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Commentary

The Sherpa meets Maslow: Medicine and the hierarchy of needs

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Abstract
A critical care physician returning to medicine after her own critical illness experiences a crisis of orientation. She finds she can no longer serve as the Voice of Medicine. She replaces the former construct with a more humble model, in which the physician serves as an intermediary. She equates this new role to that of the Sherpas of Nepal. Maslow's hierarchy of needs forms the mountain, as she reimagines her role in her patients' lives.

Keywords
Physician, coach, Maslow, Sherpa, hierarchy of needs, intermediary, guide, patient experience

When I first returned to medicine after suffering my own critical illness, I had difficulty inhabiting my white coat. It wasn't just that I didn't feel accurately represented by it after having been a patient, it was also that it symbolized something different to me than it had in the past, something subtly destructive. Like the power of water to erode rock, I had seen how even our well-intentioned efforts to treat could wound rather than heal. How we sometimes unknowingly deepened the suffering of our patients.

My orientation to disease had changed during my recovery as well. Having been a patient for so long meant that I was no longer able to represent the voice of medicine the way I'd been trained, rather I began serving as more of a translator. Someone who had carried medicine around for a long time, and then had to set it to the side to make room for other things. Set it aside so that I could acquire the many accoutrements of a patient. I still understood it, having lived alongside it for years. I knew its habits and tendencies and its sometimes irrational nature. By setting it to the side, I found I could function as a sort of intermediary between the patient and the medical knowledge. Medicine was now an object we could triangulate on, and look at together. My knowledge of disease states and treatment courses would allow me to be a sort of guide. But to do that I had to abandon the cloak of opaque authority that had predominated so much of our shared history. In those early fragile days, those ideals seemed to me to have been woven into the fabric of my white coat.

I needed a new archetype. Something that could accommodate the shift in my orientation to disease. One that reflected to me a doctor that I could both represent and recognize. One that approached knowledge with humility, understood suffering, and had faced fear. I found this in the Sherpas of Nepal. Sherpas after all were more than guides, they were facilitators of the journey itself. They spend their lives in preparation, much like physicians, and in doing so, develop adaptations that allow them to function in inhospitable environments. Where they have unique hemoglobin-binding enzymes and hearts that utilize glucose for energy and lungs that more efficiently function in low oxygen environments, physicians have learned to synthesize and apply vast quantities of data, to function on minimal sleep and extremes of emotion.[1] One could of course argue, such adaptations are potentially harmful, outside of their natural environments.

Sherpas do not choose the summit, they allow the climber to choose and only then do they prepare the path, and distribute the load based on a quiet assessment of aptitude and fitness. They may then run ahead to the next base camp to ensure the tea is boiling. We doctors are always looking ahead, calling consultants, calling for a bed, calling the family. We are always trying to redistribute the weight of illness.

The primary responsibility of the Sherpa is the safety of those in their charge. They warn of pitfalls ahead, of danger. They counsel, in a wise and tender way. Not in evidence-based terms of risk and benefit, but in authentic terms grounded in a deep knowledge of their climbers. In my mind, their sentences to climbers are nearly interchangeable with ours to our patients. We each may say, "From what I have observed and my knowledge of you that you've shared with me, that is a risk that exceeds your body's capacity. But let's think together of other ways to meet your goal." The Sherpas may say this entirely with their eyes and a gesture of their head.

They serve as coaches. At times, right up until the end of life. And, not unlike medicine, the fate of the Sherpa can become so intertwined with that of their charge, that a mistake can mean they both die. A suicide from grief and shame in Medicine, or frozen and trapped on a mountainside. One-third of all deaths on Everest are of Sherpas.[2] More than a million Americans will lose a physician to suicide this year.[3] Each relationship is a mutual exploration that can be transcendent or deadly, depending upon the day.

What is the mountain we are climbing alongside our patients in this metaphor? The mountain is in many ways life itself, with all its attendant joys and illnesses. And to consider life in this way, it's useful to project psychologist Abraham Maslow's hierarchy onto the mountain. In his five-tiered model, basic needs for food, water, shelter and safety are at the bottom, with love and belonging, and a sense of community in the middle.[4] At the very top, our highest aspirations for ourselves. The mountain is in effect an emergence model, where reaching the next level, the next base camp, requires the prior needs to have been met.

Our Medical-Life Mountain is similarly structured. Aspirational health cannot be met without meeting the basic social needs of our society, namely food, water, and shelter. When we do this poorly, the effects are immediately seen in hospital emergency rooms, which have always functioned as temporary shelters for those experiencing homelessness and hunger.[5] The second tier, safety, reminds us of our oath to do no harm. More broadly, we might say that safe health care means affordable health care for all, without fear of attendant bankruptcy. Medical care that is free from harm, whether it be the type of harm that comes from a medical error, or the harm that comes from the additive suffering inflicted by emotionally-negligent care. The third tier, belonging, reflects the individual need for sense of community. Loneliness and social isolation are understood to be independent predictors of mortality.[6] To walk alongside our patients means knowing whether these deficiency needs are met, because it's only then that we can begin to truly think about health.

Maslow understood that our growth as individuals parallels the climb to the summit. That the emergence of each need characteristically depended upon the prior need being met, and that with each new tier (or basecamp) arose new opportunities. He termed the final tiers "growth or being needs." It's here in these higher levels that we begin to look for meaning in our lives, appreciate the aesthetic nature of life, and transcend our individual needs to be of service to others. In the Medical-Life Mountain, it is here at these higher altitudes, and as our patients advance in age that we meet new challenges. New diagnoses, terminal illness, the grief of loss. Treatment plans that are rigorous in a way we weren't prepared for. It's at the top that the air gets thin. And the resources, the relationship that you've brought with you to the top, this is when it really starts to matter. To enjoy the view, even briefly, takes planning. It requires a knowledge of self, an awareness of which of our long-held views and values are truly immutable.

As a Physician-Sherpa, I cannot simply point the way. To facilitate the journey, I must know my patients. In the way that you get to know someone when you travel together, set-up a camp together, and sit and talk as the tea boils. In that space we create together, at the lower base-camps, I receive their stories. In doing so, I learn the beliefs, ability, and vision of my climbers. In telling stories of their past, they'll disclose how they envision spending their later years and final moments. I receive it all, so that at the very end, I can hold all of that for them. And hope that by doing so, I can promote growth and transformation right into the final moments. So that I can walk back down the mountain to do it all over again.

I've found I've been reaching for my white coat again. It's lost some of the weight I used to feel so acutely. It's lighter now when I put it on. Almost like the snow at the top of a very high mountain. Or the hard-earned sight of a cloud's fine mist, viewed from above.

References

1. Gilbert-Kawai, et al. King of the mountains: Tibetan and Sherpa physiological adaptations for life at high altitude. Physiology. 2014 Nov; 29(6):388-402.
2. Firth, et al. Mortality on Mount Everest, 1921-2006: descriptive study. BMJ. 2008 Dec 11; 337:a2654.
3. Wible, Pamela. "What I've learned from my tally of 757 doctor suicides." Washington Post. January 13, 2018.
4. Maslow, A. H. "A Theory of Human Motivation." Psychological Review, 50, 370-396. 1943.
5. Doran, K. et al. "Homelessness and Emergency Medicine: Where do we go from here?" Academic Emergency Medicine. 2018 Feb 17.
6. Hakulinen, C. et al. Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: UK Biobank cohort study of 479 054 men and women. Heart. 2018 Mar 27.