November 18, 2025

New Haven County Medical Association

I am honored to be here tonight to join my dear friend of so many years, Dr. Elsa Stone, as she assumes the presidency of this organization.

Dr. Stone has clearly outlined the systemic, external challenges to our profession and often to our ability to provide the care for our patients that we feel is most called for. My intent is to build on Dr. Stone's call to action and bring us into the more internal factors, to consider how these systemic challenges may be impacting us at our very core, that is, our professional identity. I will suggest that grappling with how systemic factors are threatening our professional identities is key to being able to address those challenges that Dr. Stone puts before us. To get us started, I want to pose two questions.

The first question is: What drew you to medicine? **[SLIDE 2]** Tale a moment, pause on this question. Was it a personal experience, a family member, a much-admired role model, a goal or impact you wanted to have in your life? Did you imagine yourself as a scientist finding a cure for a disease that had impacted your

family? Did you see yourself as a surgeon fixing broken bodies, an internist finding the clue to another's suffering that others had missed. Or, as I heard recently from a new pediatrician, she went with her physician parents as a child as they did their days of service in their church community center. She saw so much need and how her parents cared so deeply, she wanted to carry on the family tradition of giving and helping.

If you can, think about not just your "public answer" but what you would tell your family, children, grandchildren, your closest friends or even a student asking you this exact question as they ponder their next steps. For me, my public answer has always been that I love both history and science—history is about what happened in the past, the stories we tell about how we got to where we are now and science is about the future, discovery, progress, imagining what could be. Medicine brings these two together in a perfect harmony of practice, past and future discovery.

But my true answer goes back to when I was six years old with a life-threatening illness. I remember so clearly the look of joy when my pediatrician came into my hospital room, saw that I was finally awake and asking for some of my favorite foods, unaware of how sick I had been or how long I had been in a very deep sleep. While I couldn't have expressed it then, her joyful devotion to

my recovery made an indelible mark on me. I realize only now that she was deeply afraid that however strong her personal commitment to care, it may not have been enough to save me and that would have been not just a tragedy for me and my family but a deeply felt failure for her as a physician-healer. That in the end, she had been able to help me pull through was both a joy and a relief—her identity as a healer fulfilled. Recently, I have heard others speak about her devotion to her community and how many other children she brought through challenging illnesses—and their deep well of gratitude to her for her lifetime as a healer.

Perhaps any number of you have these kinds of "true" answers—and I wish there were time for each of you to tell your stories but for now, here is a second, related but harder question.

How do you describe yourself as a physician? **[SLIDE 3]** This is harder because I'm asking each of us to step beyond the obvious—pediatrician, surgeon, internist, oncologist, ophthalmologist, etc. Rather, how do you describe what is core to your identity as a physician, not what you do but how you think of your "physicianly" self. Can you describe what you do in terms of what is important to you, that is, how you think of yourself as a professional. Why do you keep doing it, why do you continue to see patients, care for them whatever they bring, take

calls at late hours (even if we might complain), linger by their beds after you have given them terrible news, celebrate their recoveries, go to their funerals. Why do we do this?

Here are two stories, one from the distant past and one more recent that may give voice to this question. Early in the morning of July 11, 1804, thirty-four-year-old Dr. David Hosack **[SLIDE 4]** joined Alexander Hamilton in a boat to cross the Hudson from Manhattan to Weehawken, New Jersey for Hamilton's duel with Aaron Burr. Hosack, as physician to the Hamilton family, had more than once tended to Hamilton's children, wife, and Hamilton himself when they were ill with the feared contagion of the day, yellow fever. Trained also as a botanist as well as physician, Hosack did not follow the customary treatments of bloodletting, purging, and doses of mercury that rendered patients considerably weakened and surely often hastened their death. Instead, he used various botanical solutions, tried to reduce their fevers, and kept his patients hydrated. Indeed, in contemporary terms, he might be considered a physician scientist as he was constantly seeking new treatments from the plants in his medicinal gardens that he considered essential to understanding and treating disease. Because Hosack had also tended Hamilton's son Phillip when he was fatally injured ironically also during a duel, fearing the worst on that July day, Hamilton asked his trusted

physician and by then, friend to be close by. When Hamilton was mortally wounded, paralyzed, and bleeding profusely Hosack tried to ease his pain and keep him alive as they rowed back across the river to New York and the house of a friend. Hosack stayed by his patient's bedside even as Hamilton slipped in and out of consciousness. He made sure Hamilton's family was with him and was still present thirty-one hours later as Hamilton died. Though he could not save his patient, Hosack still cared for him, tried to ease his excruciating pain, and cared for his family even after Hamilton had died.

And another story from more recent times: Dr. Thomas Phelps [**SLIDE 5]**, a family physician with a special interest in infectious disease, retired from his thriving group practice to open a free clinic in the poorest rural county in Tennessee. He wanted to provide care to families who desperately needed medical care but were unable to find a physician who could see them and certainly unable to take on any medical costs. Using his own savings to equip the office and pay a modest monthly rent, he opened a clinic in an old high school building turned community center, kept his costs low by relying on volunteer, retired nursing and office staff, and set aside an hour to spend with each new patient. Word quickly spread about a new doctor who would listen and soon he had more prospective patients than he could keep up with. Realizing that there

was a silent epidemic of drug-related hepatitis C among so many of his patients who had no medical care, Dr. Phelps set out to identify without stigma those already seriously ill and those still undiagnosed. He forged a relationship with a diagnostic lab at a local university stood up during COVID and convinced a pharmaceutical company to give him sufficient medication to treat all those whom he identified as positive. Now he mentors medical students and residents who join him for short rotations to see what rural medicine is about—and he teaches them to diagnose without benefit of quick labs and MRI's, and most importantly to listen to, not just diagnose, their patients. His practice continues to be free though donations are welcome, and he continues to spend considerable time with each patient meaning his days are long and he must regularly triage who needs more or less from him.

Perhaps you are wondering why I have picked these two examples of physicians whose practices are so far from our current times and current dilemmas—one practicing in the 18th century well before current trauma surgery methods that could have saved his patient, another retired and working in a practice impossible to grow to scale or even sustain. There are certainly thousands of stories of dedicated physicians. But I chose these two examples exactly because they offer a startling counterpoint to the themes we are faced

with today. They show devotion first and foremost to their patients in all that they bring to the whole human being, to their oath as a physician, and to the relationship of patient and doctor. Both are healers, a term that I suggest is core to why we do what we do, is often the "true story" why we chose medicine, is our shared professional identity regardless of our specialty and is fundamentally at risk because of the challenges Dr. Stone spoke to.

[SLIDE 6] The word "healing" first entered the English lexicon in the late twelfth century from the Old English *haelen*, meaning "to make whole," Indeed, the word health comes from a similar root and meaning. But the concept was recognized centuries earlier even if not named as such. Healing has been a core value in the practice of medicine for centuries. From early in the fourth century BCE **[SLIDE 7]**, the original Hippocratic Oath contains the phrase "Into whatever homes I go, I will enter them for the benefit of the sick." Contemporary versions of the oath we all swore to emphasize a lifetime commitment to the service of humanity and that the health and well-being of the patient will be our first consideration. Early depictions of physicians represent the craft as a revered commitment **[SLIDE 8].** From Christianity, Buddhism, and Native American culture, representations of physicians capture a belief in divine guidance and

practicing a sacred craft of tending to and healing the sick and injured. While perhaps we no longer believe we are divinely guided, we are still so often responsible for our patients' whole lives, physically, mentally, even spiritually **[SLIDE 9]** and this is reflected is so many paintings of the physician at the bedside including the nearly iconographic "The Doctor". **[SLIDE 10]**

Importantly, healing is not synonymous with cure though in contemporary usage, the terms are often blurred [**SLIDE 11**]. Curing involves the complete elimination of a disease or condition, while healing is a holistic process of becoming or recognized as whole and may occur regardless of the physical outcome. To be sure, our medical education tends to emphasize curing, but I suggest that our core identities as physicians are closer to the original meaning of healing. We are drawn to medicine to help people, not only diseases but the people with those diseases. Dr. Hosack could not save Alexander Hamilton but in his devotion to his patient to the end and even as a pallbearer at his funeral, he honored his patient's wholeness of experience and the fullness of their relationship. In Dr. Phelp's insistence that he spend an hour with every new patient, he isn't just doggedly adhering to a practice rule; he is ensuring that he conveys to his patient he has time for them as a person and wants to know them

as such. Both are caring for the whole patient. This is essential to their professional identities.

A word about professional identities [**SLIDE 12**]: Professional identity is core to an individual's becoming a fully developed practitioner in their field. Whether an attorney, physician, teacher or artist, one's professional identity encompasses a set of values and codes of conduct that shape how, over time, we see ourselves. Professional identity influences how we behave, the decisions we make, and our ethical stance. Like the formation of a sense of self, professional identity emerges over time through education, experiences in the individual's chosen field, the influence of role models, and explicit mentorship. Professional identity, while broadly stable in an experienced practitioner, is especially sensitive to cultural and social dynamics. And even though grounded in the ancient Hippocratic oath, the professional identity of physicians practicing medicine has always been susceptible to external pressures. Wars, natural disasters, new technologies, new knowledge inevitably impact how we think about and perform our professional roles.

The current era is no exception [**SLIDE 13**]. From the introduction of HMOs in the 70s and the push toward electronic health records at the start of the information age, the last years have been marked by turbulence that directly

impacts the practice of medicine. The landscape of medicine in 2025 feels particularly fraught especially in America, with the rising costs of health care, the increasing foray of private equity into the purchase and administration of hospitals and physician practices and even the promise but also risks of new technologies such as artificial intelligence. As we often acknowledge, medicine is now a business implying that core principles guiding the practice of medicine must take on a more financially focused emphasis with a shift from a caring service to a simple transaction between physician and patient, a commodity exchange.

One indicator of this shift in professional identities in medicine is the number of physicians and surgeons leaving the field earlier in their careers **[SLIDE 14**] or expressing dissatisfaction and personal exhaustion in their professional roles. Indeed, much attention has been paid to systemic and individual factors that are forcing highly trained and specialized physicians out of medicine. Many of these factors, also cited by Dr. Stone, have been explored extensively **[SLIDE 15]** including the evolving burden of disease, the volume of patients waiting to be seen, the pressure to keep up with the ever-changing evidence base, the changing nature of communication, the fractured network of subspecialty care, and the erosion of trust patients hold for the healthcare system in general. The corporatization of medicine has certainly changed the boundaries of physician

autonomy as business professionals (with their own professional identities) bring the principles of market share, return on investment, profit and loss, and productivity metrics into the medical environment.

Taken altogether, these newer external forces present critical challenges for the core professional identify of our healthcare workforce. I suggest **[SLIDE 16]** that a pervasive unsettling of the core identity of physicians as healers is the deeper motivator for professionals leaving the field and/or experiencing significant distress and dissatisfaction? When our professional demands increasingly challenge our core professional identity, we may experience profoundly unsettling choices—dramatically alter or go against our professional identity, resist the inevitable changes and risk being increasingly irrelevant, or leave the field.

To understand more about how the current state of professional identity among physicians, I have interviewed (and am continuing to do so) physicians in both academic and private practice, at early, mid and late stages in their career practicing in different settings in the country including both urban and rural. I have asked their views of their profession and practice currently and what drew them into medicine in the first place. Their answers are strikingly similar. What I've heard across age and experience, type and location of practice setting was an

acute sense of no longer being true to the reasons they chose medicine as a profession, that is, to help people at times of distress and need. They came into medicine inspired to care. Almost always, there was an influential figure. A family doctor. A love for science. An innate ability to manage multiple balls in the air in the service of others. An orientation to people. A desire to guide people through challenging times.

For example, as one physician working in academic medicine said:[**SLIDE 17]** "…. bridging this world of basic science knowledge and … cutting-edge future looking medicine with … taking care of a patient *here and now* really connected with me."

Or another: "…being with them in these moments of personal crisis, helping to solve, you know, problems, helping them find their way…:

Fundamentally, these physicians see themselves as healers even as they try to adapt to the changing demands of medical practice with productivity metrics based on volume of patients seen and less time to be with an individual patient. Their core professional ideal is to care for their patients when they are most needed and to build a relationship with those patients that sustains over time

when they are both well and ill. To a person, this was also why they chose a health care profession and why they stay even feeling often beleaguered and discouraged as they sense their profession is moving rapidly away from what is core to their professional identities. Their ability to care, to heal in the original sense of the word through a patient-doctor relationship, is increasingly threatened.

Much has been made of the theme of depersonalization of modern medicine [**SLIDE** 18]—that both patients and physicians feel distanced from one another by the productivity tools designed to manage the flow and volume of patients and the huge volume of information contained in the electronic health record. Indeed, how physicians use the computer during a visit with a patient has been documented as a driver of patient satisfaction. An article in the NY Times from just this past Sunday speaks to how patients increasingly feel their doctor is inattentive and distracted and thus turn to chatbots for help.

Under these circumstances, what will draw future physicians into medicine **[SLIDE 19]**—who will these future doctors be? What will draw individuals into a profession where the product is increasingly an exchange of health information rather than the satisfaction of healing and caring for others? The answer paradoxically may lie not in only in addressing the systemic challenges in the

delivery of contemporary medical care or in asking what causes burnout but in understanding and valuing what invigorates physicians and for centuries, has drawn, and may continue to draw, them into medicine—the deeply human need to care for others.

Perhaps the same thing we crave for in this age of a war on accurate information and science and on human decency and caring is the same thing that will bring future generations into medicine. To preserve our healthcare workforce, minimize burnout, and simultaneously improve patient experience, what we need is to re-invest in centering the ancient, core professional identity of physicians as healers. To be clear—I am not calling for a nostalgic return to earlier ways of practicing medicine. That is neither possible nor desirable. Modern medicine is remarkable in all that if offers each of us for better health and well-being, for healing in the true meaning of the word. But what we are calling for is looking critically at how contemporary forces challenging and changing medical practice also challenge physician's core professional identity as healers. In these both turbulent and exciting times in medicine, many call for patient-centered care. At the heart of patient-centered care is supporting the willingness of physicians since ancient times to give of themselves to those needing care.

What can we do? Here are a few beginning thoughts for our consideration [**SLIDE 20**].

1. Use technology wisely with the goal of making it possible for physicians to spend <u>more time</u> with their patients to focus on care and healing, not just to see more patients.
2. Encourage more open discussions of professional identity among physicians including medical students that allows for empathic understanding and shared problem solving on how to maintain/ restore a focus on care and healing.
3. Understand more thoroughly how patients view their medical care now, what they feel is missing, and what would they want from their doctor. With that knowledge, design systems to meet that need and at the same time, give physicians the time (and skills) they need to nurture and sustain the relationship with their patients.

In closing, let me turn to another physician [**SLIDE 21],** William Carlos Williams, who in his 1904 essay "The Practice", reflected on his identity as a physician and especially his relationship with his patients.

He wrote:

"the actual calling on people, at all times and under all conditions, the coming to grips with the intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get well when they were ill, has always absorbed me."

He spoke about "the peace of mind that comes from adopting the patient's condition as one's own to be struggled with toward a solution during those few minutes or that hour or those trying days when we are searching for causes, trying to relate this to that to build a reasonable basis for action which really gives us our peace."

It is this peace actively sought and actively protected that is essential to our core identities and needed now more than ever in our rapidly evolving medical world. True to our identity as physicians, let us come together to heal our profession. We need to honor, support, and protect that enduring sense of purpose and identity in the medical profession. If we fail to listen, we risk losing the very soul of what it means to be a physician, a healer.