

PHYSICIAN WORK STRESS – Part III

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INTRODUCTION

Introduction: Though CPHP is known for its work with physicians and physician assistants with health concerns, we often have the opportunity to work with those who are struggling with a wide variety of challenges related to their work. Here I will describe some common problems which we see and how we try to help. By the way, for shorthand purposes, I'm going to refer in this article to our clients as physicians or doctors, even though they may be residents or medical students, physician assistants or physician assistant students.

Bad patient outcomes: It's not unusual for CPHP to receive a call from a distressed doctor who has just experienced a bad patient outcome. They are usually self-referred (our most common source of referral), though a colleague, supervisor, or spouse might have been a source of encouragement to make the call. We physicians are devoted to our patients and while we recognize that the power of illness may be at times too great, and that lightning sometimes strikes even in lower risk situations, it's often extraordinarily painful and frightening when something goes badly wrong. An otherwise healthy patient who dies on the operating table, or the delivery room, can be a shock that can significantly impact a surgeon or obstetrician. A debilitating complication of surgery or of pharmacotherapy can have a similar effect. The suicide of a patient, even one with a chronic, worsening illness, or of an addicted patient, is another very disturbing outcome. We have seen examples of all of these and more.

What such incidents have in common is the effect they can have upon the doctor. Almost universally there is a sudden stock-taking of one's work, its purpose and meaningfulness. One may wonder if it's worth it, continuing to practice. Self-doubt, guilt, and loss of confidence may intrude for a time, possibly a long time. As Gabbard and Vaillant have pointed out, physicians tend to be vulnerable to self-doubt, guilt, and an exaggerated sense of responsibility, and these traits may come to the fore after a bad outcome. One may be reluctant to go back to work, to perform the same procedure, or to accept a patient with similar problems. Sometimes, in the background, is the fear of getting sued, but usually this is only in the background, because for most physicians, the failure to be helpful and effective is the crux of the matter.

I find it surprising that doctors can do what they do, and do so mostly without paralyzing fear of something going badly wrong. After all, many of our patient's illnesses have poor or uncertain prognoses, are unstable, and much about the illness isn't within our control. Actually, we have to have a certain amount of healthy denial of these worrisome contingencies in order to get through the day. Many surgeons have told me that even when facing long odds in a difficult and dangerous procedure, they go into it fully expecting to succeed, "to hit a home run". At the same time, we have to be compulsive about considering every adverse outcome and not overlook anything. This represents quite an emotional challenge. But it's no wonder that we are often stopped in our tracks when confronted by an event which represents our worst fear for the patient. The near-overconfidence that we require to function cannot be maintained, at least for the moment. And when this occurs, many physicians feel suddenly lost. They may have questions about what's to be done, how and when and whether to work.

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Sometimes they are reluctant to talk to family or colleagues. They may wonder if they have become depressed, or if they require some help in dealing with the incident.

CPHP recognizes that physicians who have experienced bad outcomes frequently have an urgent need for assistance. We do our standard intake evaluation, but, obviously, focus the on assessing the immediate situation and needs of the physician. Often, the intake interview itself helps a lot, as we sort out the doctor's feelings about what happened, and begin to help them see it in the context of their overall practice and career. We try to help the doctor identify who is likely to be most supportive to them, and what kind of support they require from those parties. It's also important to listen to the situation with an ear to those things unique to that doctor that shed light on how they are responding: Previous similar experiences (or lack thereof), past family or developmental experiences which make them more vulnerable, the point in their career in which the event occurs, whether or not they suffer from a health condition or significant non-work related stress that lowers their resilience, the presence of burnout, and so forth. We will help the doctor sort out whether they need some specific psychotherapeutic help or another kind of professional support, and will refer them if needed. Mostly, these situations begin to resolve within a few days, sometimes weeks, and usually without professional help other than a follow-up meeting or two at CPHP. At CPHP we don't do treatment, but in these kinds of crises the evaluation and follow-up process itself often facilitates the physician's working through the matter. These crises are so significant that many doctors look back on them as a moment when they redefined for themselves some important aspect of their relationship with their work, with their life outside of work, or with themselves.

Malpractice stress: One of our previous newsletters (2001) dealt to a degree with malpractice stress in the context of an overall examination of physician work stress. I mentioned there that one of the things that makes this so difficult is that unlike most things in our work life (but akin to the bad outcomes issue discussed above) a malpractice case is largely out of our control. It's a legal matter, not a medical one. The nature of this stress and how to manage it is an article – or book – in its own right. However, because we see this issue not infrequently, I include a few words on the subject here.

Malpractice stress comes in several shapes and sizes. In some cases there is no hint of a malpractice claim, but because of a bad outcome, or sometimes an unhappy patient even in the absence of a clear bad outcome, it weighs heavily on the physician's mind. In other cases there is a threat of suit or some preliminary stage of legal action prior to a lawsuit, but it may already feel like a reality to the doctor. And of course there's the suit itself, a process that makes even looking at the mail traumatic – each time there's your attorney's return address on an envelope your heart rate goes up by 20 beats. Not to mention what's inside, often filled with documents that refer to you as "the defendant".

The other thing that makes malpractice stress so profound is the vilification of the doctor being sued. The language of a lawsuit is extreme, whether in the countless written documents or in deposition or courtroom testimony. It's adversarial, and the slow, almost inexorable pace of the event, usually lasting years, wears us down. The emotional burden is heavy: Concern about the patient if there has been a bad outcome, the blow of losing (or imagining having lost – it isn't always the case) the trust of the former patient, compulsive review of whether or not one

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erred in providing care, fear of loss of respect of colleagues, friends or family, loss of self confidence or feeling like one is a bad doctor, fear of financial consequences, defensive practice, and the pressure of ongoing practice because medicine never stops. These are just a few elements of the burden. There is much on our mind, much of the time. Extremely high mental workload, from a technical standpoint.

It's no wonder that under this kind of stress physicians will often refer themselves to CPHP, or their colleagues, families or attorneys may do so. It may be an acute crisis or a chronic, corrosive emotional situation. Having the opportunity to talk openly about one's feelings, including feelings about practice, without fear of burdening family members or presenting a worrisome picture to colleagues, can be very beneficial. We evaluate such doctors, as always, comprehensively. Sometimes the stress results in a medical disorder that requires workup, and sometimes in an anxiety disorder or depressive disorder which requires treatment. As in the bad outcome circumstances, often simply going through the evaluation process is helpful, though in some cases treatment referral, if only for the purpose of coping better with the stress, is recommended. Many such doctors have questions about how to approach work more positively. We have enough experience with physicians, having evaluated and followed close to 2300 by now, that we often can address such problems.

Perhaps not surprisingly, we often find out about a malpractice case in the background when a physician presents with another problem, such as burnout, depression or anxiety, substance abuse, physical problem, family problem, or workplace behavior issue. The toll taken by malpractice stress is considerable, even under the most favorable of circumstances. Granted, one audience member spoke up during question and answer after I had given a lecture on malpractice stress, saying that when he was sued he felt no stress, and such stress was created entirely by people like me who create a negative expectation. I guess malpractice stress is not universal.

One's malpractice liability carrier may also offer support for the doctor who has been sued. For instance, COPIC offers support groups (they are not therapy groups) in which doctors, and often their spouses, at all different stages of the lawsuit process, can talk to each other. Additionally, a company's claims manager may be quite helpful. Finally, I think that one's malpractice attorney is an invaluable source of social support.

The ever-changing workplace: As Heraclitus said, you can't step into the same river twice. And so it seems to be in most situations in which we physicians work. Coping with change in the workplace is usually a chronic, or at least a frequent, episodic challenge. Unfortunately, at CPHP we rarely hear about changes that enhance the doctor-patient relationship. Physicians are often asked to see more patients in less time and to supervise more individuals that assume some of the role previously played by the doctor. I don't need to tell any reader that there are so many third parties between the doctor and the patient, including, often, the managed care company, that both the doctor and the patient often spend more time talking with these parties than they do each other. As expensive as healthcare is, there seems to be less and less financial resources for patients and fewer financial rewards for physicians. Many doctors work harder for less money, each year. Many physicians work in hospital or care delivery systems in which the indigent or uninsured are the primary patients.

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The viability of such systems is frequently balanced precariously, creating a feeling of shifting sand under the feet of both doctors and patients. At times, only the deep commitment of physicians to their patients, and the similar commitment of many other healthcare personnel and administrators, keeps us going.

The diminished doctor-patient relationship is not just bad for patients. At CPHP we hear from physicians for whom the relative loss of these relationships has diminished their satisfaction in their career. We often see doctors in transition: From private practice to HMO, and visa-versa; from individual to group practice, from one practice to another, trying to find one that fits; from one specialty to another. We see many doctors in some phase of the retirement process, in some cases quite early, age-wise. Many want help in finding another career, inside or outside of medicine (we refer to career counselors with extensive experience with doctors). Others, in medical school, training, or early practice are finding treating patients much different than they expected. Meaningful doctor-patient relationships are often what these doctors are looking for, trying to find working conditions where such a relationship is possible, and in which the stress of work is bearable. CPHP is a place where many physicians choose to discuss their efforts, disappointments, and concerns in this area. Some may question whether medicine is for them. Sometimes they blame themselves unrealistically for the problems they have encountered. Often this subject is only one of many issues that brought them to CPHP, but in recent years we have seen more doctors coming in with presenting problems of this type.

Summary: Our mission statement at CPHP addresses the health needs of physicians, but in working with a large number of doctors since 1986, we have had the opportunity to work with a wide variety of work-related problems that don't fit neatly into this rubric. At this point we are very interested in learning more about these matters, and hopefully providing some assistance.