

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

INTRODUCTION

Since 1973, when the American Medical Association Council on Mental Health published its report, "The Sick Physician" (4), the study and treatment of physician health problems began in earnest. For many years the primary focus of this effort was addictive illness among physicians.

The treatment of addicted physicians, as it is practiced in the United States, has in part relied upon principles derived from 12 step programs such as Alcoholics Anonymous and Narcotics Anonymous. Certain of these principles underscore the importance of managing stress, either combating worry by "turning it over" to a "higher power", managing resentment of others by taking a "moral inventory" of oneself, or guilt by making amends for one's harmful behavior toward others. Programs that specialized in the treatment of physicians helped them apply such tools to the issues in the workplace, such as work stress. They further confronted the typical physician's excessive devotion to work as not conducive to maintaining their health. The importance of managing work stress as part of the addiction recovery process is further underscored by the reports of recovering doctors in which they underscore that stress of the workplace is a major factor underlying relapse.

Since the mid-eighties, other psychiatric and medical conditions of physicians have also garnered the attention of physician peer assistance programs (2) and those in the research and treatment community. While work stress has always been a matter deserving the concern of those who work in the assessment and treatment of physicians with health problems, it is an increasingly prevalent source of primary complaint (5). Between July 1, 1997 and 1998, 30% of those presenting for assessment at the Colorado Physician Health Program came because of work stress related problems.

CONCEPTS OF WORK STRESS

Hans Selye, who did seminal work in the field of stress, separated stress into "distress" and "eustress" (24). In distress, the stressful event overwhelms the individual's ability to cope. It is unpleasant, unwanted, and unmanageable. In eustress, the stressful event enhances growth, motivation, and development. In choosing medicine for a career, physicians undertake a type of work which by its nature brings about much eustress; indeed, many doctors seek clinical or research experiences that continually challenge them. It is part of the reward of medicine.

Not surprisingly, there may be a fine line between an event which causes distress or one which causes eustress. An emergency physician treating a myocardial infarction in an emergency room filled with the right equipment and personnel may cause eustress. The same doctor, treating a patient who collapses in the doctor's outpatient office when he or she is already an hour behind schedule and has 25 more patients to see, is likely to experience distress.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 2 of 16

The profession of medicine is replete with distressing situations, be they related to clinical, research, ethical, interpersonal, political, or business aspects of the work.

A stressful event is but one component of work stress. Essential to the notion are two further concepts, mental workload and decision latitude. These form the foundation of the work stress idea. The higher the mental workload and the lower the decision latitude, the more stressful the work.

Mental workload may be defined and measured differently in each research situation (1, 9, 20), but the idea is easy to grasp and intuitively understandable: it is the weight of decision making and responsibility, combined with the quantity of work. Doctors generally have high mental workload.

Decision latitude refers to one's degree of control or influence in the workplace, or over one's work. Traditionally doctors have been considered to have high decision latitude. The basic model of such a situation might be the surgeon in the operating room commanding the events of the surgery. Because of the assumption high decision latitude, medicine has not been considered to be among the highest stress professions.

In my opinion, the depiction of decision latitude as high among physicians has been incorrect; more recent changes in the health care system have resulted in such a characterization being even more incorrect. Despite television caricatures, the model of the physician as dictator in the office or hospital has probably never been entirely accurate. Hospitals and offices have been run by administrators, and all medical care requires much coordination with other professionals. In the current health care environment, the physician is even further from the top of the pyramid of authority. Even more importantly, two aspects of the work are notoriously out of the doctor's control: the behavior of patients and the course of illness. Most studies of patient compliance with medical recommendations demonstrate surprisingly low rates. Most illnesses are not curable. The doctor's primary aim to ameliorate illness is often thwarted, and thus the work at a fundamental level resists control. Therefore, physicians experience less decision latitude than appearances and history might suggest.

High mental workload and low decision latitude form the foundation of the work stress concept. A work environment rich in opportunities for distressing experience is another essential element. In a study of blood pressure among house staff on call (17), significant elevations were noted to have two determinants: family history of hypertension and more junior status as a trainee. While only an example, this illustrates that more factors need to be considered in the work stress idea besides the stressful situation, in this case biological and social factors. The notion that an external stressor alone accounts for most clinically relevant stress is too simple; "host" differences must be considered.

It is often said that mental illness requires biopsychosocial understanding. Work stress does too. In the blood pressure example, social status, as well as genetics, was a risk factor. Work stress, after all, has to do with work, a social environment.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 3 of 16

The structure of the workplace, the role of the physician there, the value of the physician's role, the ability of the physician to alter his or her working conditions, not to mention the work load and work type, must necessarily affect the degree to which work stress is experienced.

Psychologically, physicians may be vulnerable to stress because of personality factors. Both Vaillant (27) and Gabbard (8) have published accounts of physician personality traits. Self-doubt, guilt, an exaggerated sense of responsibility, and compulsiveness are common features of doctors' personalities. These traits may in fact make for good doctors; such physicians will shoulder difficult problems and attend to them despite the time and emotional commitment this may require. On the other hand such characteristics will often lead physicians to blame and doubt themselves when things inevitably go awry. Under these conditions, many doctors will work harder in an attempt to deal with their distress and prevent further problems, only compounding and enhancing their stress level. In a study of doctors' mistakes (31), many physicians vowed to do more work themselves, trust others less, and be more compulsive as a means of preventing more mistakes. As this cycle, of working harder to relieve stress which causes stress, continues to spiral, doctors become increasingly mired in work and often more distant from family, friends and colleagues. Doctors are then deprived of essential and stress-relieving support. Worse, those supports themselves need the doctors' support and in the absence of physicians' time for them such potentially helpful people will become resentful and thus become sources of stress. Doctors themselves may have difficulty sorting out their obligations, and may well feel guilty about their failings on both fronts. The psychology of physicians is double-edged and may expose doctors to stress by virtue of the traits that make them good doctors.

STRESS IN THE PHYSICIAN'S WORLD

Speaking to physicians about the stress they suffer typically brings a pained smile to their faces, and a discussion of the travails of managed care that may be colored either by anger or resignation. There is little doubt that physicians in all settings, solo or group practice, HMO, academics, all report a significant increase in stress associated with financial pressures and the loss of authority to make clinical decisions. Many who work in the physician health field believe that this is more apparent in those doctors who have been practicing through the period of time in which managed care has taken root and grown. These physicians report they are considering early retirement or career change with surprising frequency. Those doctors trained in the managed care era tend to complain less of these stresses, and are more focused on early career issues such as paying back loans and attempting to balance work with the demands of starting a family. Time will tell whether the visibly painful reaction of many doctors to the changes in health care delivery is related to the loss of former practice conditions or is a more sustained response to the reduced decision latitude that has resulted from them.

Work stresses can be classified as chronic versus acute, and as traumatic versus non-traumatic. Ethical conflict, for instance, can result from a need to maintain high clinical standards while striving to save society's resources by reducing health care costs.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 4 of 16

This chronic pressure differs from the conflict that might arise acutely when one is struggling with a need to report child abuse on the part of a severely ill patient who may leave treatment, and expose himself to potentially fatal consequences, if the physician reports him. Traumatic stress can also be acute or chronic. If a doctor is assaulted by a patient the stress is acute; if sued by the patient the stress occurs over a period of years.

It is my opinion that the traumatic stresses of being a doctor are under-appreciated. Weissberg (28) studied health care personnel who treated victims of an aircraft disaster and found that most of them suffered significant symptoms of PTSD for many months. In a pilot study, this author, with Weissberg, studied a number of physicians attending a conference and found that the majority of them, at some point in their careers, had blamed themselves for the death of a patient and suffered symptoms of PTSD and depression for months afterwards. The subjects reported such experiences more than twice during their career to date. Even more frequently they experienced other traumatic events that were sufficient to cause symptoms, a phenomenon noted by others (14). These events included being assaulted by patients and being exposed to disaster victims or unusually grotesque patient injuries. One could measure in years the amount of time these physicians spent suffering during their careers. Certain potentially traumatic stresses, which may be either acute or chronic, include discrimination. Gender bias and discrimination, as well as sexual harassment (perpetrated by colleagues, staff, or patients), are more likely to be experienced by women physicians.

Balancing work with family and avocational life is one of the great challenges of being a physician. In the author's experience, the best clue to whether one is able to do this is one's past behavior. In high school, medical school, internship, residency, and early practice years, there are those that can achieve balance no matter what the pressures. As for the rest of us, it proves difficult. Moreover, many doctors do not learn from their mistakes in this area. A personal crisis may be necessary to get the physician's attention. As the doctor forces himself to focus more on home and other people, the crisis fades. Soon, the danger is forgotten, and the toll of work stress is again taken. While families cannot compete with the urgency of medicine, and are forgiving of being cast on the back burner for a time, in the long haul resentment may build in a malignant way, causing irreparable damage. The phrase "medical marriage" conveys the idea that marriage is different when one or more doctors is involved; in attempting to conduct a successful marriage, a physician has his or her work cut out for him. Indeed, though the process of finding life balance is not strictly a matter of work stress (in fact, a doctor may suffer the consequences of imbalance even though his work may not be inordinately stressful), it is a ubiquitous source of stress for the hardworking physician.

The contribution of home stress to the overall stress of the physicians, and of work stress to home stress and thus to overall stress, was for many years not considered or studied. There are currently various theories as to how home and work experiences interact. "Additivity" (26) occurs when home and work stress add to each other or when the benefits of home and work satisfaction create greater well-being. The phenomenon of asymmetric permeability suggests that there is not equal bidirectionality in the stress contribution of home and work. That is, for many physicians, work stress adds to home stress more than home stress adds to work stress.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 5 of 16

This appears to be true for both female and male doctors. Further, stress is a function of role complexity, and because women doctors experience greater role complexity than males they are subject to more stress. Women physicians tend to alter their work schedules to accommodate home demands more than do male physicians.

WORK STRESS SYNDROMES

There are two physician work stress syndromes that have been described. One, burnout, has an extensive literature that addresses medicine as well as other lines of endeavor. The other, malpractice stress, has been written about extensively but only studied to a degree.

Burnout (10,11,15,16,18,21,22, 29) is typically defined by the triad of emotional exhaustion at work, negative self-esteem associated with work, and a loss of personal satisfaction at work, including losing feeling for individual patients and instead focusing on disease. Negative changes in attitude, mood, and behavior are essential to the "diagnosis". Burnout does not appear to correlate in any simple way with hours worked or length of time in practice. It may more likely occur in generalists than specialists, solo than group practitioners, in private than academic settings, and in those who treat chronic than acute illness. Burnout is associated with a number of other symptoms, including work avoidance, unfriendly or irritable behavior at work, somatic complaints, and increased conflict or tension at home. Many studies show that as many as 30-40% of physicians suffer from such symptoms to the extent that it interferes with personal or professional life. In a study of physicians in the Northwest Permanente group (22), burnout was assessed along a continuum of severity, in which 2% to 11% had significant problems at the time of study. In some studies, career long prevalence of burnout is in the vicinity of 40-60%.

The natural history of the syndrome is unclear, but many studies, including those of the author, suggest that it often occurs more than once in a career. Also unclear is the manner in which burnout resolves. Is it by physicians changing aspects of their practice, changing their attitude toward practice or toward other important aspects of life, or by simply "taking a break" from the stresses of work that burnout resolves? Burned out doctors report that all of these strategies are useful, but which for whom is not established.

In the above referenced Kaiser study, physicians cited a variety of factors as causing burnout, which roughly correspond to those associated (and mentioned above) with stress. Northwest Permanente also proposed interventions aimed at ameliorating burnout, which involved increasing the doctors' involvement with workplace management, increasing their say in decisions about workload, and encouraging collegial communication and professional stimulation.

That burnout is caused simply and only by work stress is a difficult proposition. In principle such causation is possible, as it is for post-traumatic stress disorders. In reality, like those disorders, complexity of cause is probably the rule rather than the exception.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 6 of 16

Biologic vulnerability, home or "personal" stress, concurrent mental and physical illness, exposure to previous severe work stress or significant trauma, and the presence or absence of other self care activities (i.e. patterns of sleeping and eating) are likely relevant etiologic factors, but the degree of their relative contribution to the problem is unknown. Given that some physicians like to vacation in New York City, and others on an isolated beach, it is likely that personality and personal styles and preferences also play a role. It is probably safe to say that no one is immune, and that no one is doomed to experience burnout.

Medicine, a helping profession first and foremost, includes practitioners that may be especially prone to suffer when malpractice, or hurtful activity, is alleged. The central feature of the stress caused by such litigation is the feeling that one's integrity as a professional has been assaulted, as reported by Charles et al (3) and others. According to Charles, sued physicians often experience a variety of depressive symptoms, and usually become angry and tense. A variety of physical symptoms are common, as in burnout, such as fatigue, gastrointestinal complaints, and headache. Physicians feel betrayed by their patients and their profession, as if all the good they have wrought and the help they have provided was without worth, their dedication and sacrifice meaningless. Doctors who are being or have been sued report greater work stress, psychological trauma symptoms, and feelings of shame and self-doubt than do those who have never been sued (3). They tend to practice more defensively, ordering more tests than necessary, feeling less confident (3, 13). While self-doubt and shame diminish and confidence returns with time, the distress caused by malpractice litigation goes on for years. Winning the case, by far the most common outcome, helps the physician to some extent, but does not erase the scar left by the extended stress and uncertainty.

One way of conceptualizing the stress of exposure to malpractice litigation is to think of it as a massive increase in mental workload and a near complete loss of decision latitude. Heightened mental workload is manifested by doctors ruminating about the events that are the subject of the suit and feeling overwhelmingly burdened by guilt and worry. Decision latitude is lost because the suit, after all, is brought by patients through their attorney and is completely out of the control of doctors. The landscape in which this "battle" is fought, that of the law, is both foreign to physicians and in a sense out of their reach; it is the adversarial land of attorneys, judges, and juries, in which doctors must be represented and cannot act as their own agents. (Those who choose to represent themselves, to appear in legal proceedings pro se, generally fare poorly).

This view suggests that if mental workload associated with the suit could be reduced, and decision latitude could be increased, stress could be reduced. Thus, sued doctors should be encouraged to work actively with their attorney rather than shy away from participation or otherwise attempt to control the legal process. Sued physicians should literally seek counsel from their counsel, apply themselves to tasks of the suit, and regularly let their attorney know with what they are struggling, intellectually and emotionally. Physicians should ask their attorney about what they should be worrying, and about what they should not worry and let their attorneys address. The lawyer is often the primary psychosocial support of the sued doctor.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 7 of 16

At the same time, it is helpful to limit the extent to which one feels controlled by and mentally absorbed by the lawsuit. This task may be aided by doctors considering that managing a professional liability suit is but one of their professional responsibilities and should be treated as part of the job. This implies that it may be left at work with other work problems. Protection of leisure time, pursuit of leisure and avocational activities, and investment in family and loved ones are all useful in coping with malpractice stress. Indeed, re-thinking one's life priorities is one of the good things that came from this difficult experience.

Wilbert (30) has reported that physicians that cope well with stress do better with malpractice litigation stress than those doctors who cope less well with other stresses. This may seem obvious, but as this author mentioned in the above discussion of balancing life, some doctors seem much more adept at coping with these matters while others struggle throughout their career. One can only try to heed the advice of those who manage this stress more successfully: Share distress, seek advice and support, and strive to keep life balanced.

In today's world, malpractice litigation is but one of many causes of stress associated with feeling challenged or professionally assaulted. It is common for doctors to be questioned about their clinical care or behavior in clinical and other settings, or to receive adverse reviews from peer review committees, hospital credentials committees, hospital and practice administrators, and regulatory agencies. Such scrutiny can induce great stress, and possibly precipitate suicidal action (12). It is this author's view that associated with all these stresses are two basic reactions, fight and flight.

In the fight mode, the physicians feel outraged that their work is questioned, tend to demean or dismiss the "accuser", and want to fight every comment and every issue. They ultimately become isolated by their angry and intimidating approach. In the flight mode, doctors' feelings are dominated by shame; they tend to avoid confrontation, which may include appropriately standing up for themselves or obtaining counsel to do so for them. They too end up isolated, in painful, avoident retreat. In many cases physicians oscillate between one mode and the other. Clearly, keeping emotional isolation to a minimum should be a goal for any doctor in this position. Treating such challenges as occupational hazards and approaching them as work responsibilities to be addressed professionally is the most helpful framework.

ASSESSMENT

It is useful to remember that physicians generally do not seek help early in the course of their difficulties. By the time they seek professional evaluation, doctors have frequently informally "consulted" colleagues, and put off further action until their level of distress is quite high (6). Keeping this in mind will aid the evaluator in guarding against a tendency to underestimate the degree of distress, extent of illness, and amount of impairment that the physician patient may be experiencing. This tendency to underestimate the problems of fellow physicians often results from overidentification with the physician patient who is presumed, like the evaluating doctor, to be basically healthy. The other common problem among those physicians who evaluate physicians is the tendency to be insensitive to doctors' needs to be treated with some deference and extra

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 8 of 16

consideration. This attitude is frequently a response to feeling challenged or threatened, either by the physician patient's stance (e.g. haughty, demanding, intimidating) towards the evaluator, or by the evaluator's anxiety about assessing a colleague. Those seeking help will often fail to follow through when treated in this manner. In fact, both under-reacting and over-reacting are reflections of anxiety in the evaluator. Those engaged in the assessment of physicians should be alert to both of these potential hazards, which ultimately may interfere with good clinical care.

The assessment of a physician who presents for evaluation of work stress should include a standard thorough psychiatric history, review of symptoms, and mental status examination, as well as medical history and workup as appropriate. Obtaining a work history is very important, and should begin with early work experience prior to becoming a physician. The evaluator should inquire about the reasons the doctor chose the profession, including both internal and external pressures to do so. An assessment should be made of what, consciously and unconsciously, the doctor hoped to be the rewards of becoming a physician. Subsequent hindrances and disappointments should be noted.

The nature of the physician's work, amount of mental workload, degree of decision latitude, adequacy of coping resources, ability to use support systems, current or recent stressors, and other more chronic sources of stress should be examined. Any recent changes in the workplace, in any dimension, should be noted. The doctor's view of the problems and their potential solutions should be explored. It is useful to inquire about any previous experience of work stress and what was helpful and not helpful in managing it. On occasion, the use of a formal assessment tool may be of help (13, 16); the results must be correlated, as in all testing, with the clinical picture. Collateral sources of information are invaluable, especially the physician's spouse and, at times, children, colleagues, and supervisors.

A 51 year old internist presented for evaluation with complaints of being more irritable with his children. He denied problems other than severe work stress. His wife, a family practitioner, came in with him for his second interview, adding that he took very poor care of himself in terms of sleep, eating and allowing himself time with their family. These problems were so serious that the stress caused by work could not be addressed until he confronted his disregard for his basic needs.

A 45 year old family practitioner from a rural area was referred for evaluation because of disrespectful behavior at his local hospital. He reported that his partner had left the area in which they practiced, leaving the whole town's care in his hands, not to mention "many miles of interstate" for which he was responsible in case of accidents and injuries. He immediately added that, for a variety of reasons, things were much better now. His office manager and nurse were contacted, who reported that nothing had improved, and in fact the physician appeared more stressed day by day.

Ultimately, any plan to address work stress cannot be imposed. Effective intervention can only take place when the difficulties and their potential solutions are appreciated and endorsed by the doctor. Luckily, for many stressed physicians, even a modest improvement in work stress can result in an enormous sense of relief and rejuvenation.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 9 of 16

DISTINGUISHING WORK STRESS FROM OTHER CONDITIONS

As in much of medical and psychiatric practice, a good history is essential for an accurate diagnosis to be reached and effective treatment plan elaborated. Some doctors will present for work stress problems who are primarily depressed; others complain of depression and the examiner finds that the primary problem is work stress.

A general surgeon in his fifties presented for evaluation complaining of work stress, wanting help in convincing his colleagues that he should be allowed to work part time and take less call. Review of psychiatric symptoms revealed that presence of depressed mood with multiple biovegetative symptoms. Other stresses included a recent heart attack from which he was physically recovering well but which had left him frightened, and family problems centering around a teenage daughter. He was referred for psychiatric treatment and family therapy. He was encouraged to talk to his cardiologist about his concerns about his limitations and prognosis. After several months of care he reported feeling that work was not really the problem, and resumed his usual duties.

A 33 year old female family practitioner presented for evaluation wanting to understand why she could not shake her depression despite psychotherapy and pharmacotherapy. Her psychosocial system was intact and positive with the exception of work. She was employed at a public agency where she treated a large caseload of demanding patients who were afflicted with so much chronic illness and in possession of so few social resources that little definitive could be done for them. With help, she was able to articulate how deeply disappointed in her work she was, and how much she longed for a practice in which she could be effective. Additionally, the leadership of her agency had changed and she had less voice in policies and procedures. She ultimately chose to join a small private practice in which she felt appreciated and efficacious. Depressive symptoms promptly lifted.

One's differential diagnosis must in principal include the gamut of medical and psychiatric illnesses. In practice, the most frequently occurring problems from which to differentiate work stress include unipolar and bipolar depression, various anxiety disorders, substance abuse, other (non-work) causes of stress (e.g. divorce), and medical disorders likely to present with subjective depression and anxiety complaints. Such medical disorders most commonly to be considered are thyroid disease, neurologic disease, metabolic disorders, and AIDS. The importance of differential diagnosis cannot be overestimated. All physicians who report work stress should be evaluated thoroughly for other illness. Conversely, work stress should be considered in all ill physicians.

A young physiatrist complained that work stress had robbed him of his previously easygoing attitude at work. He attributed most blame to the payers who had cut back on remuneration in his specialty, and were requiring more paperwork. He reported increasing headaches, and had in fact had medicated himself with narcotics. He became so disturbed by his self medicating that he stopped taking the drugs and presented for evaluation. He had no primary physician and had consulted no one about his headaches. Upon referral to a physician he discovered that he suffered from high blood pressure which was immediately reversed by medication, resulting in his becoming headache free.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 10 of 16

He re-experienced a feeling of well being that extended to confidence that he could manage his work problems. He remarked, in retrospect, that the presence of intractable headaches had convinced him that work was toxic for him. Follow up demonstrated that the he returned to enjoying his professional activity.

When a significant concurrent psychiatric or other medical condition is identified in conjunction with the work stress assessment, it is essential that it be treated. Work stress is not likely to resolve in the presence, for instance, of untreated depression.

The question of work impairment is an inevitable, but often overlooked topic when evaluating a physician. Most evaluators, be they psychiatrists or other doctors, are not in a position to actually evaluate whether the stress or illness is adversely impacting the physician patient's ability to practice medicine with skill and safety. In fact, most stresses and illnesses, even when severe, do not impact the doctor's ability to practice good medicine. In evaluating the stressed physician, however, it is always important to ask if they, or those close to them (spouse, office staff, colleagues), have concerns about their functioning at work. If the evaluator has reason to believe that work function is compromised in a manner that could adversely affect patients, it is wise to counsel doctors to stop practicing for the moment, refer them to the state peer assistance (or physician health) program, and to engage them in or recommend for them appropriate treatment or respite. Depending on the laws of the jurisdiction in which the evaluator is practicing, should the doctor insist on continuing to practice under these circumstances, the evaluator may have a duty to report the matter to the appropriate licensing agency. It is difficult for the evaluating physician to take such a step but it is often life saving for the physicians and their patients. It is, after all, stressful to be the doctor of a doctor (23).

PRACTICAL GUIDE TO MANAGING PHYSICIAN WORK STRESS

The subject of this lesson has required that discussion of treatment or management issues be woven throughout the various topics. There will be therefore some repetition in this section. Activities that may help in managing work stress can be divided into three types: altering work, altering attitudes toward work, and promoting self care. Obviously, these are not mutually exclusive areas of activity, and in fact are probably mutually helpful.

One can examine, for instance, how to increase decision latitude and reduce mental workload in any work environment. If time spent in dealing with managed care entities is increasing mental workload, streamlining procedures or delegating responsibility may be helpful. If certain types of patients prove especially stressful for the doctor, decision latitude may be increased by getting more education about how to work with them, or by referring them elsewhere. If the organization which employs the doctor is demanding too much work, decision latitude may be enhanced and mental workload potentially reduced by participating in the group that prescribes workload or designs schedules. These examples illustrate common problems that the average doctor knows full well how to approach. Doctors also know that such problems are not really so simple and that they are never resolved. Delegating responsibility may involve hiring employees which costs money.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 11 of 16

Joining a committee that determines workload may take more time from home and family. The problems physicians face at work are often best conceptualized as tensions that can be reduced or heightened, not as problems that will go away or admit of definitive solution. However, the dimensions of mental workload and decision latitude do describe a landscape in which one can search for effective strategies to reduce stress in the workplace.

Changing one's attitude toward work is a very powerful activity which is also closely linked with self care. The simplest example is to consider how a crisis changes one's perspective. In fact, as suggested above, many physicians make temporary changes in attitude toward work precisely when their spouse says they can't tolerate any longer the doctor's work orientation. There is a sudden, if time limited, realization that work isn't so important. A threatened marriage, illness in family members, illness in oneself, even a malpractice suit can all forcefully reframe for a physician where the true north of existence is to be found; it is usually not found at work.

A far more preferable way of changing one's attitude toward work is to initiate such change out of a wish to reduce stress and enhance meaning in life, rather than simply waiting for a crisis to knock wisdom into one's head. As Phifferling (16) has pointed out, many physicians are more reactive than proactive. Attitude changes are more likely to be sustained if they arise out of a thoughtful process in which the needs, cares, and values of the doctor are the starting point for allocating investment of time and energy. Therefore, to begin the process of finding one's most beneficial attitude towards work, physicians should contemplate and articulate that which is important to them. Such an inventory should consider the physician's values, and extend to which people, relationships, activities, and states of mind are most central to meaningful life. The resulting creation, whether written or not, becomes the cornerstone for making decisions about how to spend time and other resources. It also becomes the touchstone for restoring perspective during the chaotic or murky moments in life. The touchstone must be used, however, to be of benefit. Crises will not be prevented, nor satisfaction enhanced, by just thinking it through once and not revisiting it on a daily or weekly basis. Discussing these matters with one's spouse, friend, mentor or psychiatrist is also useful. All of the above effort requires time and energy. Making the effort, and taking sufficient time to do so is part of what may be called self care.

Self care is a phrase with intuitive appeal but which is defined in vastly different ways, leading to contrasting approaches to the problem.

As noted at the beginning of this lesson, the use of this expression in the physician health field probably evolved out of the need for physicians recovering from addiction to actively apply 12-step principles to their lives. For Erica Frank (7), whose pioneering work in learning about the self care of women physicians employs some of the best methodology in this literature, self care involves wearing seat belts, drinking reasonably, refraining from smoking cigarettes, managing dietary fat and obtaining timely medical screens including PAP's and mammograms. For some authors (11,16) self care is getting adequate sleep, nutrition, and exercise. From the social science perspective self care has to do with the activities of lay people which, added to those of medical professional, aid in the amelioration of health problems.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 12 of 16

Such activities may include the use of support groups, getting proper sleep, nutrition, and exercise, use of "alternative" medicines and treatment techniques, relaxation or meditation routines, and the use of a variety of educational tools. For the purpose of this lesson, the author will utilize the practical perspective: What can doctors do to appropriately care for themselves?

Self care problems arise in association with work, with home and family and other relationships, and with solo existence. Time management issues weave through all areas. The essence of work related self care is to be realistic and limited in the amount of work. This involves not only the workday, but perhaps more importantly when doctors are away from work (16). For instance, making sure one shares call with colleagues, something many physicians take for granted, is basic. Taking regular vacations from work is also essential. This does not include going to professional meetings. When vacationing, doctors should not bring work along (16).

A young family practitioner requested help on referral from the medical licensing board because he had gotten so far behind on his paperwork that he'd never sent in his medical license renewal form. When asked about his practice, he remarked, seemingly without thinking much about it, that he was on call for his patients seven days a week, and hadn't taken a vacation in the 3 years since he'd entered practice. He noted that his wife had been keen on his coming in for evaluation and referral; she too was a physician but could not understand the degree to which her husband's life was shaped by work demands.

When at work it is necessary to set appropriate limits, not only in order to address specific situations, but in order to let staff, colleagues, and patients know that one has limits. In order to be successful at work related self care, physicians must confront their belief that they are indispensable, a deeply held if often denied idea. Physicians often believe that only they can care for their patients. Further, doctors must look coldly at the other most common rationalization for problems in work-associated self care, that they will lose referrals or financial benefits if they share call, take vacations, set limits, or delegate work. While there are rare instances in which significant practice or financial consequences accrue, in the vast majority of situations, working more reasonably does not measurably alter the health of one's practice.

Physicians are taught to be self reliant and to never shirk the responsibilities of caring for patients. These teachings reduce the ease with which doctors are willing to use their emotional support system, and to take the time to do so. It is essential to spend sufficient time with spouse and family, and for that time to have the quality of emotional openness. This frankness should involve talking about work stress, "sharing the burden", but much more than this. It is equally important to share feelings of all kinds, and to listen to others. The rewards of life are not as tied to work accomplishment as many doctors think. Life's satisfactions are intimately tied to emotional connections with loved ones. Rewarding relationships further buffer the physician from work stresses. It is also important for doctors to develop and use a support system of colleagues. Colleagues will listen to physician's work problems long after family is tired of hearing about it. Some doctors find it useful to have a colleague who is willing to tell them when one looks to be stressed, is behaving badly, or is otherwise in trouble.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 13 of 16

A psychiatrist in his 40's reported that he sought help with stress when confronted by his colleague. "We've had an agreement for 15 years that we'd tell the other guy if one of us was acting crazy. I've been pretty irritable. Its good to have someone call you on it."

Self care in the solo sphere is often the most difficult area for physicians. Having been trained, and often raised, to attend to others' needs, doctors sometimes feels selfish and self indulgent when they attend to themselves, especially if they believe another party will as a result feel deprived or angry.

A 60 year old internist reported overwhelming stress at work and at home. When asked what he'd considered doing about it, he replied, "Go to a desert island. That's all I can think of. If I take more time off work, my family will just expect more from me. I'd feel too guilty to take that time for me. I wouldn't even know how."

While few physicians would argue that sleep, nutrition and exercise are selfish activities, doctors are notorious for compromising these matters if patient care or family demands are high. Physicians, like all human beings, require time alone. Many doctors do not consider contemplation, meditation, and relaxation to be "productive" endeavors; they are nevertheless essential parts of self care. Physicians often downplay the spiritual aspects of existence. An elemental view of self care places one's spirit in the center of the stage (18). All activities that nourish the self, soul, spirit (or whatever word best describes one's innermost being) are spiritual. This nourishment may be attained by watching a sunset, listening to a late Beethoven quartet, going to church or synagogue, praying, meditating, pursuing an artistic endeavor - the means are both personal and universal. Most physicians can identify for themselves the activities most likely to be so nourishing, but often put them off or reduce their frequency to an extent that is harmful. For many physicians, even a modest but regular increase in the experience of such nourishment leads to reduced stress, invigoration, and a more balanced approach to work and life.

Many doctors will be unable to implement better self care and reduce stress without help. Help may be informal or formal. Informal help may come from simply letting family, friends or colleagues know what one is intending to do to better the situation; these individuals can then inquire about the doctor's success, and thus serve to confront procrastination or ongoing distress. Formal help may be obtained from psychiatrists, other physicians, or other mental health professionals who have experience in working with doctors. Many physician health programs, such as that in Colorado, offer such experienced evaluation and support. Intensive workshops or training are available from time to time for physicians wanting to gain skills for reducing stress. These are most effective when used in conjunction with ongoing counseling which aids physicians in maintaining their focus on effecting change in everyday life.

SUMMARY AND CONCLUSION

Physicians are subject to significant work stress, which appears to be on the increase. Work stress negatively impacts both work and home life. Physicians are bred, if not born, to care for patients first, attend to their families later, and themselves last. Because the doctor who asks for help usually does so only when the problem has evolved considerably, those evaluating doctors must take seriously all complaints, including apparently straightforward ones such as work stress.

PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 14 of 16

It is not easy for physicians to evaluate their colleagues. Once assessment is complete and work stress found to be a significant problem, doctors should be encouraged to examine ways to change their work situation, their attitude towards work in the context of their life priorities, and to implement appropriate self care. These tasks require time and energy, support from family, friends, and colleagues, and sometimes professional assistance.

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PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 15 of 16

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PHYSICIAN WORK STRESS – Part I

Michael H. Gendel, MD

Page 16 of 16

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