Virtual Mentor
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Physician Well-Being and Burnout

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FROM THE EDITOR

Yogi and Booboo, or A Funny Thing Happened to Me on the Way to Bally.

Audiey Kao, MD, PhD

As a teenager, I oftentimes escorted my mom to various meetings and events that featured non-Western health philosophies and therapeutic remedies. My father usually had no patience for this "new age" stuff. Since I was the next oldest male in the household, I ended up accompanying my mom to sessions with acupuncturists, reflexologists, herbalists, and meditation gurus. On the off chance that my mother reads this article, let's just say that I tolerated these events.

As a physician, I was not trained in non-Western traditions of health and wellness, but unlike many of my colleagues, I am not completely dismissive of their therapeutic value and benefits. My opinion derives in part from the fact that I am Chinese, and many of these centuries-tested therapies were "Made in China." It is also true that many medical treatments I prescribe for my patients are not grounded in clear and proven science. While I would never recommend non-Western treatments as main therapies for such illnesses as cancer, I have recently come to appreciate that some non-Western therapies promote wellness and reduce stress.

Six months ago, I changed from Bally to a new health club facility that opened up nearer to my home. One day I was at the gym lifting weights, when a friend prompted me to try a yoga class. To my amazement, I loved it. For some people (including my former self), yogis and men who practice yoga are thought of as hippies or members of some spiritual cult. Some also think that yoga practice simply involves sitting in room with burning incense and chanting. As one who keeps in shape through distance running and resistance training, I never thought that yoga would be a challenge, physically, mentally, or spiritually. But let me tell you, you have to be in damn good shape to get into some of these yoga poses.

More important than the physical benefits, I have found yoga to be a valuable way of dealing with stress and anxiety (and booboos) in my life. Given the many factors that have contributed to increased professional burnout in medicine, we physicians must seek ways to take good care of ourselves. Whether it is yoga, some other form of exercise or play, meditation or spiritual practice, each of us needs to find a personal means of promoting wellness and reducing stress in our lives. If we do not take care of ourselves, if we are stressed and burnt out, we cannot be expected to treat our patients with compassion and empathy.

In this issue of *Virtual Mentor*, we explore the important and burgeoning issue of physician wellness and burnout. The learning objectives in this issue are:

1. Understand why physician wellness is important.
2. Identify the main indications that a physician is not healthy enough to be most effective in his or her profession.
3. Identify causes and effects of burnout and what can be done to prevent and manage it.
4. Learn about resources for helping physicians maintain health and balance.
5. Learn about resources for helping physicians who are impaired or "burned out."

Namaste,

Audiey

PS
I would like to thank my yoga teacher, Josh, for his guiding hand and patient spirit.

Audiey Kao, MD, PhD is the editor in chief of *Virtual Mentor*.

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CASE AND COMMENTARY
An Impaired Physician's Physician, Commentary 1
Commentary by Peter Mansky, MD

Case
Dr. George Redden is an obstetrician/gynecologist in a small town. He has been in practice for 26 years, the last 20 of them in his current practice. Most of his patients are healthy young women with low-risk pregnancies. He often sees children he delivered at his grandchildren's school performances. He likes to stop and chat with the women he saw through pregnancy and find out how they and their children are doing. Dr. Redden has been thinking of retiring in the next 7 or 8 years and has been talking to his wife recently about his desire to continue practicing medicine part-time during his retirement.

About 2 years ago Dr. Redden visited his own long-time physician, Dr. Charles Turner, for a regular check-up. Dr. Turner checked Dr. Redden's blood pressure, his cholesterol, and prostate.

"George, you seem to be doing well. All systems are go," Dr. Turner explained. "I did notice one thing that I would like to check into further. I have been seeing a slight tremor in your left hand."

Dr. Redden crossed his right hand over his left and shrugged. In the past few months his hand had begun to tremble uncontrollably when he was resting it on an armchair or just sitting with his hands in his lap. This tremor was embarrassing and becoming more and more difficult to hide. He had found that he if moved his hand immediately or tried to pick up an object sometimes the tremor would stop. But recently his wife had commented on it and he had simply brushed it off as a muscle spasm.

"It seems to be a resting tremor, George. Maybe we should do some further tests," Dr. Turner suggested.

"I think it's just a tremor. You know, we're getting old, Charlie," Dr. Redden explained. "It's not a problem, I'm right-handed anyway, and it doesn't bother me."

"If it gets any worse I want you to come back to me so we can run some tests."

Dr. Redden did not see Dr. Turner again for another 8 months when he came in with a case of strep throat that his granddaughter had brought home from preschool.

Dr. Turner swabbed Dr. Redden's throat, and then left to give the sample to the lab to run a culture.

He returned to the exam room and sat down to write a prescription for Dr. Redden.

"George, how is that hand of yours? It seems to be getting worse," Dr. Turner commented as he noticed Dr. Redden's hand sitting in his lap shaking. "I noticed that you seemed a little unsteady, are you having any problems walking?"

"No, I'm fine. Maybe just a little tired today. You know my throat has really been bothering me."

"What about trouble getting out of chairs, or out of the car?"

"No, no problems."

"What about problems with writing or typing?" Dr. Turner asked as he glanced down at the form that Dr. Redden had filled out in the waiting room. The print was incredibly small and difficult to read.

"Charlie, I'm fine. Are you going to give me that antibiotic or not?" Dr. Redden answered tersely.

"George, I think there is the possibility you are not fine. You seem to be progressively losing motor control. You need to see a neurologist. And I think you need to consider the fact that you may not be able to continue delivering babies."

Dr. Redden took the script Dr. Turner offered him, and turned to his friend and colleague, "Dr. Turner, delivering babies is my life, if I have to give that up what will I have to live for? I'll be at my office caring for my patients until the day I can't get out of bed."

Commentary 1

Dr. Redden is a physician who is dedicated to his practice and appears to attend to his own health needs as well. He has a primary physician and sees him on a routine basis. He has been doing so for years. Physicians in general start out with better health than the general population but they do not take as good care of themselves. Many physicians in good health often do not have primary physicians to whom they go to on a regular basis. These physicians will settle for curbside diagnoses or consultations and then treat themselves.[1-4] It is noteworthy that Dr. Redden did not treat himself for a sore throat but sought treatment through his primary care physician. Many physicians would have just written a prescription for themselves. It is not illegal or medical misconduct to write a prescription for oneself or to diagnose an illness in oneself, although the AMA's *Code of Ethics* advises against doing so. It's just doesn't provide good medical care.

The one exception in Dr. Redden's self care is his failure to address his movement disorder and to obtain an expert diagnoses. Instead of showing concern, he minimizes the significance of his resting tremor. This is most likely due to his concerns that he might have Parkinson's disease and represents a denial that is not uncommon especially in the face of a disease that could be disabling.

Dr. Turner showed appropriate concern for his patient and fellow physician who exhibited an abnormal tremor, most likely parkinsonian in nature. Dr. Turner's concern is based on his skills as a clinician and his ethical responsibilities to a fellow physician. There is no doubt that Dr. Turner's concern and his expression of this concern for his patient and colleague is to be applauded. I am not an ethicist, but it appears to me that Dr. Turner's actions were highly ethical and in accordance with the Hippocratic Oath and Maimonides Physician's Prayer. Both of these documents form a strong basis for our ethical standards as physicians and have been included in the graduation exercises of medical schools in this country.

The ethical standards in the Hippocratic Oath specify giving excellent care and support to our fellow physicians as well as to our patients: "I will keep this Oath and this stipulation to reckon him who taught me this Art equally dear to me as my parents."[5] The Maimonides Physician's Prayer asks that the physician only see the human being in the sufferer and "ever be ready to cheerfully help and support rich and poor, good and bad, enemy as well as friend …Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession." The prayer also calls for support of the physician "in this great task so that it may benefit mankind," and for illumination of the physician's "mind that it recognize what presents itself and that it may comprehend what is absent or hidden." The essence of this prayer is an entreaty for physicians to be able to give unbiased care to patients based only on their clinical skills, which include both the professional knowledge of diseases and an understanding of the human factors effecting patients. This is so very important when we treat our fellow physicians. Our admiration for their ability and skills, our identification with the struggles they are facing accompanied by their anguish and pain, and our relationship to them as colleagues in the community need to be tempered by our clinical skills.

Reflecting upon caring for fellow physicians allows one to realize that helping a colleague has very high value in the mission of the medical profession to diagnose, treat, and promote healing in our patients. Help and care that is given to a fellow physician can be multiplied by the positive effect of the professional activities of that physician in his or her own practice. Thus, helping a colleague helps many patients to benefit from the care of that physician.

In treating other physicians, one must be careful to do so in a way that is compassionate but does not lead to the immediate rejection of the clinical recommendations. This may require skills that we have not routinely used as practicing clinicians. Dr. Turner's first 2 statements "George, I think there is the possibility you are not fine. You seem to be progressively losing motor control.

You need to see a neurologist." are stated in an ethical, effective, and caring manner. It takes more than a modicum of courage to confront our fellow clinicians. The last statement—that Dr. Redden should consider giving up his obstetrical practice—leads immediately to resistance. Dr. Turner needs to first obtain an expert evaluation before he can counsel a change in the work situation. If the treating physician immediately brings up the practice issue, this may lead to resistance and even to the issue being dismissed and ignored.

State Physician Health Programs (PHP) may provide aid and assistance to physicians such as Dr. Turner in helping their colleagues especially when it relates to factors that affect a colleague's practice. The programs can help physicians deal with illness that may have a potential for disability and possibly impairment at the work site. State PHP's exist in 48 states and the District of Columbia. Most have affiliation with the state medical society. About 60 percent regularly help physicians deal with a physical illness. Those that don't regularly provide this type of help may provide advice and guidance for physicians such as Dr. Turner who want to be effective in counseling their fellow physicians concerning practice issues. When one physician confronts another about the effects of illness on the practice of medicine, it is easy for the confronted physician to disregard the advice and even to degrade the clinical skills of the physician giving the advice. When presented by several physicians or a group of clinicians who have both awareness of the illness and the impact of illness on the practice of medicine, the confronted physician is more likely to heed the advice.

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Peter Mansky, MD has been the medical director for the New York Committee For Physicians' Health of the Medical Society of the State of New York (the NY Physicians' Health Program) for over 11 years. He is a professor of psychiatry and

pharmacology at Albany Medical College and has a small private practice. He is also a member of the board of directors of the American Society of Addiction Medicine and treasurer of the Federation of State Physician Health Programs.

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CASE AND COMMENTARY
An Impaired Physician's Physician, Commentary 2
Commentary by Claire Wang, MD

Case
Dr. George Redden is an obstetrician/gynecologist in a small town. He has been in practice for 26 years, the last 20 of them in his current practice. Most of his patients are healthy young women with low-risk pregnancies. He often sees children he delivered at his grandchildren's school performances. He likes to stop and chat with the women he saw through pregnancy and find out how they and their children are doing. Dr. Redden has been thinking of retiring in the next 7 or 8 years and has been talking to his wife recently about his desire to continue practicing medicine part-time during his retirement.

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"George, you seem to be doing well. All systems are go," Dr. Turner explained. "I did notice one thing that I would like to check into further. I have been seeing a slight tremor in your left hand."

Dr. Redden crossed his right hand over his left and shrugged. In the past few months his hand had begun to tremble uncontrollably when he was resting it on an armchair or just sitting with his hands in his lap. This tremor was embarrassing and becoming more and more difficult to hide. He had found that he if moved his hand immediately or tried to pick up an object sometimes the tremor would stop. But recently his wife had commented on it and he had simply brushed it off as a muscle spasm.

"It seems to be a resting tremor, George. Maybe we should do some further tests," Dr. Turner suggested.

"I think it's just a tremor. You know, we're getting old, Charlie," Dr. Redden explained. "It's not a problem, I'm right-handed anyway, and it doesn't bother me."

"If it gets any worse I want you to come back to me so we can run some tests."

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"George, how is that hand of yours? It seems to be getting worse," Dr. Turner commented as he noticed Dr. Redden's hand sitting in his lap shaking. "I noticed that you seemed a little unsteady, are you having any problems walking?"

"No, I'm fine. Maybe just a little tired today. You know my throat has really been bothering me."

"What about trouble getting out of chairs, or out of the car?"

"No, no problems."

"What about problems with writing or typing?" Dr. Turner asked as he glanced down at the form that Dr. Redden had filled out in the waiting room. The print was incredibly small and difficult to read.

"Charlie, I'm fine. Are you going to give me that antibiotic or not?" Dr. Redden answered tersely.

"George, I think there is the possibility you are not fine. You seem to be progressively losing motor control. You need to see a neurologist. And I think you need to consider the fact that you may not be able to continue delivering babies."

Dr. Redden took the script Dr. Turner offered him, and turned to his friend and colleague, "Dr. Turner, delivering babies is my life, if I have to give that up what will I have to live for? I'll be at my office caring for my patients until the day I can't get out of bed."

Commentary 2

Several medical organizations address physician impairment in their codes of ethics. The American College of Emergency Physicians states that "whenever a colleague or consulting physician is believed to be incompetent or impaired by drugs, alcohol, or psychiatric or medical conditions, there is a duty to report the impaired physician to the chief of service, the chief of medical staff, and appropriate committees or regulatory agencies."[1] The American College of Physicians concurs, stating that "there is a clear ethical responsibility to report a physician who seems to be impaired to an appropriate authority."[2] The American Medical Association also holds the opinion that "physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues."[3]

In Dr. Turner's situation, he suspects that his patient, Dr. Redden, has Parkinson's disease and may someday be unable to deliver competent care to his patients.

Before Dr. Redden's condition progresses to the extent that he is clearly unfit to practice, what can Dr. Turner do to prevent the unpleasant prospect of reporting his colleague and friend?

"Ignoring it won't make it go away"

As patients, physicians may deny or minimize their own symptoms for fear of what the symptoms mean, a reluctance to interact with the health care system as a patient, and worries over how an illness will affect their practice.[4] Unfortunately, such tendencies may hinder timely diagnosis and treatment and intensify emotional hardship.

If, as suspected, Dr. Redden has Parkinson's disease, the chronic progressive course of the disease will ultimately interfere with his ability to provide safe and effective care. This is true regardless of whether Dr. Redden chooses to accept or deny his condition. However, neurological evaluation and treatment may slow the course of disease progression and alleviate symptoms, enabling him to engage in meaningful activities for as long as possible.

Knowing how important it is for Dr. Redden to continue caring for his patients, Dr. Turner should acknowledge this immediately. He can also use this as an argument to pursue evaluation and treatment. For example, Dr. Turner can say, "I know how important it is for you to continue delivering babies, George. That's why I think it's best for you to see a neurologist. A neurologist can evaluate your condition and let you know where you stand. She may be able to prescribe treatment to control your tremor or slow the progression of your symptoms. Ignoring your condition won't make it go away, but it could make things harder for you in the long run."

The goal is not only for Dr. Redden to receive evaluation, treatment, and follow-up, but also for him to learn to accept his condition. Once Dr. Redden is willing to accept his condition, he can begin to plan for eventual changes in his lifestyle and practice.

"It's better to take control of a situation than to let it take control of you"

Early planning can help Dr. Redden equip himself emotionally and practically for future changes. In particular, when his motor and cognitive symptoms progress to the extent that he is unable to deliver babies competently, it will be time for him to retire from this aspect of his profession.

Dr. Turner can introduce this issue by asking, "What is it about delivering babies that makes it important to you, George?" Based on Dr. Redden's answers, Dr. Turner can help him explore alternatives that will still provide personal fulfillment. For example, if he enjoys interacting with his patients, can he delegate specific physical tasks to a partner? When he retires from practice altogether, can he interact with former patients and their children by engaging in volunteer work? If he values his identity as a healer, can he contribute through research or teaching? Would he

like to preserve the memories of his years in practice by recording them in a journal?

Dr. Turner should help Dr. Redden understand that he has the option to make proactive decisions about his future rather than having changes imposed on him. Dr. Redden can take control of his situation by acknowledging that certain changes are inevitable (eg, "I will someday need to retire from clinical practice), predetermining when to make changes (eg, "I will retire from clinical practice when my neurologist advises me to"), and finding solutions to maintain his quality of life (eg, "When I retire, I will continue to contribute to my community through volunteer work.")

"We will keep our patients from harm"

In the best case scenario, Dr. Redden will agree to retire from practice when he becomes incapable of providing safe and effective care. However, in the event that he resists, Dr. Turner should counsel Dr. Redden, asking him to consider the safety of his patients and pointing out benefits to retirement. For example, Dr. Turner can explain that by planning his retirement, Dr. Redden will have the opportunity to say goodbye to his patients while ensuring that they have continuity of care. Also, he can avoid potential calamities, such as harming a patient, losing patients, or having his medical license revoked.

If all else fails, Dr. Turner should report Dr. Redden to an appropriate regulatory group, such as an institutional committee or a state medical licensing board.[1-3] Such regulatory groups are obligated to protect health care consumers and will consider the well-being of the consumer and the physician in determining a course of action. Because Dr. Turner will have reported Dr. Redden only as a last resort, he should feel confident that he has acted in the best interest of his patient and his profession.

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Claire Wang, MD is a scientist in the American Medical Association's Unit on Medicine and Public Health.

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CASE AND COMMENTARY
An Impaired Physician's Physician, Commentary 3
Commentary by Leonard J. Morse, MD

Case
Dr. George Redden is an obstetrician/gynecologist in a small town. He has been in practice for 26 years, the last 20 of them in his current practice. Most of his patients are healthy young women with low-risk pregnancies. He often sees children he delivered at his grandchildren's school performances. He likes to stop and chat with the women he saw through pregnancy and find out how they and their children are doing. Dr. Redden has been thinking of retiring in the next 7 or 8 years and has been talking to his wife recently about his desire to continue practicing medicine part-time during his retirement.

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Dr. Redden took the script Dr. Turner offered him, and turned to his friend and colleague, "Dr. Turner, delivering babies is my life, if I have to give that up what will I have to live for? I'll be at my office caring for my patients until the day I can't get out of bed."

Commentary 3

Dr. Redden, as is often the case, is expressing denial concerning his health. He undoubtedly has served his community as an obstetrician-gynecologist for 26 years with distinction. He plans to continue to practice minimizing an involuntary tremor of his left hand because it is not interfering with his skills and dexterity. The obvious concern is that Dr. Redden's involuntary tremor is a manifestation of a degenerative neurologic disease that might necessitate the modifying of his medical practice. His physician, Dr. Turner, should have insisted on a neurology consultation when the tremor was first recognized. If Dr. Redden refuses the consultation, Dr. Turner should have asked the patient's permission to review his findings and recommendations with Dr. Redden's wife and family. With family encouragement Dr. Redden may have been more cooperative. I believe Dr. Turner initially should have been more persuasive in directing appropriate diagnostic and consultative care.

Physicians do not work unobserved and all "physicians have an ethical obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements of each state."[1] The AMA's *Code of Medical Ethics* Opinion 9.031 is based on Principle II of the AMA's 9 Principles of Medical Ethics, which states that "a physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities."[2]

Dr. Redden, unfortunately, has early signs of physical impairment. He deserves a comprehensive neurologic medical evaluation to determine the cause of his tremor and to establish whether he has an impairment that presents a risk to his patients. Since he practices in a hospital, if the test results are positive the chief of obstetrics and gynecology should be informed. Following thorough neurologic evaluation and treatment, a decision concerning Dr. Redden's ability to safely resume his practice will be made. Perhaps, with treatment Dr. Redden's tremor will be significantly subdued and he will be able to return to work. If not, other options can be considered that will maximize Dr. Redden's interests, skills, and ability.

Dr. Redden's family deserves reassurance, and most importantly, so do his patients. It has been my experiences that when doctors, as patients, initially are in denial, extreme gratitude often follows clarification of the issues.

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2. American Medical Association. Principle II of Medical Ethics. *Code of Medical Ethics 2002-2003 Edition*. Chicago, IL: American Medical Association; xii.

Leonard J. Morse, MD is currently the commissioner of public health in Worcester, MA and a professor of clinical medicine, family medicine, and community health at the University of Massachusetts Medical School. He is a past chair of the AMA's Council on Ethical and Judicial Affairs.

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CASE AND COMMENTARY
The Tale of Dr. Wells: Competent and Irascible, Commentary 1
Commentary by Michael Gendel, MD

Case
After 18 years of marriage, however, Dr. Wells divorced and returned to the US. She was dismayed to learn that she had to complete residency again in the US despite her years of successful practice and her fine reputation.

By the time Dr. Wells had finished her US surgery residency and gained staff privileges at Women's Hospital, she was almost 50. She is now 58 and is angry at the US medical education system for delaying her career; furious at US health insurance system for demanding justification of her clinical judgments, and disgusted at the young medical students and interns who have their whole lives ahead of them and complain all the time anyway.

Dr. Wells is impatient and cross with the OR nurses and has been known to throw an instrument back at a trainee who hands her the wrong one. On rounds, she asks patients how they are doing and cuts them off in the middle of their answers. She asserts, "I'm going to have a look at the incision," after she has already begun to remove the dressing and expose the incision. She has never been heard to say, "With your permission, I'd like Dr. So-and-So, and Dr. So-and-So (the residents) to have a look also." Dr. Wells has dictated false information for medical charts so that her patients could receive insurance reimbursement for an extra day or 2 in the hospital that she believed they needed. "When I have to explain medicine to some pencil pusher, that's when I'm out of here," she says. If a colleague questions a decision or suggests another possible course of action, Dr. Wells usually says, "You want to do it that way? Do it that way. I'm going ahead as planned."

Setting aside her gruffness and sometimes surly manners, Dr. Wells is a highly skilled surgeon. Her rate of complications and returns to the OR is extremely low. She has an intuition about each patient's anatomy and a deftness that, together, minimize the surgery's insult to the body she is operating on. The classes of residents are usually divided in their reactions to Dr. Wells. Some say that her insults to staff and rudeness to patients constitute a lack of professionalism that is tantamount to incompetence. Other trainees advise, "Ignore all that bedside manner stuff and watch her work. You'll learn something about surgery."

Commentary 1

Over the years, the window for acceptable physician behavior in the workplace has narrowed considerably. Perhaps it's not as narrow as that for ordinary human beings—and I use this phrase with my tongue in cheek—but we may be expected to behave according to usual civilized standards at some time in the future. On the surface, and the surface is quite important, Dr. Wells is behaving with arrogance, disdain for the opinions of colleagues, rudeness to nursing staff, belittling and dangerous behavior towards trainees, and a lack of empathy and respect for patients. She is compromised in her attention to the principles of medical practice that relate to interpersonal respect and care. In falsifying medical documentation she is further expressing her arrogant disregard for the rules we live by, but she is also undermining the principles of medical practice that relate to honoring the truth—the science we live by. She is endangering medicine by dishonoring herself, her colleagues, and associates. She is endangering students by throwing instruments at them and requiring them to tolerate humiliation. She is endangering patients by running over important personal boundaries, such as the consent to be examined. She is endangering her hospital by exposing it to risks of law suits by patients (malpractice) and by employees (hostile work environment) and to sanctions leveled by government agencies and insurers associated with trying to manipulate patients' benefits by falsifying information. Dr. Wells's behavior poses serious problems.

Dr. Wells is also, evidently, a talented if not brilliant surgeon who, but for these problems, would be an asset to her profession, and who has undoubtedly contributed to the health and well-being of thousands of patients. Students, too, have benefited from exposure to her, though I gather it is mainly those with enough social callus to ignore her style and behavior who are able to profit from working with her, and those more sensitive may learn little and/or be traumatized by associating with her. So we have a situation that is commonly faced by our medical community, a physician with much to offer but who is also very problematic, in this instance because of destructive attitudes and behaviors. How do we, as a community, conceptualize and approach such a problem?

Let's consider the "differential diagnosis." Is Dr. Wells's behavior a product of her personality? One can see signs of both obsessive-compulsive and narcissistic personality traits. If so, this kind of behavior should be relatively constant over time. Is her behavior a product of embitterment caused by having to retrain in a specialty in which she was previously highly regarded, going back to what she may feel are the indignities of being a trainee and losing her previous prestige? This could prove quite traumatic. If so, her difficult behavior is likely to have occurred only since she moved to the US. Could her behavior be related to a mood disorder such as depression which can reduce a physician's patience and tolerance and make her more irritable? Could she be using alcohol or other drugs excessively? Addictive disorders often present with behavioral problems even while the technical aspects of medical practice are intact. Could she be suffering from some other serious illness that she has not disclosed to any of her colleagues? If she is ill, did

her depression, or addiction, or other illness begin after her move, or before? Why did she divorce and leave her adoptive country after 18 years? What happened in her marriage? Did she have behavioral problems at work in Egypt? Obviously, we have more questions than answers. To determine what is wrong beneath the surface, Dr. Wells needs expert evaluation. We cannot really prescribe an approach to the deep causes of her problems, because the "treatment" depends on the "diagnosis."

But we are not at a place where Dr. Wells's deeper issues can be addressed. Dr. Wells's difficulties must be met at the superficial level first, which means confronting her with the inappropriateness of her behavior and insisting on improvement. Because physicians are often powerful and intimidating people, this is not an easy thing to do. Often, such physicians are left alone for as long as possible which results in their engendering much hostility and fear in those around them and causes the physician to become isolated and suspicious, creating a vicious cycle and more avoidance of the problem. It is much easier to address problems early, soon after they become manifest. And addressing the problematic behavior must occur before the doctor in question can get any help.

The techniques for confronting such a physician are fit subjects for discussion, but not in this short space. The point of such a meeting is to identify the problematic behaviors, outline the expected improvements, and note the consequences of not complying. Expressing the wish to help is also essential. Referral for clinical evaluation of the problem is often appropriate, out of which treatment recommendations may flow. Referral to the state Physician Health Program will facilitate this process.

There are a couple of expressions, buzz-words of medicine, which bear discussing. Physician impairment is the inability to practice medicine with reasonable skill and safety as a result of illness or injury. Most ill physicians are not impaired at work, because, especially in chronic illness, they adapt to their condition and protect the workplace for as long as possible. The corollary of this is that if the workplace is impacted it is likely a late stage of the illness. In Dr. Wells's case, her work is impacted. Her social skills and judgment are affected. But we don't know whether or not she is ill, so as of now, technically, I would not describe her as impaired. I would simply say that she has behavioral problems and poor judgment with intact technical skills. Physicians with behavioral problems are often termed "disruptive physicians." I don't like this term because not all behavioral problems manifest as disruption; plus, it sounds judgmental. The term reflects the anger or upset which Dr. Wells's colleagues, students, patients, and administrators likely feel toward her. It is important for those trying to intervene and help Dr. Wells to be cognizant of such anger, and to speak to and work with her from a more balanced stance.

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CASE AND COMMENTARY
The Tale of Dr. Wells: Competent and Irascible, Commentary 2
Commentary by Noni MacDonald, MD and Vonda Hayes, MD

Case
After 18 years of marriage, however, Dr. Wells divorced and returned to the US. She was dismayed to learn that she had to complete residency again in the US despite her years of successful practice and her fine reputation.

By the time Dr. Wells had finished her US surgery residency and gained staff privileges at Women's Hospital, she was almost 50. She is now 58 and is angry at the US medical education system for delaying her career; furious at US health insurance system for demanding justification of her clinical judgments, and disgusted at the young medical students and interns who have their whole lives ahead of them and complain all the time anyway.

Dr. Wells is impatient and cross with the OR nurses and has been known to throw an instrument back at a trainee who hands her the wrong one. On rounds, she asks patients how they are doing and cuts them off in the middle of their answers. She asserts, "I'm going to have a look at the incision," after she has already begun to remove the dressing and expose the incision. She has never been heard to say, "With your permission, I'd like Dr. So-and-So, and Dr. So-and-So (the residents) to have a look also." Dr. Wells has dictated false information for medical charts so that her patients could receive insurance reimbursement for an extra day or 2 in the hospital that she believed they needed. "When I have to explain medicine to some pencil pusher, that's when I'm out of here," she says. If a colleague questions a decision or suggests another possible course of action, Dr. Wells usually says, "You want to do it that way? Do it that way. I'm going ahead as planned."

Setting aside her gruffness and sometimes surly manners, Dr. Wells is a highly skilled surgeon. Her rate of complications and returns to the OR is extremely low. She has an intuition about each patient's anatomy and a deftness that, together, minimize the surgery's insult to the body she is operating on. The classes of residents are usually divided in their reactions to Dr. Wells. Some say that her insults to staff and rudeness to patients constitute a lack of professionalism that is tantamount to incompetence. Other trainees advise, "Ignore all that bedside manner stuff and watch her work. You'll learn something about surgery."

Commentary 2

In the Tale of Dr. Anita Wells we unfortunately find a familiar contradiction for the medical profession—a physician held in high regard for her technical skills and clinical judgment but one whose colleagues express increasing concern about her interpersonal skills and manner of practice. Within the medical profession there is a growing recognition that disruptive behaviors, such as Dr. Wells demonstrates (eg, demeaning remarks, insults, and verbal put-downs), are no longer acceptable and that physicians demonstrating these behaviors need help. If help and change are not forthcoming, there is a high probability that serious problems will eventually occur for the physician, eg, reprimands, loss of hospital privileges, self-injury, patient lawsuits; for colleagues, eg, increased workplace stress and higher rates of burnout; and for the institution, eg, patient lawsuits and workplace harassment complaints. In this tale, there is the added concern that students and residents are being exposed to negative role modeling which may influence their career choices, practice patterns, and interpersonal communication styles—all of which may lead to future problems. Abusive disruptive behaviors may beget abusive disruptive behaviors and all parties suffer.

Physicians who display disruptive behaviors are particularly difficult to deal with both for colleagues and for institutions. They are often high achievers with a prodigious output of "quality " work. They can also be charming and engaging when they so choose. They are usually well-respected for the work they do and are seen as single-minded in trying to achieve their goals. New onset of disruptive behavior is especially concerning as it may reflect other problems such as chemical dependency or severe personal distress. One must not lose sight, however, of the possibility that some disruptive behavior may be precipitated or exaggerated by health care system issues that do require correction.

There are several points in the Tale of Dr. Wells which merit a closer look. The frustration and anger expressed by Dr. Wells at having had to "repeat" her training in order to work in the US is echoed by many foreign-trained graduates in similar circumstances. What are the best measures for assessing the quality and comparability of foreign training and experience? How can "the system" ensure satisfactory acclimatization to American health care standards, demands, and expectations if not through American training? Is "repetition" of training always necessary? What is the evidence? Is it possible to develop an assessment method on a more individualized basis to ensure competency?

For Dr. Wells, herself, are these behaviors new or are they of long standing? What are the causes of her anger? What are the work-related factors? She clearly finds the health insurance system deeply frustrating, because she sees it as questioning her clinical judgment, but what are the other work-related factors that are causing her stress? Is her age affecting her ability to cope with the rigors of a full surgical workload and call? Are there more personal issues such as unresolved marital conflicts? How amicable was the divorce and are there children? How did marrying into a very different culture and working in a culture where women are valued in a

different way affect how she sees herself? How is she coping as a woman in a medical field that is male-dominated with a long history of valuing "macho" behavior? Does she have serious financial retirement issues given her late start in the US system and her divorce? What are her expectations and what does she see as success? How is her health? When was the last time she had a holiday? What does she do to relieve stress and to "restore her soul"? Are there relationship issues? Does she have family or friends that support her or is she isolated?

So what are we, her colleagues and her institution, going to do when faced with this situation? Experience has shown that disruptive behavior rarely self corrects. Furthermore, long-term unresolved anger may lead to injury to others and/or to self. Patient safety is indeed an issue here.

From an institutional viewpoint, it is crucial to ensure that bylaws cover policies on appropriate behavior and conduct and that guidelines are in place with strategies to follow if the policies are contravened. Policies that define negative, unethical, and unprofessional behaviors—as well as positive behaviors to be emulated—can be more helpful than a list of disruptive behaviors alone. These policies need to be made known to all medical staff and there must be a transparent and fair process for applying them. Such policies are best accompanied by a wellness program that supports a healthy work place, works to intervene with individual medical staff before stress leads to distress, and supports medical staff in the event that distress occurs.

In the mid 1990s while at the University of Ottawa, one of the authors (NEM, a pediatric infectious disease specialist) co-chaired a task force on faculty stress with child psychiatrist Simon Davidson, which led to the development of a wellness program. Through focus groups, interactive workshops, and seminars, we learned that many academic faculty were indeed very stressed. Retirement concerns such as adequate retirement income, marital retirement issues, and worries about loss of self-esteem upon retirement were raised by many faculty of both genders in Dr. Wells's age group. Faculty in all age groups noted that concerns about privacy and confidentiality made them anxious about seeking help from inside the faculty. Yet this was coupled with a strong desire for access to the "best care" if they were to come forward for help. Many faculty expressed sadness and concern about fellow faculty members whom they noted to be in distress due to difficulties such as serious marital discord, problems with alcohol, symptoms of depression, or disruptive behaviors, but most felt impotent to help.

In response to these findings, the "Neighbourhood Watch and Connector Program" was developed. The "Neighbourhood Watch "component provides education about the markers of distress through workshops, seminars, and continuing medical education programs. Each faculty member is encouraged to look out for signs of distress among colleagues as well as within himself or herself. The "connector" component was set up to address the confidentiality and best care concerns for individuals who need help. A faculty member in distress is encouraged to call a

"connector." The 5 connectors are all experienced clinical psychiatrists who determine through a brief series of questions the optimal referral for assessment, eg, psychiatry, psychology, legal, financial experts. The connector then sets up the appointment with the appropriate professional for a more thorough review assessment. All of this is done with strict adherence to confidentiality. If desired, the faculty member in distress need not even divulge his or her name to the connector. The appointment is set up using a proxy and only the expert providing the help knows the correct name. With complex cases like that of Dr. Wells, referral to more than one professional may be indicated, possibly, for example, a financial adviser, a psychologist, and a communication skills expert. For co-workers who call a connector about concerns for a colleague, the connector's role is to assist the coworker in developing options and opportunities to encourage the distressed faculty member to receive help.

Due to the high risk of negative outcomes in the Tale of Dr. Wells if her problems are not addressed, it is important that Dr. Wells be approached by a person in authority. This person should raise the concerns of colleagues using specific examples of her behavior, but must also seek out Dr. Wells's perception of how the workplace is functioning, her assessment of her performance, and what she sees as the workplace issues and problems. The person in authority who contacts Dr. Wells should also probe gently for personal issues that may be contributing to Dr. Wells's behavior. Dr. Wells needs to hear that she is indeed valued for her technical work. With the input of Dr. Wells, it may be possible to help her recognize which elements of the problem she has some control over, eg, her verbal response to workplace situations, and also to establish what types of assistance might be most helpful to her as she works to change her behavior.

In the cases like that of Dr. Wells, one always hopes that help offered in a constructive and confidential manner will be accepted. However, often persons with disruptive behaviors do not recognize how serious a problem they have and do not readily come forward for help even when it is offered in a compassionate manner. In these circumstances, clear bylaws and the combined work of the department head, chief of the medical staff, and the vice president of medical affairs can often successfully "encourage" the staff member to get help and change these behaviors.

Her fellow coworkers may also need education on how to help Dr. Wells in her rehabilitation—perhaps a change in the call or OR schedules, a mini paid sabbatical, or other tangible change might help to show Dr. Wells that she is indeed a valued member of the staff and also give her the time to work on her interpersonal skills. Improvement in this area will benefit not only her work life but also the work life of her colleagues by decreasing their distress due to her current disruptive behaviors. In addition, the handling of Dr. Wells' disruptive behaviors in a constructive, compassionate, and respectful manner by the institution and her colleagues will provide excellent role modeling for students and residents who may need to deal with similar problems in the future.

Since 1999, we (Noni MacDonald and Vonda Hayes) have adapted and expanded the University of Ottawa program at Dalhousie University Faculty of Medicine. Taking into account our local resources and our distributed faculty, we teach in more than 100 sites throughout 3 provinces. The Wellness Program has been broadened to include not only stress and mental health issues but also physical health and workplace health including cultural and gender issues. The program (directed by VH) involves faculty, staff, students, and residents. While overnight success is not possible, there has been steady forward progress on changing the culture in the Faculty so that "care for caregivers" is becoming an accepted and valued concept. The enthusiasm of the students and the residents for the program bodes well for the future success of the profession.

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CASE AND COMMENTARY
Managed Care and Physician Burnout
Commentary by David S. Brody, MD and Pamela Brody, PhD

Case
Dr. Richard Kent walked into the office and pulled up his schedule for the day on the computer. Another full one. Four patients had been scheduled for every hour. Contractually, he was allowed 20 minutes per visit, but Hippocrates Health Care, the organization for which he worked, operated on the assumption that 1 out of every 4 patients doesn't show for his or her appointment. Great; suppose all of his "assumed" no-shows for the day showed up. Suppose 4 didn't, but they were all scheduled for 4 pm. His day would be hectic. He found himself hoping that all the assumed no shows would indeed fail to keep their appointments. In truth, he hoped even *more* than that wouldn't show.

Hippocrates Health Care had been moving into the area and signing up increasing numbers of company health benefits contracts over the last 5 years. Now, few physicians in the region were not part of the system. When more and more of Dr. Kent's patients had told him they'd have to leave him and find a physician on the Hippocrates list, he and his partners signed on as Hippocrates employees. They immediately enjoyed some perks, full patient load on days when they worked, no more filing paperwork for reimbursement from 10 or even 12 separate insurance plans, no more uncollectible accounts.

But the numbing sameness of his days was getting to him. Patient records were automated, and there were computers in each examining room. On initial visits, Dr. Kent would sit at the computer and ask each patient 30 or so questions beyond what the nurse or PA had already asked and click in the proper field on the answer given by the patients. Then he would leave while the patient undressed, go ask patient 2 the same 30 questions, and return to examine the patient 1.

Physicians under contract to Hippocrates were required to practice within the boundaries of what was "customary and standard" throughout Hippocrates' nationwide service area. Dr. Kent had to document deviations from those standards of care, get approval before rendering the service, or apply retroactively for reimbursement for an extra day in the hospital or for a particular brand of drug.

What compromised Dr. Kent's sense of professional integrity more than anything was having to explain Hippocrates' business-based decisions to his patients. When Hippocrates suddenly dropped a brand name drug from its formulary, Dr. Kent

would have to tell patients, some of whom had been successfully dose-calibrated and maintained on that drug for years, that they would have to change. He had to be truthful in telling them why he was changing their prescriptions; he couldn't say medical judgment was behind the decision, because it wasn't. The same was true in limitations or delays placed on diagnostic tests that, based on his own medical judgment, Dr. Kent would have ordered without delay. He worried that explaining the reasons for such bottom-line-oriented decisions was eroding his patients' trust in medicine and in him.

What a rut, Dr. Kent thought. Imagine hoping that patients don't show up. This doesn't feel like the noble profession of medicine.

Commentary

Managed care is often blamed for decreasing physician work satisfaction. Surveys indicate that many primary care physicians believe that managed care has adversely impacted relationships with their patients, as well as the quality of care they provide.[1, 2] Physicians' sense of control over their practice environment has been shown repeatedly to be the key factor in determining their job satisfaction or dissatisfaction. Physicians like Dr. Kent believe that they must see more patients in order to maintain their income. They are frustrated about pharmacy formularies that limit their ability to prescribe the medications that they and sometimes their patients prefer. They may also be frustrated about utilization review decisions that prevent them from ordering tests they think their patients need or force them to shorten their patients' hospital stays, and they may feel frustrated about limitations that are placed on whom they can refer patients to or where they can send their patients for specific services.

To some degree, a sense of frustration about these incursions into their control over their practice is normal. When it results in emotional and physical exhaustion, a sense of alienation, cynicism, negativism, and detachment to the point that the physician begins to resent work and the people who are associated with it, it is a problem that is referred to as burnout.

Burnout can affect as many as 40 percent of physicians. The symptoms of burnout vary. Some physicians become angry and irritable, others continuously complain and blame any annoyance on external factors. Some become quiet, introverted, and isolated, which can be a manifestation of an underlying mood disorder. Others manifest burnout by overeating or abusing alcohol or other mood altering substances. Still others experience chronic physical symptoms or diseases.

Burnout can affect a physician's ability to perform his or her job. Physician satisfaction or lack thereof can influence patient satisfaction. Two studies found that patient adherence to prescribed medications and follow-up appointments was affected by physicians' attitudes about their work.[3, 4] Dissatisfied physicians may also have more costly practice styles. Studies have found that dissatisfied physicians use more total outpatient procedures and make more referrals than

physicians who are satisfied, even after adjusting for case mix and other covariates.[5, 6]

Obviously, not all physicians who see predominantly managed care patients experience symptoms of burnout. Individual's perceptions of and reactions to the same source of stress vary. Factors that influence one's perceptions of and reactions to workplace stressors include one's need for control and perceived ability to establish control (or self-efficacy); one's overall optimistic or pessimistic perspective, and how one attributes the cause of negative events (eg, were they caused by internal or external factors).

Satisfaction with life outside of work can have a protective effect. Social supports, hobbies, and other outside interests, as well as religious or spiritual beliefs can help buffer work stress. Physicians whose identity and sense of self-esteem are largely dependent on their work may be at greater risk of burnout when confronted with issues related to loss of control.

Coping successfully with a sense of loss of control involves both behavioral and cognitive strategies. These strategies may be aimed at modifying the problem itself or modifying the physician's emotional reaction to the problem. Dr. Kent might try to modify the problems he is confronting by negotiating a schedule that includes fewer patients or fewer hours in return for assuming other responsibilities or earning less income. He might develop strategies for minimizing his frustration over formulary limitations by using a computer system that contains updated lists of the formularies for all of the managed care companies he has contracts with. He might work with other physicians in his practice to pursue changes in the health care systems that have frustrated him and impaired the quality of care that is provided to his patients.

Dr. Kent may learn to work more efficiently by identifying appropriate goals for the visit, prioritizing these goals, and focusing on the most important issues. Changes in his chart and practice and additional resources may also help him feel more comfortable seeing patients at 15 to 20 minute intervals. He might also develop communication skills that will help him minimize the conflict that he has been experiencing with his patients. Levinson and colleagues have identified 3 key skills to resolving conflict with patients: (1) understanding their worries and concerns, (2) empathy, and (3) encouraging patients to play an active role in decisions about their care and negotiating differences of opinion when necessary.[7] When addressing an angry patient who has just learned that his anti-hypertensive medication is no longer covered by his insurance plan, Dr. Kent might begin by empathizing with the patient's feelings and asking if he has any specific concerns about switching to another medicine. When there is more than 1 type of medication he could reasonably switch the patient to, Dr. Kent might involve the patient in the decision-making process.

Coping strategies can be effective even when the causes of the problems themselves are difficult to change. For example, one can alter one's expectations about the situation so that it is more consistent with the reality. Most of us came into medicine with an idealized impression of what it means to be a doctor and were shocked by the reality of the current practice environment. Many accept this reality and strive to make the best of it, but some continue to see the difference between their expectations and reality as a persistent source of frustration and distress. While practicing medicine may not be exactly as expected, its essential elements remain unchanged. The ability to focus on the more positive aspects of the doctor-patient interaction may help reduce the distress associated with more problematic external factors.

The recent stock market crash has taught all of us the value of diversification. This lesson is also relevant to the difficulties we are encountering in the practice of medicine. The practice of medicine must not become the only important aspect of our lives. Spending time with family and friends and regularly engaging in activities that provide relaxation and pleasure and enhance our sense of self are necessary to balance the stressors that are inherent to our profession. In order to be good at what we do and enjoy it, we need to take care of ourselves by eating right, getting sufficient rest, exercising routinely, and by paying more attention to our internal signals of stress. We need to learn to understand the sources of our stress and the thoughts and feelings they evoke, and we need to practice stress-reducing strategies that can modify the stressful situation itself or the emotional impact of that situation.

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MEDICAL EDUCATION

Pregnancy and Parenthood in Residency, Commentary 1

Timothy Flynn, MD

The theme of physician health and well-being cannot be thoroughly explored without introducing the complicated case of a resident physician who is pregnant. The issue is complicated because of the many interrelated, competing (and potentially conflicting) interests of the parties involved. These include the family and health interests of the resident and her fetus; the interests of others in the residency cohort who may have to cover for the pregnant resident and who may have ranked their own family interests secondary to their residency demands; and the interests of the program director who must balance the needs and interests of the pregnant resident with those of other residents and those of patients. Because of the annual matching program by which residents obtain their jobs and training positions, a resident's unexpected need for extended time off or for a reduced work schedule cannot be accommodated easily and may cause interruption in her training which may result in delayed completion of residency.

What policies do you think residency programs should adopt to balance these competing interests most fairly and effectively?

Commentary 1

There is no doubt that this is a highly charged issue for all involved, but it is unfair to characterize it as a "pregnant resident" problem since that stigmatizes the individual who is most vulnerable. The days of residents being unmarried men living in the hospital are long gone and are not coming back nor should they. We should think of this in the context of the complex family issues all residents encounter. Sometimes I think faculty believe residents have no other life except to serve the program. Moreover we should not look at this situation as somehow unique because the individuals involved are residents. People in their twenties become fathers and mothers; it is what is supposed to happen. The better-run, most profitable corporations in this country have already figured out how to deal with this issue and retain productive employees, even those who have children.

The real issue is not policies but attitudes. While I agree that programs absolutely need clear policies, it is up to the educational leadership to create an environment that does not expect residents to be in reproductive limbo for the duration of training. As employers (we could argue whether residents are employees or students, but to do so would be missing the point), we have a legal and ethical responsibility to be supportive of the family needs of our residents. This is not an

issue of training; it is an issue of who does the work. As program directors and faculty, we ought to be able to figure this out. Although, as the furor around the 80-hour week has so well demonstrated, it might not be easy. Yet, it is unfair to blame the residents for a system that we have created.

So the first policy is that residents have the right to pursue having children as they see fit in relation to their own situation. Ironic as it seems for those purported to be in the healing profession, faculty must give support to this notion and make it clear that the program will be supportive. Once it has been established that the program will find ways to support the resident, then it is important that clear policies be written so that everyone knows what to expect. The resident must take responsibility to notify the program administration as soon as possible about her pregnancy or that of a spouse if paternity leave is requested. This must apply to adoption as well. The program director and resident should discuss what rotations the resident should be on while pregnant and ways to accommodate the workload so as to not endanger mother or child. Although not entirely predictable, the duration of the time off should be specified. Most policies identify 6-8 weeks. There must be agreement on what type of leave will be used—vacation, sick leave, leave without pay, and whether any of this can be carry over from previous years. It is also helpful to review the resident's fringe benefits, especially if there is a chance that there might be complications for the mother or child. The resident must be notified by the program of the effect that time away may have on his or her Board eligibility. The program should also anticipate what steps it would take if there were complications and the leave period had to be extended. All policies must be in compliance with federal law. It is helpful to consult your institutional Graduate Medical Education office to be sure policies meet the legal requirements.

Setting policies is usually the easy part. For the resident taking leave, the experience will be shaped by the reaction of the program director, faculty, and peers. Setting the expectation that parental leave is acceptable is the first step. The real determinant of how a resident's leave will impact the program and the attitude of the other residents is how the program director makes up for the loss of the resident in the schedule. This problem cannot be left to the peer residents to solve. The program director and faculty must find a solution that does not simply shift the work to the remaining residents. This may involve reassignment of mid-level providers, temporarily rearranging services, or having faculty fill in. Whatever solution is chosen, acceptance will be determined by the expectations set initially.

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MEDICAL EDUCATION

Pregnancy and Parenthood in Residency, Commentary 2

Lara Bonasera, MD

The theme of physician health and well-being cannot be thoroughly explored without introducing the complicated case of a resident physician who is pregnant. The issue is complicated because of the many interrelated, competing (and potentially conflicting) interests of the parties involved. These include the family and health interests of the resident and her fetus; the interests of others in the residency cohort who may have to cover for the pregnant resident and who may have ranked their own family interests secondary to their residency demands; and the interests of the program director who must balance the needs and interests of the pregnant resident with those of other residents and those of patients. Because of the annual matching program by which residents obtain their jobs and training positions, a resident's unexpected need for extended time off or for a reduced work schedule cannot be accommodated easily and may cause interruption in her training which may result in delayed completion of residency.

What policies do you think residency programs should adopt to balance these competing interests most fairly and effectively?

Commentary 2

Here is the bottom line on residency training: it is not family-friendly. Residents work long hours, take call, and work weekends. This work schedule does not include the academic demands that accompany the job. Throw pregnancy or family into a hectic work week and the stress-meter rises. Male colleagues struggle with the juggling act of work and family, but their wives—bless them—usually pick up the slack in making family life run smoothly. Many fathers are as present in their children's lives today as mothers are—a happy and promising change. Nevertheless more is expected of mothers. And physicians who are mothers, even those with supportive spouses, have complicated choices to make, especially physician-mothers of young children.

Unless a resident's pregnancy is complicated, residency programs need do little to accommodate her. The problems of endless nausea and need for a nap are just a new state of being hormonally "souped up." Being pregnant and tired is not that different from baseline exhaustion on any given post-call day. That said, more rooms in hospitals designated for the napping needs of a parturient woman would be a small accommodation that make a big difference. If the pregnancy is complicated and a woman needs time off to deal with pre-term labor, on the other

hand, she has no choice but to finish training later than expected. Bedrest or a reduced work schedule, with resultant delay in completing residency, is a small price to pay to avoid delivering a premature baby.

Despite the continued increase in the number of women in medicine, the struggle of how to balance work and family seems far from settled. Though men are now more involved in their children's lives, raising young children still seems to be chiefly a woman's concern. Ellen More, medical historian and author of *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995*, reports one male resident's view: "The prevailing attitude is that child-rearing is woman's work. If I ask to leave rounds to attend a sick child or cover for an absent babysitter, I run the risk of appearing as though I have a lackadaisical attitude or my work comes second...The first step is to try to understand that the enormous responsibility we have as parents is a shared one--not borne by the mother alone."[1] Our profession pays lip-service to the importance of family and living a balanced life, but, in truth, it holds childrearing in low regard, as anyone knows who has taken a day off to care for a sick child. One feels as though a pound of flesh is due to atone for the inconvenience inflicted on colleagues. Nor is this devaluing of childrearing limited to the medical profession. To openly place the needs of our children and family ahead of our work demands, is to risk being a second-class citizen among our working peers. To avoid this we must either be twice as clever or twice as hard working. I have yet to meet a physician-mother who does not feel that she has made significant compromises at home or work, or both. They are proud of the work that they do, but wish for more time with their children and spouses.

Last week, to take just one example, my son had a miserable bout of diarrhea, and the daycare staff told me to keep him home until things improved. My husband was out of town, meaning that I would have miss work. When I called the OR coordinator to let her know I would not be in the next day, she was gracious and sympathetic to my plight. Still, I was sure there would be a price for this "inconvenience" to my colleagues. I had already been issued a warning, in confidence, by a different member of the practice. I was counseled that I should make different child care arrangements once I earned an attending's salary. After all, nannies are perfectly capable of managing a nasty bout of rota virus. Calling in sick, either because of myself or my child, was a definite black mark on my record. I felt demoralized, deflated, angry. I vowed in that moment that, no matter how sick *I* was, I would show up for work. After all, I do have student loans to pay. But when it comes to my son's or my family's needs, the decision is simple. Jobs come and go; families don't—or *shouldn't*. I want to be present to toast my son on his wedding day with as few regrets as possible.

To quote More again: "Unquestionably, the greatest obstacle still facing women practitioners is the need to accommodate the demands of childbearing and childrearing."[2] How a woman balances work and family will be unique and tailored to the demands of her life. There are no easy answers here for residents or residency programs. Admitting that our lives and the lives of our colleagues are multifaceted

is a start. We have to honor that raising children is a sacred task, sacred not only because children are our future, but because they are a precious part of making our lives whole.

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IN THE LITERATURE

Achieving a Sense of Well-Being: Physicians' Prescriptions for Stress Management

Philip Perry, MSJ

Practicing physicians experience burnout more often than most people realize. Tait Shanafelt and a team of researchers based at the Mayo Clinic tell us the bad news first: among practicing physicians, as many as 30 to 60 percent (both specialists and general practitioners) are "experiencing burnout when measured with validated instruments."[1] Burnout is defined here as "a syndrome of emotional exhaustion, depersonalization, and a sense of low personal accomplishment that leads to decreased effectiveness at work." Residents *and* physicians say it leads to lower quality patient care.[2]

Recovery from burnout is the immediate goal, but "this is certainly settling for less than what can be achieved."[3] The Mayo authors advocate the more ambitious goal for physician health: they want well-being. The trouble is, even now, there's no simple prescription for healing a burned-out physician.[1, 4] The authors of the Physician Worklife Study said in 2002, "…surprisingly little research has addressed predictors of stress in US physicians."[4]

The good news here is that wellness strategies can be identified. In a theme issue of *Western Journal of Medicine* devoted to physician well-being, author Eric Weiner highlighted a list of 5 strategies based on responses from 130 physicians who answered the question, "How do you solve dilemmas related to your physical, emotional, and physical well-being?"

The strategies suggested most often were (1) relationships, (2) religion/spirituality, (3) self-care practices, (4) work attitudes, and (5) life philosophies.[1, 5] In general terms, relationships means finding someone with whom to share feelings—"spending time with family, friends, or colleagues or other community involvement;"[6] self-care means more exercise, better nutrition, activities, reading, avoiding alcohol and drugs, and counseling if needed. For many, self-care also involves spiritual development—which refers to a variety of experiences, religious and otherwise. Work attitudes can mean placing limits on work to preserve personal time to recycle or recharge or efforts to find the most satisfying specialty or career opportunity. A life philosophy helps one survive crises intact. "A philosophic approach to life incorporates a positive outlook, identifying and acting on values, and stressing balance between personal and professional life."[7]

Coping with Residency
Medical residents had their own ideas, as expressed in a survey of more than 100 residents, graduates of 45 medical schools.[1, 2]

They suggested several self-care strategies: relationships, personal and professional, were rated "important to essential" by 90 percent-plus, hobbies and exercise by 90 percent-plus, and religious or spiritual practice by 34 percent.

In *Burnout and Self-reported Patient Care In An Internal Medicine Residency Program*, residents recommended "talking with family or a significant other (72 percent)" and "talking with other residents or interns (75 percent)." Managing stress was best accomplished by physical exercise and a "survival attitude," the residents said. Moreover, they recommended some organizational changes they considered essential—4 days off per month, at least; more help from support staff; and a night-float option.[2]

Because control issues involve organizations as well as the individual, the Mayo authors appeal to health care organizations to reexamine the corporate culture(s) of academic medicine, health care delivery (HMO's) and physician organizations, specifically to:

- promote physician autonomy,
- provide adequate support services,
- cultivate a collegial work environment,
- be value-oriented,
- minimize work-home interference, and
- promote work-life balance.[1]

Converting these various strategies into personal and corporate habits is the next step. Shanafelt asks "How well are we integrating these strategies into our lives?"[8]

The answer is, not very well, yet. The human condition is partly to blame. Physicians become depressed or suicidal at about the same rate as the general population in our society.[9] (See Journal Discussion 2, this issue.) Shanafelt is concerned about signs among young people that financial security is often the controlling purpose of education, rather than the development of a meaningful life. Those yuppie priorities are a well known recipe for personal unhappiness later on.

Institutional change is an important step in de-stressing the medical profession. Getting a life in balance can mean a conflict with "dominant professional expectations of …colleagues and institutions," Clever says.[10]

Based on the Mayo research, many health care institutions could improve matters by giving doctors more control over their work schedules and by adapting to work-home needs of health care professionals, with backup coverage available to allow for time to attend to personal or family needs.

Stress vs Impairment

If stress is the problem physicians are facing, they can turn to many local resources, as the Mayo team points out. For instance, RENEW, founded by San Francisco physician Linda Hawes Clever, helps people make better choices by refining the values that can improve well-being.[11]

If physicians reach the stage of impairment, there are programs in each state specifically designed to treat them.[12] The Mayo authors did not mention them specifically, perhaps because their main interest was defining and maintaining well-being.

Academic medical centers have an added responsibility to their physicians in training, Shanafelt says. The education establishment has historically underestimated the stress students endure. Schools need to find "healthy approaches to balancing personal and professional life."[13]

Focus Research Efforts on Medical Education

Finally, Shanafelt's group calls for some new research to guide future change. Gender issues need work—adapting to the needs of female physicians who are now in the workforce in growing numbers. Long-term follow-up on medical education programs, to "de-stress" them as much as possible, is another area they single out for immediate attention.

Within each of these broad areas in need of improvement, the authors specify action to take. They conclude, "being a physician carries with it the potential for both great joy and great distress."[13]

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IN THE LITERATURE
Physician Depression and Suicide
Michelle Lim

Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA*. 2003;289(23):3161-3166.

The *Journal of the American Medical Association* recently published a consensus statement on physician depression and suicide developed during a workshop sponsored by the American Foundation for Suicide Prevention.[1] The statement's 15 authors (11 of them MDs) urged physicians, medical institutions, and health organizations to give more attention to the treatment of depression and prevention of suicide among physicians. Hendin (the corresponding author) et al contend that attention to physician depression and suicide is long overdue and point to the culture of medicine and the lack of a supportive environment for physicians with mental illness as part of the problem. The authors call for a shift in professional attitudes and institutional policies to encourage physicians to seek help and obtain treatment for mental illness.

In 2000, suicide was the 11th leading cause of death in the United States with more than 28,000 resulting deaths.[2] Hendin et al claim that suicide is a disproportionately high cause of mortality in physicians, particularly in female physicians. The authors point out that, in the general population, the suicide rate of men is more than 4 times higher than that in women, but among physicians, the rate for women is comparable to that in men physicians. In the absence of recent studies of suicide rates for US physicians, the consensus statement cites a 1984 to 1995 survey that compared the causes death in white male physicians with the causes of death in white males in other professions. Looking at the percentage rates of death in each group for 14 different causes, the survey found that, although the percentage rates for death due to cancer, heart disease, and diabetes were similar in the 2 groups, the physicians' proportionate mortality rate for suicide was more than 1 ½ times the rate for other white male professionals.[3]

Depression is a common risk factor for suicide, and Hendin et al argue that it is as common in physicians as it is in the general population. The consensus statement cites that the lifetime prevalence of self-reported depression in physicians is about 13 percent for men and 20 percent for women, which is similar to that of the general population. Studies also show that medical students and residents in particular have higher rates of depression than the general population and a higher prevalence of suicidal ideation.[4]

A concerted effort to tackle physician depression and suicide requires identifying and overcoming barriers to care. While physicians may have ready access to mental health services, many avoid seeking treatment because of the stigma associated with mental illness. One study cited found that physicians often do not take advantage of the preventive services available to them, with as many as 35 percent of the physicians surveyed reporting that they did not have a regular source of health care.[5] Another reason physicians may avoid seeking mental health treatment is that they fear punitive responses and discrimination in medical licensing, hospital privileges, and professional advancement.[6] For many medical students, seeking mental health services may be cumbersome inasmuch as it can be time consuming and costly. They may also worry that their records will not be kept confidential. Many students think that stress (even excessive stress) is a normal part of their medical education and training and, therefore, do not feel that they need mental health care. One study found that only 22 percent of medical students who screened positive for depression used mental health services and only 42 percent with suicidal ideation received treatment.[7]

Hendin et al stress the importance of preserving physician mental health and well-being because of the direct effect it has on the quality of patient care. Physicians with poor health behaviors concerning smoking, alcohol intake, exercise, or seatbelt use are less likely to counsel patients about those habits .[8] Likewise, physicians who suffer from untreated depression are unable to effectively screen, diagnose, and treat depression in their patients. Studies have consistently cited that 25 to 60 percent of depressed patients are not properly screened or diagnosed.[9, 10]

The consensus statement authors recognize the absence of current and reliable data on the prevalence of depression and suicide in US physicians. They recommend further research on prevalence rates of mental illness, patterns of seeking help, risk and protective factors, and barriers to treatment. They urge physicians to seek help for mood disorders and establish a regular source of care, to become informed of legal protections for their confidentiality, and to routinely screen patients for depression. As for institutions, the authors recommend that professional organizations educate the physician community about depression and suicide in medical school and continuing education programs, develop policies that encourage physicians to seek help, and impose an accountability system for the detection and treatment of depression in all primary care patients.[11] They state that raising awareness of physician depression in the medical community will improve the mentoring and training of young physicians and patient screening and care, and that ultimately physicians will become adept at recognizing depression in themselves, their peers, and their colleagues, and be empowered enough to seek help.

Questions for Discussion

1. Do you think state licensing boards should have access to a physician's history of mental illness? Should the boards have access to any health information?

2. Given that medical education and training can be highly stressful, and medical students tend to think that stress is simply a normal part of their experience, do you think that there should be required mental health counseling for all medical students during their education?
3. Do you agree with the consensus statement authors that a physician who has untreated depression is less likely to be able to diagnosis and treat it in a patient?

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STATE OF THE ART AND SCIENCE
Depression and Heart Disease
Audiey Kao, MD, PhD

A recent study that followed nearly 1200 Johns Hopkins Medical School male students over 40 years found that those with a history of clinical depression—even a depressive episode more than 10 years prior—were twice as likely to develop coronary artery disease, and the history or incidence of depression raised their risk for heart attack by 20 percent.[1]

Over the past several years, a growing body of research has uncovered a significant association between depression and increased risk for such cardiovascular diseases such as congestive heart failure and stroke. To state it another way, happier, more cheerful people have a lower rate of heart disease. Studies examining the link between depression and heart disease have revealed that:[2]

- Middle-aged men with depression were 3 times more likely to develop strokes during the next 14 years.
- In a longitudinal study of 5000 people aged 65 and over, those who had frequent depressive symptoms were 40 percent more likely to develop coronary artery disease.
- In a 10-year study of 1300 men, each increase in their level of optimism (as measured by answers to a survey) reduced their chance of developing coronary heart disease by 25 percent.

The hypothesized biological causal link between depression and heart disease is based on the deleterious effect that stress hormones have on the cardiovascular system. During normal stress situations, the body releases more adrenaline and cortisol. While these stress hormones have short-term benefits, long-term exposure to higher than normal levels of cortisol, which are found in patients with depression, have adverse physiological effects. For example, hypercortisolemic depressed patients suffer from resistance to insulin and increased visceral fat, which might partially explain why major depression can be considered a risk factor for cardiovascular disorders.[3]

The preferred antidepressants for people with, or at risk for, heart disease are selective serotonin reuptake inhibitors such as fluoxetine, paroxetine, and sertaline. These medications have fewer cardiac side effects than older tricyclic antidepressants.[4]

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STATE OF THE ART AND SCIENCE
A Physician's Guide to Balance
Steven Landau, MD

I couldn't practice medicine without doing meditation and yoga.

I began doing yoga at the age of 10. I thought to myself, "This will save the world!" after finishing a brief rest in the corpse pose. Then the second thought came, "If only people will do it." (Aye, there's the rub.) Then I stopped doing it.

I started doing meditation regularly in Harvard in my senior year of undergraduate training. It helped calm my mind, and I've been doing it ever since, with the Ananda Marga Yoga Society. Now I teach classes in prisons, battered women's shelters, and my own Johnston Memorial Hospital. I even have a straight scientific talk I do for CME on Medical Aspects of Yoga and Meditation. And you're probably wondering what all those initials mean after my MD. The FAAFP is a symbol of family practice, the primary holistic discipline in mainstream medicine. The ABHM is the sign of the even more holistic discipline in non-mainstream medicine, the American Board of Holistic Medicine. The RYT stands for Registered Yoga Teacher.

I was asked to do this article because of my association with the Yoga Alliance, a non-profit group of idealistic and practical yoga teachers who also want to save the world through yoga. They've set up minimum standards of training in this art and science that was previously almost totally unregulated, and is still usually taught from master to disciple.

Have you noticed how much I've used the word "I" so far? That's a little like the practice of meditation. First you get the "I" trash out, and after a while it all gets handled nicely. Then, as your selfish concerns wear off, you start getting the larger picture and transcend into the realm of bliss.

Ashtanga (8-limbed) yoga incorporates the multiple elements used to put out the trash and keep it out. It has parallels to medicine, as follows:

1. YAMA (intro-external controls)
    a. Ahimsa—noninjury by thought, word, or deed ("First, do no harm").
    b. Asteya—abandoning the thought of stealing or of depriving someone of their due (keeps me clear of Medicare fraud).
    c. Satya—benevolent truthfulness—action of mind in the right use of words with the spirit of welfare (the "art" of medicine: what do I tell,

to whom, and when? Tell someone "You look great!" even though they're feeling terrible, so they'll actually start looking and feeling better).
    d. Brahmacharya—looking upon everything as a manifestation of Consciousness, and not just as the crude form (the holistic approach—we're not just bodies and chemicals).
    e. Aparigraha—non-indulgence in those material amenities that are superfluous to the maintenance of life (with due regard to the prevailing standard of living in the society at large).
2. NIYAMA (extro-internal observances)
    a. Shaocha—purity and cleanliness, mental and physical (wash your hands often. Wash your mind often too).
    b. Santosha—contentedness with the fruits of reasonable labor (no more 80-hour work weeks, if we can help it).
    c. Tapah—willingly undergoing pain for the benefit of others. Service without thought of reward, just because you recognize the Supreme in the object of your service (we all do indigent care, at home or abroad).
    d. Svadhyaya—scriptural study with a view to understanding the underlying meaning (read your journals).
    e. Iishvarah Pranidhana—chasing the Supreme—establishing oneself in the Cosmic Shelter; looking upon oneself as the instrument rather than as the doer ("I will lead my life and practice my art in purity and holiness" --Hippocratic Oath).

Yoga requires balance in the mind, body, and spirit. But where do emotions come in? Emotions are just thoughts with enough power to stimulate hormonal and physiologic reactions. Yoga deals with these directly. Here's how:

ASANAS—yoga postures

1. Asanas balance out the hormones. Don't ask me how—you just have to experience it. There's been no convincing scientific data that I've seen to show that cortisol or thyroid levels go anywhere predictably. That's probably partly because people doing different studies use different techniques and yoga postures, of which there are thousands. One way that asanas work is by pressing on chakras. These are psycho-physical plexi corresponding to various points in the body. Known for thousands of years, they also correspond to conjunctions of voluntary and involuntary sphincters, sympathetic and parasympathetic nervous plexi, and major endocrine glands. The yogic description of the chakras and nervous system also looks just like a common rendition of the caduceus (see diagrams 1, 2).
2. Muscles get stretched out and utilized in a way that tones them and doesn't fatigue them terribly much. An overall sense of euphoria develops. Stretched muscles work better and with less effort. The day flows smoother.

3. Self-massage following asana practice causes release of immune modulators from the skin. Feels great, too.
4. Corpse pose, everybody's favorite, allows total release from stress, and is the basis for the Jacobson desensitization technique. You can do it at lunch for a few minutes after you've been on call the night before. Works well.

PRANAYAMA—Breath and energy control
With the help of asanas, and certain specific breathing exercises (slow breaths at 1-2 times/minute, or alternate-nostril breathing) one gains control over the physiology of breathing. This enhances lymphatic flow (the lungs and diaphragm are the main pump to get lymph flowing from the rest of the body into the thoracic duct) and thereby the immune system. It also calms the nerves and emotions. By breathing more slowly, habitually and consciously, one's stress reactions are diminished. Have you ever noticed that tachypnea causes anxiety? Hence the morphine used in terminal care. Yogis use endorphins instead. When you're tired or tensed in the office, a few deep breaths will help put you at ease.

PRATYAHARA—Withdrawal of the attention from the sense-objects
Meditation is the practice that convincingly alters the mind in a very quick and reproducible fashion. Brain waves synchronize, various parts of the cerebral cortex are activated while others are deactivated, and a sense of bliss ensues fairly reliably. This, of course, depends on disconnecting the flow of constant stimulus from the outside world. When you get pretty good at this, intuition develops. Do this twice a day, preferably before eating, but anytime is okay.

DHARANA—Concentration
With practice, the mind becomes steady. Use of a mantra (Baba Nam Kevalam is one—means "Only the Name of the Beloved"), or focusing on the breath, or counting "OM - one, OM – two," or staring at a candle or a blank wall, or reciting Ave Maria, all of these work for some people. Try your own. You'll find it amazing that you have so much thought in your head that you can't clear out initially. But after a while, you do. You'll feel great, and it even lasts throughout the day. Make sure you sit up straight (in a chair if you do TM or Kabala style, or on the floor like a yogi. Pillows and back supports are allowed).

DHYANA—Meditation
Once your concentration becomes good, you really start to enter the realm of bliss, where your mind flows like oil or honey from a pot.

SAMADHI—Merger
At this point, you've abandoned your concept of self and merged it into the Self—the object of your concentration and meditation. Then you realize that the Self has really been meditating on you the whole time. This unity is really transcendent, and transmits unconsciously to all your patients and all those around you.

Having said and done all that, there's still a need to achieve and maintain balance in the society. So, here's a tip from Tony Robbins: make a wheel, with spokes, each arc of which represents a segment of your life. Then fill them up to the level at which each segment is functioning at this very moment in time. Are they equal? Then your wheel of life is going smoothly, and can go around very fast. Are they unequal? Then your wheel of life is going to go bump-bump-bump down the road and be very uncomfortable. So now you know which portions of your life you need to concentrate on and improve (see diagram 3).

Another critical point: How do you know when to use intuition and when to use intellect? When do you listen to that "still, small voice"? The answer is that you listen to it all the time, and obey it when you can. You learn to combine its wisdom with the practicality of the intellect and science that you've been taught, and you'll find that it works wonderfully well.

Last point: Always see the bright side of everything, and focus on it. By worrying constantly about bad outcomes, you'll bring them about. By focusing on the good outcomes and how you'll make them happen, you'll discover ways of bringing that about, too. You always have the choice. And as my guru, Shrii Shrii Anandamurti, told me, "Forget all past mistakes. Live your life afresh from this very moment. Do something concrete for the suffering humanity. And smile a little bit!" And with that, he took his hands and made my lips smile a little bit. And so you do, too.

With love and best wishes,
Steve Landau

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POLICY FORUM

Before Burnout: How Physicians Can Defuse Stress

Mamta Gautam, MD

Medicine can be a stressful career. In fact, the area of physician health is developing an increasingly high profile, and has become a recognized topic of importance, interest, and research at an international level. Many recent studies have shown that increasing numbers of physicians and residents are feeling stress and burnout and are feeling dissatisfied with their professional life.[1-6] The 2003 Canadian Medical Association Physician Resource Questionnaire found 45.7 percent of responding Canadian physicians reported symptoms in keeping with advanced stages of burnout.[7]

The factors that lead to stress among physicians are many and varied. They can be largely divided into 2 categories: personal factors unique to the physician, and workplace factors.

Personality and Stress

Physicians have common personality traits that predispose them to feeling stressed.[8-10] We are very conscientious and spend a lot of time and energy attending to details and to the needs of others. There is an exaggerated sense of responsibility and a need to fix things even when they are beyond our control and a feeling of guilt if we do not meet these perceived responsibilities. We have unrelenting "perfectionistic" traits, constantly striving to do more and be better. This makes it difficult for us to delegate. Physicians have difficulty relaxing and taking care of themselves. Physicians like to be in control and to have control of things and people around them. Much energy is spent in attempts to please everyone, but we are often left with the feeling that we have pleased no one. If we do receive positive feedback, approval, or love, we are not comfortable with this and dismiss or minimize it. There can be chronic self-doubts and insecurity, with a sense of being an imposter and having fooled just enough people so far. Thus, we fear having our cover blown; losing our power and authority, and being "found out." Additionally, we are masters of self-denial and delayed gratification. We put off meeting our own needs until everything else is done, or everyone else's needs have been met. Often, our own needs go unmet.

These personality characteristics are part of the reason we succeed. However, they also make us more vulnerable to stress. Being perfect, conscientious, responsible, and in control requires time and energy. Feeling inadequate and delaying our own

gratification prevents us from doing the very things we need to do to better manage our stress.

Stress in the Workplace

Factors in the workplace add to our stress. The workplace is full of pressure to do more with less, as physicians struggle to maintain a high standard of patient care in a changing health care system with fewer financial and personnel resources. We are on call and do not get enough sleep. The patients are demanding. Concerns about litigation and complaints can be real. We are constantly exposed to illnesses and diseases and the risk of violence. We are not fully trained to run the business side of our practice. We do not always feel we have control over how we have to practice medicine. We have little time to remain current in our knowledge, read journals, and attend conferences. We lack time for our families or loved ones. Even less time remains for ourselves.

Not only are physicians feeling stressed, they are working with colleagues and health care personnel who are also feeling the same and cannot provide support.

Burnout and Its Warning Signs

Chronic overstress is described as burnout.[11] Initially, we feel emotionally exhausted. We manage to get through the day at work, but have little else to give. Afterwards, we are exhausted, irritable, and impatient. It becomes so difficult to be with others that we withdraw, depersonalize, and prefer to isolate ourselves. We begin to feel negative about people and work we used to enjoy. We develop a reduced sense of accomplishment and satisfaction from our work and can become cynical and distant. Physicians at this stage often consider leaving the profession of medicine.

Burnout can lead to serious consequences. Medical students and residents experience school difficulty and exam failure. Practicing physicians who are burnt out may be subject to complaints, loss of privileges, or litigation. Emotional illnesses can result such as anxiety disorders, eating disorders, addictions, depression, and suicide.[10]

Focus on What You Control

The main approach to dealing with stress is to remember the cause of stress. Regardless of the source, stress comes down to one thing–-that in a given situation, we feel stressed because we do not feel we have any choice or control. Yet, this is only our perception. In reality, we have more control than we think. We focus on controlling and changing things *around* us, and from that perspective, appropriately, feel we have no control. The only factor we control is us–-our thoughts, feelings, expectations, behaviors, strengths, and weaknesses. We must learn to identify what part of the situation is under our control and focus on that.

Rx for Stress

There are some specific strategies that can keep stress positive and prevent burnout.

First and foremost, take care of yourself well. Make time for yourself. Eat regular healthy meals daily. Develop good sleep habits. Exercise regularly and stay fit. Get a family doctor and consult him or her yearly or as needed. Learn relaxation techniques. Explore meditation and spirituality.

Learn to manage your time efficiently at work. Be organized, schedule realistically, and try not to overcommit yourself. Recognize and accept that you cannot do everything, and set priorities that include yourself, and your family and friends. Set and maintain limits. Learn to say "No." Stop trying to please everyone.

Take regular breaks and vacations. Do not wait for a crisis to force this. Learn to "waste" time—that is, do something you want to do, not something you have to do.

Anticipate and prepare for situations, both at home and at work. Don't spend time trying to do things "the way it has always been done," or the "perfect" way. Look for options. Accept that good enough is good enough. Set realistic expectations of yourself.

Make it a rule not to take your work home. If you have to do this, it should be the rare exception to the rule. At home, define when and where you will work, and stick to these parameters. Give your family your full attention when you are with them.

Laugh more often. Look for and enjoy humor on a regular basis. Share a laugh with family, friends, and colleagues. Add fun to work.

Seek and use supports. Make your family a priority. Have at least 1 good friend. Share concerns with trusted colleagues. Reach out and get a mentor. Ask for help if needed. Foster a team spirit at work.

Take time for yourself and your family without feeling guilt. Acknowledge your guilt, and let it go. See this time as an investment that allows you to be better available for all your other responsibilities. Guilt is the main reason why physicians do not make changes to manage their stress. Let go of your guilt.

Create a financial plan. Stick to basic principles, and reduce nondeductible debts, and plan to save. Do not live beyond your means. Being financially overcommitted is the second most common reason that physicians do not make changes to decrease their level of stress.

While the stress of medicine will always be present, we can work to keep it positive, motivating, and enriching.

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MEDICINE AND SOCIETY

The Feminization of Medicine

Shelby Ross, MD

Out of the mouths of the medical establishment has come the term, "the feminization of medicine." The increased number of women in medicine is cited as the cause of the changing face of medical practice. We need to acknowledge the real reasons for much of this change, namely the shift in societal values, bureaucratic control, and the lack of adequate resources to provide timely care. We need to welcome women into the leadership network that has been historically all men. As physicians, both men and women need to work on an equal basis to ensure that the public receives the care it needs despite ongoing reform in the delivery of health care.

Women comprise 50 to 60 percent of medical students in Canada and the US today. Compare this to my year of graduation from the University of Alberta Medical School in 1974, where I was 1 of 20 women in a class of 100, or to the year 1953, when 4 of 50 graduates were women. It is predicted that by the year 2020 in Canada, women physicians in practice will outnumber men physicians.

What makes the thought of the increasing number of women in medicine a worry to many? The Medical Women's International Association identifies the threat of medicine becoming a "pink collar profession," losing the status and influence and monetary compensation traditionally attached to the practice of medicine. When you compare medicine to the more-women-dominated professions of nursing and education, the difference in status, influence, and monetary compensation is readily apparent. Inside the profession of medicine, one sees that the woman-predominant specialties are often lower paid. This is due, in part, to the fact that women choose specialties that allow more flexibility and therefore ability to balance their lives; the fee schedule for these specialties is not as great as for other specialties that are male-dominated. Another factor in lower pay for women physicians is that women often practice differently, spending more time with patients. In a fee-for-service setting fewer patient visits equals less money. If one glances further afield to the former communist countries such as Russia, where women have dominated the profession for many years, the fear of loss of status escalates.

Medicine has always been considered a man's job. Even when the number of women in medical schools was small, there were mutterings of what a waste of time it was to train women. It was felt that once trained, they would marry and drop out of the workforce. The unspoken thought was that they would deprive dedicated

young men of the opportunity for training, on the presumption that men would contribute more time to the practice of medicine than their women counterparts. However, this has not proven to be true. It is true that some women work part-time in clinical practices or in salaried jobs while raising their children, but they often return to full-time practice and involvement in organized medicine once their children are raised. When men physicians reach the stage of their career when they are decreasing their working hours, women physicians are increasing theirs and working for more years than the men.

Concurrent with the increasing enrollment of women in medical schools, the attitudes of society have changed. As a consequence, medical students of today prefer to work for a living rather than living only to work. This is equally true for men as for women. They have demanded and obtained a better balance to life. They want reasonable hours of work, more sharing of responsibility, time for family and recreation, and a good income.

If this change is to be blamed on more women in medicine, should they be congratulated or rebuked? Is it indeed such a bad change?

Personally, I feel that women physicians should be congratulated. Some of the changes in medical practice that are attributed to women have been long overdue and are equally advantageous for men as for women. Such changes are more flexible residency training programs, part-time work, maternity and paternity leave, and tax benefits for daycare costs. All these changes contribute to making more time for family life and leisure activities, which benefits both women and men physicians. Women's influence on medicine has made it acceptable for physicians of both sexes to refuse to work to the point of physical and mental exhaustion. Having a balance between work and home often reduces physician burn-out.

Those entering medical school still have that inner passion and altruistic vision that they are contributing to society in a positive way. When you compare medicine to professions such as accounting and law, the average physician works the same number of regular hours. New physicians acknowledge the need for 24/7 medical care, but they are unwilling to be always available. In many cases these physicians' expectations have changed the way medicine provides 24/7 coverage. One example of this change is the increasing use of hospitalists, salaried physicians who do regular shifts to care for hospitalized patients. Another example is the demise of the solo practice family doctor and the birth of large groups where physicians work shifts to provide coverage. New physicians are not willing to shoulder the burden of family practice with responsibility that is never-ending while their counterparts do a shift in the walk-in clinic for better remuneration and defined working hours. Such changes in practice have been accompanied, however, by the loss of personal touch in medical practice.

One of the criticisms of women physicians is that they do not take their share of leadership roles. This is not always by choice. Not all women physicians are

content to limit their role to the practice of clinical medicine. Many medical organizations pay lip service to wanting more women on their boards because doing so appears politically correct. However, once a woman shows that she has ability and appears to be headed for a role normally earmarked for a man, she encounters the very real glass ceiling that stops her from reaching her leadership potential.

Those who worry that medicine might become devalued as a "pink collar profession" should instead recognize all physicians—women and men—who have leadership potential and mentor them now for their future leadership roles. My second suggestion is that we acknowledge the positive changes in medical practice that happened as more women have entered the profession and move beyond blaming women physicians for the unpleasant changes. We must recognize other causes for these changes that reduce physician autonomy such as the lack of resources and third-party control. My third suggestion is that we move beyond the insistence that the new graduates work as we have always worked. We must admit that their way may be better than ours. Let us move on to finding ways to deliver health care that will meet the needs of both the public and the physician. Bright minds are not going to be attracted to a profession that fails to provide job satisfaction, status, influence, and monetary reward.

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