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Clinical Case

Can healers have private lives?

Commentaries by Alexia M. Torke, MD, and G. Caleb Alexander, MD, MS, and by Howard Liu, MD, and Michelle B. Riba, MD, MS

At 3:00 on Friday afternoon Clair Snell, MD, a highly regarded psychiatrist with a passion for patient care, was having a bad day. She had just received a second page interrupting her examination of Mr. Dodge, an outpatient in her hospital-based practice. The first page, coming shortly before Mr. Dodge's appointment, had been the ER requesting that Dr. Snell admit a patient with full-blown mania to the psychiatry inpatient unit. She could not help but sigh as she saw that the second page was also from the ER, most likely with regard to this earlier case. Sufficiently distracted from Mr. Dodge, who suffers from paranoia, she excused herself and answered the call. The ER physician informed her that the patient was now preparing to leave the hospital "against medical advice." Dr. Snell told the ER physician to persuade the patient to remain in the hospital until she could come down and talk with her again. Dr. Snell then returned to complete her appointment with Mr. Dodge.

One hour later, after successfully persuading the reluctant patient to remain in the hospital, Dr. Snell retreated to her office. Here she found messages asking her to return calls to a disability agency (to advocate for short-term disability for a patient with severe depression), an HMO physician reviewer (to make a case for authorizing continued inpatient stay for a heavily pregnant woman addicted to cocaine) and a pharmacy (to authorize an urgent prescription refill requested after Dr. Snell's staff had left for the night). Glancing at her e-mail she saw a message from the medical director reminding her to complete her online HIPAA training ASAP.

Dr. Snell checked her watch and saw that, for the second time this week, she had missed dinner. Her 2-year-old daughter had recently begun asking, "Where is mommy?" during the meal. She felt an all too familiar pang of guilt and plowed through the tasks before her, hoping to be home at least in time to give her daughter a bath. Just as she began to pack up for the night the answering service paged her. Mr. Snyder, the son of a patient, was requesting that she call him before 7:00 that evening. This particular family member was a busy executive and would offer only a 1-hour period per day during which she could return his call, and these times varied from day to day. One day when she had not returned his call he had left her an irate voicemail and it had taken Dr. Snell the better part of an hour to "de-escalate" him. She understood that he was scared because his mother was so ill and that calling her

physician for detailed daily briefings was his way of staying connected. Under less-stressful circumstances Dr. Snell was happy to handle these complex family dynamics, but today she felt she was being forced to make a choice: stay and “heal” this family member or leave and devote some attention to her own.

Commentary 1

by Alexia M. Torke, MD, and G. Caleb Alexander, MD, MS

If I am not for myself,
Who will be for me?
If I am only for myself,
What am I?
If not now,
when?
—Hillel

Dr. Snell’s situation may feel painfully familiar to many medical students and physicians. All too often physicians face the challenge of balancing their own health and well-being with the near-limitless demands of the clinical setting. Accepting that physicians cannot “do it all” can be difficult; physicians rightly care deeply for their patients, and many are also high achievers who are prone to perfectionism. Women physicians may find these concerns especially difficult, as they attempt to maintain busy careers and fulfill traditional expectations of motherhood. In general, women physicians work fewer hours per week than men [1] and are more likely to work part-time, citing family responsibilities as the main reason for doing so [2]. The increasing presence of women in medicine may be leading to greater equilibrium between work and family life for everyone within the medical profession [3]. Nevertheless, inevitable challenges will occur when physicians of both sexes must carefully balance their careers and personal lives.

In this case, Dr. Snell is being forced to make difficult choices about how to allocate her time. The competing options outlined in the case are all worthwhile actions—immediate patient care, communication with a patient’s family, advocacy in health and governmental systems for her patients, and the care of her own family. While the particulars may change over the years, the fact remains that there is an endless amount of good a physician can do, so each physician must set limits. Where should the psychiatrist in this case draw the line? Are there any ethical principles that can guide her?

Much attention has been focused on the conflicts of interest that physicians may face. For example, there may be tension between a physician’s research goals, which involve maximizing patient enrollment in a clinical trial, and the best interests of his or her particular patient, which may not be served by participating in the research. Similarly, physicians face conflicting obligations. Special relationships such as those with a child, a spouse or a patient involve unique obligations. Thinking about how to balance these obligations may help Dr. Snell navigate these difficult choices.

When a physician faces a conflict between interests or obligations, he or she should ask three key questions [4]. First, is the conflict avoidable? Second, are the competing interests legitimate? Third, are the interests reasonable?

Is the conflict avoidable?

Dr. Snell seems forced to choose between calling back the family member, Mr. Snyder, for what will probably be a lengthy conversation at the time he requests and going home to be with her daughter before bed. In this case, the conflict is unavoidable because Dr. Snell has obligations both to her child and to her patient and patient's family.

Are the competing interests legitimate?

Mr. Snyder's request to speak to Dr. Snell is legitimate because, assuming a patient's approval, communication with a concerned family member is an important part of patient care. Mr. Snyder may be genuinely interested in his mother's well-being. Also, Dr. Snell may regard caring for families—and not just individual patients—a part of her role as a physician.

Are the interests reasonable?

In this case, the son's request does not appear reasonable. Mr. Snyder's request to be called daily during a given one-hour time period is extremely burdensome. Dr. Snell is a busy professional too; she need not put Mr. Snyder's needs and wants above those of all other patients and her family. In such a situation, the physician could respond to the request by setting clear guidelines for how and when she can be contacted and making a great effort to stick to her own commitment to be available. For example, Dr. Snell could ask Mr. Snyder to schedule a time to talk in advance, via her secretary, and could establish a time of day after which she could only be contacted in emergencies. Working to establish healthy boundaries is not only good for the physician, it can be helpful for patients and their families too.

Our second-best world

These three questions form a helpful framework for resolving many apparent moral dilemmas—but not all. Sometimes, conflicts cannot be avoided; competing interests are legitimate and reasonable.

When this happens, physicians must work to focus their efforts where they will be best spent. Beneficence, or the obligation to act for the benefit of the patient, would seem to be a key consideration in determining where one's efforts would be best spent [4, 5]. But even the concept of beneficence cannot fully resolve these dilemmas; sometimes the need is so great that it requires more “goodness” than the physician can dispense. Just as bedside rationing, while common and some would argue necessary, occurs despite physicians' discomfort with the concept [6], so physicians must also decide how to “ration” their limited time. Concepts of fairness and utility can be helpful in thinking about this. In each case Dr. Snell must evaluate the potential benefits and harms that would come from meeting a patient's need,

putting it off until a future time or refusing to meet the need. Some situations are clearly emergencies: if the last patient of the day has worrisome chest pain while in the office, of course the doctor will stay late—to do otherwise would be dereliction of duty. Other situations must be met creatively with compromises that maximize benefit for patients, the physician's family and the physician herself.

The other activities of Dr. Snell's work day range from admitting unscheduled emergency patients and seeing her scheduled patients, to talking with insurance companies, disability agencies and family members. Some redesign at the practice level, such as changing reimbursement to include payments for e-mails or phone calls, may help to address isolated challenges that physicians face in allocating and accounting for their time. Several professional organizations have proposed new practice models involving these types of changes [7-9]. Yet new systems of reimbursement or methods of practice redesign will never eliminate all of the conflicting obligations that physicians face. Dr. Snell's tough choices are certainly shaped by social forces. But even in a redesigned practice, time demands will always require physicians to make difficult choices and face the limits of being human.

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Commentary 2

by Howard Liu, MD, and Michelle B. Riba MD, MS

Psychiatrists often advise patients to seek a balanced life. But even as we do so, our gaze turns to our own piles of unfinished charts, unanswered invitations and looming deadlines. Whether one works in an academic or private practice setting, there never seems to be enough time to satisfy obligations at work and at home. The equilibrium is always delicate, tipping heavily toward professional duties during the week and springing back toward our private lives on weekends. It is an important struggle because lack of balance can limit the longevity of one's career. A recent study showed that dissatisfied physicians are two to three times more likely to leave medicine than satisfied physicians [1]. This article will review some of the competing forces which affect the satisfaction of a practicing psychiatrist: patient care, managed care and our personal lives.

Patient care

When we graduate from medical school, we promise to care for our patients to the best of our abilities. Ideally, that would mean that we could shut our pagers off and devote our full attention to each patient. Pragmatically, however, competing demands on our time require psychiatrists to adopt a triage mentality. This involves deciding which patients need immediate intervention and which can be sent to the proverbial waiting room. In our vignette, Dr. Snell is able to triage both her hospitalized patient and her outpatient in one busy afternoon.

But multi-tasking has its limits, and there are situations when all of us are stretched to the breaking point. Dr. Snell must try to manage a patient's persistent family member who expects more time from her than she can grant. When we have reached this point, it is best to acknowledge it to ourselves and our patients. If we explain our time constraints to patients, most of them are surprisingly empathic. Once an understanding is reached, then flexible compromises can be considered. In our case, Dr. Snell could ask for help from a social worker or communicate by e-mail from home. In the long run, knowing one's limits and asserting them is a necessary aspect of avoiding burnout.

Managed care

In the hierarchy of competing demands, managed care is a daily factor in most psychiatrists' (and, in fact, most physicians') lives. Unless psychiatrists run fee-for-service practices, they must communicate with HMOs and insurance companies for reimbursement. In the last two decades, managed care has led to specific changes in

both inpatient and outpatient psychiatry, with inpatient stays becoming generally shorter and less frequent than they were in the past [2-5]. Accordingly, the number of patients who use outpatient mental health services has increased [6, 7]. This has led to mixed results in the quality of care delivered under managed mental health care [8].

As the system has changed, psychiatrists have faced new limits on their ability to obtain needed services for their patients. The Community Tracking Study Physician Survey found that psychiatrists were less likely than other specialists to say that they were able to deliver high-quality care [9]. Upon closer examination of this data, Edlund and colleagues found that the major inhibiting factors were inability to secure hospitalizations in nonemergency situations and adequate length of stay [8]. However, we must not accept this current practice environment without seeking greater parity for reimbursement of mental health services. Psychiatrists retain an important role as patient advocates because many of our patients are not be able to argue their own cases. Although there is a direct cost in time and convenience, we must remain proactive in our communications with managed care companies.

Private lives

The most poignant part of this vignette is the disappointment that Dr. Snell feels in missing another dinner with her daughter. In a profession where we carry the burdens of our patients, we often fail to assess the quality of our own private lives. Recently, however, this issue has arisen in the context of resident work hours and women in medicine. For decades, resident physicians worked long hours with little regard to safety or quality of life. In 2003, however, the Accreditation Council for Graduate Medical Education restricted resident work schedules to 80 hours a week [10]. The intent was to limit sleep deprivation and thus increase patient safety, resident education and resident quality of life. A systematic review of these changes by Fletcher and colleagues in 2005 found mixed results [10]. In internal medicine, residents generally obtained more sleep but reported variable levels of stress under the new system. In psychiatry, a single study of a night float system (a system where one or more residents work night shifts to cover patient care) found a mean improvement in well-being, education and clinical duties [11]. Although data are still emerging, the resident work-hour restriction suggests a new consciousness of the need for quality of life during training.

Gender also affects physician quality of life. Studies have shown that lack of control at work is a strong predictor of burnout in women physicians [12, 13]. Other articles have detailed the inherent tension between academic medicine careers that expect the greatest productivity exactly during a woman's child-raising years [14]. Roberts and Hilty offer some advice to women in academic psychiatry in their *Handbook of Career Development in Academic Psychiatry and Behavioral Sciences*. They suggest finding a mentor, negotiating protected time, aligning research interests with clinical duties and knowing when to say no to time consuming duties [15]. For other women physicians, part-time or shared positions may be a solution, especially if they have young children. Studies have shown that part-time physicians have higher

productivity than their full-time colleagues [16-18] and achieve equal or higher quality performance [19]. Overall, there is no simple solution, and individual compromises must be reached between career goals and family.

Conclusions

As we train a new generation of medical students and residents, there are important lessons to teach in the pursuit of a balanced life. In patient care, we must learn to triage our time, depend on colleagues and recognize our limits if we are to avoid burnout. In the managed care environment, we must remain proactive in protecting patient welfare and obtaining necessary services. Finally, we should continue the trend toward resident well-being and negotiate compromises between career and private lives. Overall, we must not be afraid to address our own needs and should not sacrifice our families for the sake of our patients. As Graham Jackson stated, “No doctor on his deathbed wished he/she had spent more time in the clinic.... Now and in the years to come find the time to take care of yourself for your own sake and that of your nearest and dearest” [20].

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