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Journal Discussion

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

Physicians can use stress management strategies to avoid burnout while faced with the demands of the medical work culture.

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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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Suggested Resources

- Morse L. What steps should be taken if a colleague is an alcoholic? *American Medical News*, Ethics Forum, Oct 5, 1998.

Dr. Morse wrote: Despite their extensive education, a significant number of medical doctors fail to acknowledge their susceptibility to alcohol and other addictive substances. When it is recognized, I would confer, preferably, with a close colleague or family member who could encourage the physician to take a voluntary leave of absence.

If this personal approach fails or is inappropriate, then notification should be made to the physicians health service of the state medical society. A colleague who is addicted to alcohol is a hazard to patients and her- or himself, and should be reported to the physician's department head in the hospital and to the hospital administrator. The hospital is required to report its action to the licensing authority and require reassurance that the physician is compliant with the recovery program.

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