely that you will haveresonated with some of these metaphors more than others. If you have ever done any personal writing

(journalling, stories or poetry) it could be interesting to see whether or not you've used any of the particular metaphors mentioned above – or perhaps others not mentioned.

5. What other as yet unknown aspects exist in your life issue(s)?

The unknown is often feared, and yet can be a wellspring of life-giving sustenance. The main tool in exploring the unknown [note the journey metaphor] is reflection – which will hopefully lead to personal insights. Keeping a journal, recording events in short poems or stories, drawing, recording your dreams or even meditating can bring unknown aspects of yourself into consciousness.

Conclusion

Looking at the components of our life issues can be helpful in seeing why our lives have unfolded the way they have. It can also be helpful in making choices for the future.

For each life issue identified, actions or behaviours can be associated and expected to follow. Again a series of questions are posed by Bryson (modified) to assist us in addressing these.[3] [I have added my own life issue example from a couple of years ago to illustrate these points.]

1. What are the practical alternatives, 'dreams' or 'visions' I might pursue to address this life issue? [I should see someone about my depression in the hope of getting well.]
2. What are the barriers to the realisation of these alternatives, dreams, or visions? [My stubbornness and unwillingness to admit weakness and my need; or my reluctance to ask for help.]
3. What steps could be pursued to achieve these alternatives, dreams, or visions directly, or to overcome the barriers to their realisation? [An external force (my wife) was needed to give me the necessary push.]
4. What steps need to be taken over the next year to resolve/maintain this life issue? [Treatment, follow-up and 'discharge'. Learning of new patterns of behaviour in response to certain negative stimuli.]
5. What specific steps must be taken with in the next six months and who is responsible? [Regular appointments, taking of medication, increased exercise, reduction in alcohol, improved diet. Recognition that I am responsible for sorting out my own life issues – past, present and future.]

The process of examining your life issues can be returned to again and again. It can also be completed once and never re-initiated. The process may never even be completed. It's all entirely up to you.❐

References

1. Hampson T, Whalen L. Tales of the Heart: Affective Approaches to Global Education. Friendship Press Inc. New York. 1991.
2. Bach R. Illusions: The Adventures of a Reluctant Messiah. William Heinnemann Ltd. London. 1977: 1-24.
3. Bryson JM. Strategic Planning for Public and Nonprofit Organisations: A Guide to Strengthening and Sustaining Organisational Achievement. Jossey-Bass Inc.; 1988.
4. Terry RW. Authentic Leadership: Courage in Action. Jossey-Bass Inc. San Francisco. 1993.
5. Ilbury C, Sunter C. The Mind of the Fox: Scenario Planning in Action. Human & Rousseau. Cape Town. 2001.

(continued from page 46)

pines' sedative properties. These agents bind selectively to type 1 benzodiazepine receptors in the brain, in contrast to the older nonselective agents. Zaleplon and zolpidem possess comparable hypnotic efficacy in diminishing sleep latency, and they both have a rapid onset of action.

Zolpidem has a half-life of 1.5 to 3.2 hours. Due to its short-half-life and lack of active metabolites, initial studies have indicated that bedtime administration of zolpidem is not associated with residual sedation or memory impairment when given at its recommended dosage. When used in higher than recommended doses (eg 20 mg), psychomotor and cognitive impairment can occur up to 8 hours after administration. Tolerance is not common but has been noted at very high doses. The development of dependence has been reported in extremely high doses among individuals with a prior history of substance abuse. The use of zolpidem should therefore be restricted to recommended doses of 5 to 10 mg.[15,16]

Zaleplon is absorbed and eliminated in approximately 1 hour, possessing both a rapid onset of action and a short half-life. The short half-life also allows it to be administered in the middle of the night, on an as-needed basis, for patients with sleep maintenance insomnia. The minimum recommended safe period is 4 hours after administration.[17]❐

Please refer to CPD Questionnaire on pg 51.

References:

1. Roth T, Roehrs T. Sleep organisation and regulation. *Neurology* 2000; 54(5): S2-7.
2. Rajput V, Bromley SM. Chronic insomnia: a practical review. *Am Fam Physician* 1999; 60(5): 1431-8; discussion 1441-2.
3. Holbrook AM, et al. The diagnosis and management of insomnia in clinical practice: a practical evidence-based approach. *Cmaj* 2000; 162(2): 216-20.
4. Simon GE, VonKorff M. Prevalence, burden, and treatment of insomnia in primary care. *Am J Psychiatry* 1997; 154(10): 1417-23.
5. Ford DE, Kamerow DB. Epidemiology study of sleep disturbances and psychiatric disorders. An opportunity for prevention? *JAMA* 1989; 262: 1479-84.
6. Balter MB, Uhlenhuth EH. New epidemiologic findings about insomnia and its treatment. *J Clin Psychiatry* 1992; 53 Suppl: 34-9; discussion 40-2.
7. Holbrook AM, et al. Meta-analysis of benzodiazepine use in the treatment of insomnia. *Cmaj* 2000; 162(2): 225-33.
8. Doghramji K. Sleepless in America - Diagnosing and Treating Insomnia. Medscape.com 2000. vol 2(Psychiatry Clinical Management Modules).
9. Attarian HP. Helping patients who say they cannot sleep. Practical ways to evaluate and treat insomnia. *Postgrad Med* 2000; 107(3):127-30, 133-7, 140-2.
10. Morin CM, Culbert JP, Schwartz SM. Non-pharmacological interventions for insomnia: a meta-analysis of treatment efficacy. *Am J Psychiatry* 1994; 151(8): 1172-80.
11. Lacks P, et al. The treatment of sleep-maintenance insomnia with stimulus-control techniques. *Behav Res Ther* 1983; 21: 291-295.
12. Dolberg OT, Hirschmann S, Grunhaus L. Melatonin for the treatment of sleep disturbances in major depressive disorder. *Am J Psychiatry* 1998. 155(8): 1119-21.
13. Kaplan HI, Sadock JB.(1995) Comprehensive Textbook of Psychiatry. Sixth Edition.(Williams&Wilkins)
14. NCSDR Working Group. Insomnia: assessment and management in primary care. *Sleep* 1999; 22(suppl 2): S402-S408.
15. Nowell PD, et al. Benzodiazepines and zolpidem for chronic insomnia: a meta-analysis of treatment efficacy. *Jama* 1997. 278(24): 2170-7.
16. Salva P, Costa J. Clinical pharmacokinetics and pharmacodynamics of zolpidem. Therapeutic implications. *Clin Pharmacokinet* 1995; 29(3): 142-53.
17. Elie R, et al. Sleep latency is shortened during 4 weeks of treatment with zaleplon, a novel nonbenzodiazepine hypnotic. Zaleplon Clinical Study Group. *J Clin Psychiatry* 1999; 60(8): 536-44.