

# PHYSICIAN HEALTH

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State of knowledge and  
preventive approaches

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SANDRA ROMAN, M.D.

CLAUDE PRÉVOST, M.D.



PROGRAMME  
D'AIDE  
AUX MÉDECINS  
DU QUÉBEC

## About the authors:

### Dr. Sandra Roman

Family Physician, physician advisor at the Québec Physicians' Health Program (QPHP) and at the Direction de santé publique du CISSS Laval

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### Dr. Claude Prévost

Specialist in Public Health and Preventive Medicine at the Direction de santé publique du CISSS Laval

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## Preface

The general public usually perceives physicians as being very healthy. Not only do they belong to a privileged social group, but it is also hard to imagine physicians being unable to treat themselves when they present with symptoms of a disease. Moreover, one might think that physicians should be able to avoid burnout, since they are self-employed and thus manage their own workload. However, as shown in this document, this is not the case at all; indeed, physicians are at a higher risk of suffering from an array of mental health problems that can lead to suicide, substance abuse and burnout.

It is this enigma that a group of Université Laval researchers, including myself, sought to understand as part of a study carried out on Québec physicians who were forced to temporarily step away from their medical practice due to mental health problems.\* This study showed us that physicians are not as independent as is generally believed — in fact, they are accountable to a number of superiors! They answer first and foremost to themselves, given that they tend to be perfectionists and workaholics, character traits that have generally served them well in their academic and extracurricular undertakings, notably enabling them to be admitted to medical school. They are also at the mercy of the profession itself, which, as embodied by colleagues and prescribed by their college or regulatory body, sets high standards for medical practice, meaning that physicians must remain up to date in a world where knowledge and expertise are constantly evolving. Finally, perhaps their hardest taskmaster is society, whether as a whole or in the form of each individual patient, given the high demands it places on doctors. In order to satisfy these personal, professional and social demands, physicians must give unsparingly of themselves, and burnout often ensues because of their attempts to do so. They also struggle to bridge the gap between what their professional conscience perceives as standards of good medical practice, and what they can actually do with the resources they have at hand (staff, time, equipment, etc.). This obligation to compensate for the system's inadequacies can lead to a state of ethical suffering and a disengagement from work, especially when medical practice flies in the face of the physician's values. One physician told us: "What they ask us to do, what the standards require, and what we're allowed to do — but without the necessary resources — none of it matches up, so we're constantly facing moral dilemmas."

It is thus encouraging to observe that this document goes beyond a preventive approach centred solely on the individual and his or her weaknesses to include a community and organizational dimension. This type of approach helps counter pre-conceived notions regarding physicians with mental health problems, which were reflected in the following type of remarks voiced during our interviews: "If a doctor has a heart attack, people say, *He collapsed on the job. He did himself in by working too hard.* But if a doctor has to stop working because of burnout, people say, *He wasn't strong enough. He couldn't take the pressure.*"

By making peer exchange and support a key component of the preventive approach, this document seeks to address the root cause of the problem, that is, the tacit silence and denial around this issue. This will help create forums for discussion of how current standards for sound medical practice can be applied, while offering physicians the assistance they need to find solutions to certain problems in their practice.

### Michel Vézina, M.D., FRCPC

Professor, Département de médecine sociale et préventive, Université Laval

Medical Advisor, Institut national de santé publique du Québec (INSPQ)

Research Associate, CHUQ Research Centre

Direction de recherche du Centre de Santé et des Services sociaux de la Vieille Capitale (CSSSVQ)

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# INTRODUCTION

Medicine is a demanding profession in all regards: the workload is heavy, the hours long, and the levels of stress and responsibility high. In addition, physicians are regularly confronted with suffering, and must address sometimes complex ethical dilemmas. And yet, it is a field that has always had broad appeal, managing to attract outstanding candidates who are prepared to take up the numerous challenges inherent to the profession.

However, many elements point to a profound malaise within the profession: its members are becoming increasingly dissatisfied. This dissatisfaction is especially apparent within health-care teams, which are more and more vulnerable due to a lack of resources. An ever-larger number of our colleagues are speaking out about their distress. Physicians are experiencing more and more work-related stress, and burnout is becoming increasingly common. Since 2006, the number of requests for consultation made to the Québec Physicians' Health Program has risen steadily. Has the stress inherent to the profession reached a critical level? And to what extent is it endangering the health of our human resources?

All of these questions led us to set up a regional primary prevention project with a view to preserving and promoting physician health and the vitality of the medical community. The first step, which underpinned our entire approach, was to review the literature in order to determine a number of priorities for action. To this end, we consulted several works dedicated solely to the topic of physician health, as well as studies that had been conducted in North America, Europe and elsewhere. This document is not an exhaustive review of the literature in question, but rather an overview of the health problems experienced by physicians in terms of prevalence, risk factors and consequences.

*Since 2006, the number of requests for consultation made to the Québec Physicians' Health Program has risen steadily. Has the stress inherent to the profession reached a critical level?*

We will first take stock of what is currently known about physician health, and try to understand how physicians themselves address the issue. We will then look at certain problems that are more specific to physicians, either because of their frequency or how they present. Given its high prevalence, we will focus in more detail on burnout, especially its impacts and related factors. Finally, we will look at various preventive approaches that are currently advocated in the literature and suggest courses of action designed to improve health and professional satisfaction in the medical community.

WHAT WE  
KNOW **ABOUT**  
**PHYSICIAN**  
**HEALTH**



# WHAT WE KNOW ABOUT PHYSICIAN HEALTH

## Are physicians healthy?

Physicians are generally in good physical health and have long been found to have a greater life expectancy than the general population [1-4]. Research shows that physicians are less likely to develop the types of cancer that are associated with lower socioeconomic status (stomach, oral, pharyngeal) but more likely to develop types of cancer linked to higher socioeconomic status (colon cancer, melanoma), whereas still other studies show higher rates of mortality stemming from cirrhosis [2, 5]. This longer life expectancy could be attributed to physicians' higher socioeconomic status, but their life expectancy is still longer than that of other professionals of similar status [1, 4, 6]. This would seem to be explained by healthier lifestyle choices, especially the marked decline in tobacco use compared to the population as a whole [7]. Indeed, since the 1960s, physicians have smoked less and less, and the number of deaths linked to tobacco use and especially to lung cancer have shown a similar decline [1, 8, 9]. But as observed by Kay in her study on doctors' physical health, despite the fact that they live longer, physicians are just as likely as the rest of the population to develop chronic pathologies, such as cardiovascular, respiratory and musculoskeletal diseases, as well as cancer [10].

With regard to mental health, generally speaking, the data suggests that just as many physicians suffer from depression, anxiety, bipolar disorder and psychosis as do non-physicians. However, they are less likely to suffer from schizophrenia, since this disease generally presents at an early age [9, 11, 12]. Because of methodological differences, it is difficult to accurately determine the actual prevalence of mental health problems among physicians, but there is a higher frequency of burnout and death by suicide compared to the population as a whole [9, 13]. Moreover, it is the pattern of substance abuse rather than the frequency of the problem that differentiates physicians from the general public [11].

*In one study, 49% of the physicians surveyed considered that they were neglecting their own health, and 65% said that they were incapable of taking time off from work when they were sick.*

## How do physicians manage their own health?

Because they are reluctant to consult others about their health, preferring instead to see to it themselves, physicians can often be compared to the "poorly shod shoemaker." Studies show that, excluding countries where patient registration with a general practitioner is compulsory, roughly half of all physicians report having their own family doctor, which does not necessarily mean that they consult regularly or appropriately [3, 10, 14-16]. For example, Richards reports that although 71% of respondents stated that they had their own doctor, only 10% of them went for routine check-ups [17]. Studies show that physicians tend to prefer informal consultations, often called "corridor consultations", over formal appointments, regardless of whether they have a family doctor [14, 18, 19].

Physicians who do have a family doctor tend to choose him or her from among colleagues, family members or friends. In her study on preventive health behaviour among physicians, McCall reports that less than half of respondents said that they had their own general practitioner and, of that proportion, 30% consulted a colleague and 12% considered themselves their own doctor [20]. And yet, when asked about their preferences, the majority said they would rather consult a doctor with whom they had no personal or professional relationship [21].

Furthermore, physicians' attitudes to their own health differ from those of the general public. In one study, 49% of the physicians surveyed considered that they were neglecting their own health, and 65% said that they were incapable of taking time off from work when they were sick [22]. Another study showed that in the year leading up to it, over 80% of the physicians surveyed had worked while ill, citing organizational and cultural factors for not staying home, including the difficulty of finding colleagues to replace them [23]. Different studies on the topic generally conclude that physicians downplay or deny their symptoms and consult too late, often once their illness has progressed considerably. Allibone reports that close to half of physicians with health problems considered that they had delayed seeking help longer than was prudent [24]. They may also be more reluctant, when experiencing certain health problems, to comply with the practices or treatment they prescribe to their own patients [21, 25]. As part of certain studies, physicians were asked to respond to a number of different clinical scenarios, and the majority said that they would recommend that

their colleagues, if sick, consult their GP, but would opt for self-treatment in the exact same scenario [26, 27].

Self-treatment appears to be a widespread phenomenon in the medical community, and physicians often justify it by citing a lack of time and the “pressure” they feel to remain on the job [21, 26, 28, 29]. A study by Chambers and Belcher shows that 84% of the medication taken by doctors over the five years leading up to the study was self-prescribed, and one third of medical investigations had been self-initiated [30]. Medication that is most frequently self-prescribed includes antibiotics, contraceptives, anti-inflammatories, hypotensives, analgesics and sleeping pills [2, 17, 30, 31]. A study carried out on American neurologists shows that 94% of them would self-treat for an acute minor illness and 37% for a chronic condition; 42% would order blood tests on themselves for diagnostic purposes; and 40% would order imaging studies for the same reasons [32].

## Why this reluctance to consult?

The findings of various studies have identified the main barriers to consultation among physicians [14, 33]. In addition to organizational factors such as a lack of resources and time, physicians also cite an array of “psychological barriers.” First and foremost among these is the fear of imposing upon their colleagues, especially for symptoms that they may consider trivial or vague, as well as the fear that their self-diagnosis might be wrong. Thus, some doctors worry that their treating physician will judge them incompetent; others, on the contrary, are reluctant to consult a colleague they consider less qualified than themselves.

Research shows that physicians are even more hesitant to consult when it comes to certain types of symptoms, including chronic pain, substance abuse, sexual dysfunction, gynecological problems and STDs, but especially mental health problems [34, 35]. With regard to the latter, physicians are acutely aware of the potential consequences that a “formal diagnosis” could entail, such as the possibility of having to scale back their workload, modify their tasks, or take leave. Often, physicians end up downplaying their symptoms of depression or suicide for fear of being hospitalized or losing their privileges or even their licence to practise [12]. Fear of having to disclose a psychiatric illness to their college or regulatory body is also a major concern and a barrier to consulting [36]. A study carried out on physicians in the UK shows that 73% of respondents preferred to confide in family and friends about their mental health problems rather than consult health professionals, for fear of the impact on their career [37]. Studies also report physicians’ concerns about the requirement to disclose their diagnosis to their insurance company in case of disability, and the potential impact on their future ability to qualify for insurance [36].

*Self-treatment becomes a strategy that is accepted and even encouraged by colleagues, since it allows physicians to stay on the job and avoid the discomfort of having to assume the role of patient.*

Another barrier to consultation is confidentiality and the protection of personal data. Physicians say that they are concerned about the very existence of their medical file and the fact that colleagues can easily access it [3]. Here again, concerns are graver among those with mental health problems. A US study confirms that physicians reporting moderate to severe symptoms of depression are more likely to self-prescribe antidepressants – so as to not have to seek treatment due to confidentiality concerns – than those with mild symptoms [36].

Physicians also cite difficulties finding a doctor they feel they can trust or with whom they feel comfortable, and many report having had bad experiences as a patient [2, 3, 38]. Physicians are often perceived as being “difficult” patients; indeed, it is frequently reported that physicians are reluctant or uncomfortable with the idea of treating a colleague, and many researchers decry the lack of knowledge about what taking on a doctor as a patient involves [14, 15, 21, 33, 38-40].

Many authors believe that these attitudes and behaviours can be attributed largely to the medical culture itself, given the intense pressure it exerts on its members to portray an image of invulnerability, control and competence [3, 9, 29, 41, 42]. In this context, self-treatment becomes a strategy that is accepted and even encouraged by colleagues, since it allows physicians to stay on the job and avoid the discomfort of having to assume the role of patient [3].

These organizational, psychological and cultural barriers would appear to prevent many physicians from being treated as soon as they should, even in the case of serious physical or psychological illnesses [2, 9].

It would thus seem that despite their enviable position within the health-care system, physicians have more trouble accessing services for themselves than does the general population, especially for health problems to which they are most prone [14].

# SUICIDE



# SUICIDE

## What do we know about suicide among physicians?

Research data on physician suicide elicits controversy and debate within the medical community, especially because of the methodological problems inherent to studies on the topic. However, it is generally recognized that death by suicide is more frequent among physicians than among the general population [1, 9, 11, 43]. According to a meta-analysis conducted in 2004 comparing physicians with the general population, male physicians showed a modestly elevated relative risk (RR 1.41), whereas the relative risk that their female colleagues would commit suicide was markedly higher (RR 2.27) [44]. Existing data, although limited, suggests that the gap in suicide rates begins as early as medical school, where overall suicide rates are higher than in the age-matched population [45-47]. In one of her studies, Dyrbye reports that one in nine medical students in the United States had experienced suicidal ideation in the year leading up to the study, a markedly higher rate than in the age-matched population of non-medical students [48].

A study on the causes of mortality shows that suicide is the only cause of death that is more prevalent among physicians than the general population and even, according to another research study, than among other professionals and university graduates [1, 49, 50]. It must also be pointed out that the findings have a substantial margin of error due not only to the low number of cases, but also to problems classifying these cases and to other methodological flaws. Thus, certain deaths reported as accidental may, in reality, be disguised suicides [4].

Many authors have tried to explain the issue of physician suicide, a complex phenomenon involving a combination of genetic, psychological and social predispositions. As is the case with the general population, one of the most important elements is undoubtedly the presence of one form or another of psychiatric illness. Experts point specifically to the dangerous combination of mood disorders and substance abuse [4, 9].

Although physicians are, for the most part, attuned to these risks in their patients, and to the importance of ensuring that they follow an appropriate course of treatment, this in no way seems to shield them from the potentially devastating consequences of being in the same situation themselves. Indeed, many physicians who commit suicide were never formally assessed or treated, presumably having chosen instead to self-diagnose and self-treat [4, 9, 12].

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## Are some physicians at greater risk?

Silverman paints a typical portrait of a physician at risk of suicide. Factors include psychiatric disorders and substance abuse, the presence of chronic pain or debilitating illness, marital disruption and separation or divorce, excessive workload, recent changes in occupational status and threats to the individual's reputation or financial stability. The risk increases as physicians approach their fifties and among so-called workaholics, as well as among those who have access to a firearm or potentially lethal medication [4].

Gabbard and Myers, during their long careers as psychiatrists treating physicians, have underscored the potentially negative impact of personality traits that are frequently observed in this field, especially perfectionism and narcissism [12]. Such individuals tend to be particularly vulnerable following an adverse event such as medical error or complications in a patient. A professional investigation or lawsuit can be a highly traumatic experience, since physicians see it as a genuine attack on their professional integrity. The authors point out that these individuals can sometimes react by attempting suicide very quickly, even before depressive symptoms present. For these people, the impact is such that suicide appears to be the only option. Gagné, in his study on suicide among Québec physicians, also addresses the issue of impulsivity in certain cases that have been documented, and posits that easy access to potentially lethal medication should be considered a "professional risk factor" [43].

*Many physicians who commit suicide were never formally assessed or treated, presumably having chosen instead to self-diagnose and self-treat.*

## *Easy access to potentially lethal medication should be considered a “professional risk factor”.*

In his study of American surgeons, Shanafelt shows that suicidal ideation can be associated with adverse professional experiences, especially where the victim has committed a medical error in the previous three months [51].

Silverman concludes in his study that a physician who is depressed, has financial problems, has experienced significant personal or professional losses, is dissatisfied with his or her work or family life and has an unprofessional attitude towards patients and colleagues may be at imminent risk of suicide [4]. The author also points out that psychiatric treatment alone is not necessarily sufficient to prevent the completion of a suicide act. Thus, family members and treating physicians must remain particularly vigilant and aware of the importance of the social support network, even after treatment has begun. Further data suggests that the quality of the treatment provided to a suicidal physician may be undermined due to the fact that the treating physician may identify with his colleague [9, 52]. In trying, out of empathy, to avoid subjecting said colleague to hospitalization for psychiatric treatment, even though this may be what is required, the treating physician may actually be putting his patient’s life at risk.

In addition to the difficulty they have acknowledging their own distress and seeking help, physicians must deal with systemic barriers to consultation, which have been the topic of numerous articles and consensus statements denouncing both the prejudices associated with mental health problems and the adverse impact that a documented psychiatric disorder may have on a physician’s medical licensing, hospital privileges, health insurance—in short, on his career as a whole [9, 52-55].

## **Prevention methods**

In 2002, in Philadelphia, the American Foundation for Suicide Prevention assembled a group of experts to study the issue of suicide among physicians. Once their work was completed, they published a consensus statement with a view to educating the medical community about this reality. They set out research priorities and recommendations intended especially for medical schools, associations, and licensing and accrediting bodies [9]. These experts underscored the vital importance of ensuring that physicians are in good mental health and of effecting an attitude shift within the medical culture, which too often discourages doctors from seeking the help they need. They criticized accrediting

bodies which, in their opinion, miss the mark by focusing on the physician’s psychological history rather than on the real issues at hand, such as impaired professional abilities. Indeed, it is important to distinguish between “psychiatric disorder” and “impaired professional abilities.” As Myers points out, physicians can be mentally ill and yet not occupationally impaired [56]. This crucial distinction between a diagnosis and impaired professional abilities is unfortunately not recognized everywhere, and a number of examples in the literature attest to prejudice and discriminatory practices [9, 55]. In the opinion of experts, these practices only exacerbate the secrecy and shame associated with such disorders and, ultimately, the fear of seeking help, thereby delaying optimal treatment even further.

Center’s group also targeted medical schools, recommending that specific courses on stress in the medical field be incorporated into the curriculum [9]. The University of California School of Medicine followed up on this recommendation in 2009 by launching the Suicide Prevention and Depression Awareness Program, which targets the entire medical community, including students, residents and professors. This program comprises a strictly confidential Web-based screening component developed by the American Foundation for Suicide Prevention. As for the educational component, it includes information on burnout, depression and suicide. Although still in its early stages, this innovative program is showing encouraging results thus far [57].

*A physician at the very heart of the health-care system and surrounded by resources can be suffering without receiving the appropriate care. This defies belief and challenges us to explain how such a thing can occur.*

Thus, “to prevent suicide at age 40, intervention has to begin at age 20” [4]. Since the gap between the suicide rate among physicians and that of the general population appears to begin widening as soon as students start medical school, early detection and treatment of mental health problems and the recognition of certain risk factors must begin before graduation, and students must also be made aware of the specific challenges that are inherent to practising medicine [58].

Current data on suicide among physicians is still limited due to methodological flaws and the stigma associated with the issue. However, the fact remains that physicians

suffer from mental health problems for which they do not receive appropriate care and, every year, many of them take their own lives.

According to Legha, the important thing is not whether physicians commit suicide more or less frequently than the rest of the population, but rather, that a physician at the very heart of the health-care system and surrounded by resources can be suffering without receiving the appropriate care. This defies belief and challenges us to explain how such a thing can occur [58].

SUBSTANCE  
**ABUSE**



# SUBSTANCE ABUSE

## How is substance abuse among physicians different?

As is the case with information on suicide, data concerning substance abuse by physicians has been the subject of controversy and myths suggesting that they are more predisposed to addictive behaviours. In fact, although the actual prevalence of substance abuse by physicians remains unknown, available data puts it at between 10% and 15% [11, 59-61]. This is similar to the rate observed in the general population, but the choice of substance differs. Various sources posit that alcohol is the substance most frequently abused by doctors, followed by prescription drugs, mostly notably opiates and benzodiazepines [4, 11, 61-63]; physicians appear to be less inclined to consume illicit drugs such as cocaine, marijuana, hallucinogens or heroin [63].

There is scant data on the breakdown of substance abuse by medical specialty; however, monitoring of doctors with substance abuse problems done in the US as part of physician health programs shows that anesthesiologists are overrepresented, and that they are more likely to die of substance abuse than their colleagues in other medical specialties [59, 64-66]. But as Cicala points out, no group of physicians is immune to the problem: the numbers are similar for every specialty and every age range [67].

Colleagues often do not detect the problem, despite its relative prevalence, and years can elapse before anyone takes appropriate action. Different experts have tried to explain the development of substance abuse problems among physicians [59, 60, 67-69], pointing to the significant efforts they make to conceal their addictions. They often become loners so that colleagues will not notice the effects of the abuse. Only rarely will they show typical signs of intoxication in the workplace, and even then will attribute them to stress or an excessive workload; in fact, most physicians continue to be functional on the job, even at more advanced stages of the disease.

## Potentially disastrous consequences

The moral and ethical issues at play here should be underscored. As is the case with airline pilots or police officers, physicians who abuse drugs or alcohol risk compromising their professional abilities and the quality of the care they provide. Their fear of having their college or regulatory body

*No group of physicians is immune to the problem: the numbers are similar for every specialty and every age range.*

impose heavy penalties contributes to their denial of the problem and their refusal to consult; admitting that they abuse drugs or alcohol is tantamount to jeopardizing their reputation and even their career. No doubt this is why many colleagues hesitate to confront a physician who is clearly experiencing difficulties. This situation was denounced for the first time in 1973 in a ground-breaking article published in the Journal of the American Medical Association on "sick physicians" [70]; it revealed the conspiracy of silence around the issue of substance abuse. As described by Boisabuin, too often, colleagues tend to take refuge in denial or to rationalize the problem by hoping that the abuser will eventually seek treatment or that the situation will resolve itself on its own [69].

In addition to putting the safety of the physician's patients at risk, colleagues' failure to step in delays treatment of the disorder. According to McCall, addiction is probably one of the only medical conditions that a physician's peers deliberately avoid diagnosing, even though he or she may be in critical condition [60]. And yet, the consequences for him or her can be disastrous, both personally and professionally: risk of medical error, risk of complaints or lawsuits, loss of privileges, criminal charges for self-prescribing or driving while intoxicated, in addition to the impact on the physician's health, which can go as far as death by overdose or suicide [67].

*Addiction is probably one of the only medical conditions that a physician's peers deliberately avoid diagnosing, even though he or she may be in critical condition.*

Data from the literature suggests that the risk factors for developing a substance abuse problem are similar to those found in the general population; such dependence frequently has a strong familial association, sometimes going back several generations. Cicala reports that close to 90% of people who engage in substance abuse have a concurrent psychiatric disorder, such as severe depression, bipolar illness, or a personality or anxiety disorder [67]. In some physicians, substance abuse originates as an attempt to self-medicate an underlying illness; in others, it may be due

to a difficult childhood in a dysfunctional family, as shown by Vaillant in 1972 in his abundantly cited prospective study on the topic [71].

It is important to better understand the phenomenon of substance abuse among physicians and how the symptoms present. The substance in question also has a considerable influence on how the illness runs its course: for example, alcoholic physicians can conceal their problem for years, whereas opiate or cocaine abusers may go from experimentation to complete collapse in a matter of weeks [72].

## And yet...

The literature shows that the course of the illness can be profoundly modified once the physician begins treatment. A number of high-quality studies have assessed the prognosis of physicians grappling with substance abuse problems and their ability to return to work safely [62, 73]. It would appear that when they follow a recognized protocol of treatment, supervision and monitoring, they can resume their duties and move forward in a positive manner, often with higher success rates than the rest of the population. Experts in drug addiction treatment believe that this is due to their higher education levels, greater financial resources and especially their motivation to pursue their career [69].

Most physician health programs in the US offer a specialized service of intensive monitoring and long-term follow-up for alcohol and drug addiction problems and, according to available research findings, these programs have been shown to be effective [62, 74-78]. Some programs in Canada also offer this type of service. A prospective study conducted in Canada on doctors in a specialized substance dependence monitoring program reported that after five years, 71% of participants had experienced no relapse for the entire duration of the program, 14% had continued their treatment after a single relapse, and a total of 85% of participants had successfully completed the program [62]. However, the prognosis is less favourable in cases of dependence on more powerful narcotics, where the relapse rate is higher. In such cases, the possibility of the physician returning to work must be carefully evaluated, especially where the work environment affords ready access to the substance in question [64].

Thus, although studies have shown no significant discrepancy between physicians and the general population in terms of the prevalence of drug abuse, doctors' easy access to certain highly addictive substances is certainly a decisive factor. In addition to its potentially devastating consequences, substance abuse among physicians raises legitimate concerns with regard to the safety of their patients and the quality of the care provided to them.

*With a rigorous treatment plan and long-term follow-up, their prognosis for recovery is excellent.*

Physicians may be reluctant to seek help because of potential adverse impacts on their career. They thus find themselves alone in dealing with their problem, often in denial, surrounded by colleagues who prefer to turn a blind eye, who do not dare to address the matter or who do so too late. And yet, with a rigorous treatment plan and long-term follow-up, their prognosis for recovery is excellent.

# BURNOUT



# BURNOUT

Given the quantity of troubling information on the subject, physician burnout merits attention. Often confused with depression, which is a separate clinical disorder that affects all aspects of an individual's life, burnout is a phenomenon specifically linked to work. It tends to be more prevalent in professions where practitioners interact with individuals who are suffering physically or emotionally, for example, health-care workers. Moreover, those most susceptible appear to be the most conscientious and dedicated to their work [79].

Described for the first time in the 1970s by Freudenberger, the concept of burnout became clearer when Maslach created the Maslach Burnout Inventory (MBI) Scale, and defined the phenomenon based on three main factors: emotional exhaustion, depersonalization, and a low sense of personal accomplishment [80-82].

Work, formerly a source of gratification, becomes difficult, burdensome and, in the advanced stages of burnout, meaningless. Depersonalization refers to the state of cynicism and detachment people assume in order to emotionally distance themselves from their work, so they can continue to keep up with the demand. Lastly, victims of burnout feel ineffective, exhausted and utterly hopeless, experiencing a veritable "erosion of the soul" [83].

## A common problem among physicians

Studies show that burnout is a widespread phenomenon, affecting residents, professors of medicine, and physicians in all medical and surgical specialties [13, 84, 96-98]. One of the many studies on the topic was conducted by the Canadian Medical Association in 2003, involving a survey of 8,172 of its members. It revealed that 45.7% of respondents were at an advanced stage of burnout [99].

In Québec, a study conducted in 2008 on a group of ophthalmologists showed that close to half of all respondents had difficulty achieving work-life balance, and that 35% of them had high rates of burnout and psychological distress [100].

A US study comparing the prevalence of burnout at different stages of physicians' professional lives shows that those at mid-career are more often on call, work longer hours and, compared with their colleagues at the beginning or end of their careers, are less satisfied with their choice of specialty and their work-life balance, and have higher burnout rates [101].

A recent US study published in the Archives of Internal Medicine confirmed that burnout has reached "an alarming level." Conducted by Dr Tait Shanafelt (Mayo Clinic, Minnesota) on 7,000 physicians practising in a wide range of specialties, this study shows that close to one out of every two physicians has reported signs of burnout and that front-line responders (practitioners of family medicine, general internal medicine, and emergency medicine) are at the highest risk. Findings were compared with those for the general population and, for the first time, showed that physicians are more likely to be dissatisfied with their work-life balance and to present with symptoms of burnout [13].

*Close to one out of every two physicians has reported signs of burnout and front-line responders are at the highest risk.*

## What are the sources of the problem?

The literature shows that there are several factors associated with burnout, although no causal link has been formally established with any of them. As a rule, they can be divided into three categories: intrinsic, extrinsic and individual [102, 103]. These categories are described in greater detail below.

### Intrinsic factors

These factors are so called because they deal with characteristics that are inherent to physicians' work. In medicine, this includes elements such as intellectual rigour, the burden of decision-making, stress levels due to uncertainty and emergencies, and being constantly confronted with suffering and death [82, 104]. Dagrada also mentions problematic interaction with certain patients, especially if they are perceived as being demanding or harbouring unrealistic expectations [82]. Although the patient-physician relationship is at the heart of the medical profession and is one of its most gratifying aspects, it can also represent, in emotional terms, one of its heaviest burdens [104].

In addition, physicians may make medical errors or experience failure in certain cases, and they are often insufficiently or improperly prepared for these incidents and how they may be affected by them [105]. Although patients are the primary

victims, the adverse impact on physicians and other caregivers is often so great that they are described as the “second victims.” Distress, guilt, shame and depression are some of the consequences reported; other studies suggest that these effects can be long-lasting, with some physicians describing themselves as being traumatized for life [106-113].

In his prospective study on the frequency and impact of medical errors among a cohort of internal medicine residents, West and his co-authors showed a strong correlation between self-perceived medical errors and burnout, emotional distress and reduced empathy [114]. The authors also indicated that this distress is, in turn, associated with increased odds of future self-perceived errors, suggesting that perceived errors and distress may be related in a reciprocal cycle. Balch, in a study of American surgeons who had been sued for malpractice, also establishes a link with burnout, depression and even suicidal ideation [115].

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## Extrinsic factors

Extrinsic factors refer not to medical practice itself, but rather to how it is organized (schedules, workload, environment, autonomy, etc.) [102, 103].

The array of extrinsic factors that can contribute to burnout among physicians includes perceived ineffectiveness, excessive workload, decreasing professional autonomy, and difficulty achieving work-life balance. Some authors associate these elements with more global concepts, such as lack of control and an inability to find meaning in work [45, 82, 83, 116-120].

Although few studies have established a link between the number of hours physicians work per week and burnout, one study by Balch has done so. His survey of American surgeons found that the prevalence of burnout increased from 30% among those who worked less than 60 hours a week to 50% among those who worked over 80 hours per week [121].

Heavy schedules and long working hours are particularly common during residency, especially in certain specialties such as surgery. This phenomenon, coupled with the difficulty residents have in balancing professional obligations with their lives outside of work, can have repercussions

even after they complete their studies; indeed, the oft-used strategy of delaying gratification in their personal lives has gradually become the new norm. Thus, many physicians come to believe that they cannot simultaneously be fulfilled personally and professionally, and must therefore put their personal lives on hold until retirement [79]. In fact, when there is an imbalance between personal and professional obligations, research shows that it is often resolved to the detriment of physicians' personal lives [45, 122]. Langballe reports a difference between male and female physicians in terms of these factors; according to her study, work-home conflict is the strongest burnout predictor in female physicians, whereas workload is the strongest burnout predictor in male physicians [123].

Arnetz emphasizes that fundamental changes in medical organizations and a worsening work environment, as experienced by numerous physicians in recent years, have contributed to the paradox of increased work demands combined with declining authority over their practice. At the same time, their role is changing and they exert considerably less influence within their organizations. The advent of new technologies and alternative medicine and the constant pressure on physicians to keep abreast of new developments and meet their patients' expectations must also be taken into account, along with the recent decline in their social status [104].

*Work-home conflict is the strongest burnout predictor in female physicians, whereas workload is the strongest burnout predictor in male physicians.*

A recent Canadian study conducted on over 3,000 physicians concludes that besides workload, the incongruence of their individual values with values in their workplace contributes equally and independently to burnout, especially for female physicians [124].

## Individual factors

Factors specific to the individual also contribute to burnout [125]. Dagrada points out in his literature review that people who do not worry are immune to burnout [82]. Certain personality traits put people at a higher risk of burnout. For example, perfectionism, a characteristic that is particularly sought after and valued among physicians, generally goes hand in hand with exceptional levels of dedication and professionalism. However, this characteristic can also present in a dysfunctional and rigid manner, and give rise to an urgent need to control one's environment and over-commit to work. Gabbard

and Myers refer to three characteristics that make up what they call the “compulsive triad”: self-doubt, guilt, and an exaggerated sense of responsibility [12, 83, 126]. In addition, even though perfectionism is a valued trait in the medical culture, it can nonetheless be a risk factor for stress and even suicidal ideation [127].

It would appear that these characteristics are disproportionately present within the medical profession, likely because of the selection process for medical students, which tends to give preference to candidates who demonstrate these traits, since they are often associated with academic success. Clode, in her review of the literature, underscores the negative influence medical school can have on pre-existing personality traits in new students. Medical training is a particularly stressful process, not because of academic requirements, but rather because of its competitive and unforgiving nature, which only reinforces obsessive and perfectionist personality traits [2]. Once students have completed their medical training, medical culture continues to shape their beliefs, values and behaviour. Fear of lawsuits and the desire to protect their reputation and fulfil the expectations of both their colleagues and their patients can lead to what Gabbard and Myers have called the psychology of postponement. As we mentioned earlier, these physicians will be more likely to put their personal lives on hold in order to further their career, and this may, on occasion, become an avoidance tactic for physicians who eventually come to feel more comfortable in their work environment than in their personal relationships [12]. We may criticize, as Clode does, the glaring discrepancy between imparting scientific knowledge to medical students and neglecting the emotional aspects of medical practice. The lack of recognition granted to these aspects may prevent students from developing the skills required to face related challenges in their training and in subsequent professional practice. In this regard, self-denial and altruism, so valued by the medical culture, may represent serious risks to physicians’ health and stability, and impede their ability to deliver quality health care to others [2].

Thus, one of the tragic paradoxes of burnout in medicine is that those who are most susceptible also appear to be the most conscientious, responsible, and motivated. Individuals with these traits are often idealistic and have perfectionist

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qualities that may lead them to devote themselves to their work until they have nothing left to give [79, 128, 129]. Some authors posit that individual factors, perhaps more than the nature of the work itself, would seem to make practitioners more vulnerable to stress and burnout. It would be more appropriate, as Riley points out, to refer to a mismatch between the nature of the job and doctors’ personalities [117].

## Consequences

Faced with constantly growing demand, physicians naturally seek to absorb their excessive workload by doing even more, regardless of their health and job conditions. These initial reactions, which certain authors have called “hyperwork” and endurance, can solve the problem temporarily, provided regular periods of respite are scheduled [129]. The hyperwork response kicks in when physicians are no longer able to reduce their workload, even if they find it excessive, whereas the culture of endurance forces them to keep going, despite organizational deficiencies or personal problems. These defence mechanisms are so ingrained that they become the norm, and are even used as a criterion for selecting or retaining physicians. Unfortunately however, physicians commonly use these mechanisms to compensate for deficiencies in the health-care system, and the organization of their work becomes dependent thereon [129, 130].

And yet, as Riley points out, whereas expectations have never been higher, the explosion of scientific knowledge, guides to good practice and other demands mean that meeting these expectations is virtually impossible. If the situation remains unchanged, the risk of burnout, or even another form of physical or psychological decompensation, becomes imminent [117].

In an article published in the New England Journal of Medicine, Zuger underscores the deep divide between the demands of the profession and what physicians can realistically accomplish in the practice of medicine [131]. The compromises forced by current practice are at odds with the standards set in physicians’ training [130]. Over the long term, this phenomenon can lead to what Genest describes as “ethical suffering”, or physicians’ inability to care for their patients as they would like to because of constraints over which they have no control, thereby creating a profound conflict of values [132].

*Burnout can have an impact on professionalism and certain fundamental work values, such as altruism and a sense of responsibility.*

Indeed, several studies show that burnout can have devastating consequences on individuals' health and personal lives. In addition to contributing to family and marital tensions, burnout is associated with an array of somatic symptoms such as heart conditions, perturbed sleep patterns and anxiety, and may lead to depression, substance abuse and even suicide [45, 102, 116, 133].

Various studies point to the adverse effects of stress and burnout on the quality of care provided to patients by physicians who are affected, and on the health of the physicians themselves [45, 102, 114, 133-138].

Shanafelt and his colleagues report that, out of a group of internal medicine residents, 76% met the criteria for burnout, and were two to three times more likely to self-report providing suboptimal patient care [96]. In addition to having negative effects on empathy, studies also show that burnout can have an impact on professionalism and certain fundamental work values, such as altruism and a sense of responsibility [138].

According to Wallace, professional dissatisfaction and burnout are closely linked to physicians' desire to quit their jobs or even leave the profession. Citing a study conducted on physicians affiliated with the University of Ottawa, she reported that 50% of them considered leaving their positions each week, while 30% of them considered giving up medicine altogether [133].

Other studies point to burnout leading to reduced working hours and the desire to take early retirement or transition to a new career [45, 139-143]. Such phenomena inevitably create instability and trigger a chain reaction among medical teams [130]. The physicians who stay on the job are in turn caught up in a spiral of overwork and stress that puts them at risk of burnout, which can lead to further departures and, ultimately, compromise the

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continuity, quality and accessibility of patient care [144]. The cost of replacing a physician is estimated at between US\$150,000 and \$300,000, taking into account decreased productivity, lack of continuity of care, and the cost of recruiting and training new resources [133]. Furthermore, various studies show that physician dissatisfaction leads to patient dissatisfaction, and dissatisfied patients will be less motivated to follow their doctor's recommendations and course of treatment and more likely to miss appointments. By the same token, there appears to be a strong correlation between physician satisfaction and their patients' satisfaction, trust and tendency to follow their course of treatment. There is better continuity, and patients evaluate the quality of care they receive more positively. Finally, greater job satisfaction on the part of physicians is associated with optimal care and a lower rate of medical error [45, 136, 145-147].

Thus, when a physician is experiencing burnout, the repercussions are such that the very performance of health-care systems is jeopardized. Perhaps physician health should be considered an important health determinant or, as Wallace suggests, another missing indicator of the quality of our health-care systems, but one which nonetheless merits the same attention as more traditional performance indicators [133].

# PREVENTIVE APPROACHES



# PREVENTIVE APPROACHES

The 2003 European Forum of Medical Associations, in conjunction with the WHO, recognized that high burnout rates among physicians pose a risk, not only for their health, but also for quality of and access to care, and urged medical associations to acknowledge the scope of the problem and develop effective prevention and intervention programs at the organizational level [148].

As we have seen earlier, research shows that physician wellness can not only benefit the individual, it can also be vital to the delivery of high-quality health care to the individual's patients [133]. Reports show that physicians who have themselves experienced the positive effects of a healthy lifestyle are more likely to actively promote such a lifestyle to their patients. They tend to anticipate obstacles to adopting healthful behaviours, propose solutions and demonstrate the benefits of behavioural changes [4, 8].

And yet a certain culture of denial seems to persist within medical organizations. According to Spinelli, health-care policies would seem to focus their efforts on achieving a "triple aim": improving patient care quality, improving the experience of care for patients, and decreasing total cost of care. But how, wonders the author, can we explain that the well-being of those who provide this quality care is never taken into account? He denounces the lack of attention granted to this issue, since it has been clearly shown that any innovation of the health-care system is doomed to failure if physicians do not feel valued or engaged in their work [149].

## Professional satisfaction, wellness and resilience: new concepts in medicine

The concepts of professional satisfaction, wellness and resilience have only recently begun to emerge in the literature on physician health [86, 130, 150-165]. Like professionalism, a quality that is intrinsic to the practice of medicine and a core expectation of medical licensing bodies, these concepts are increasingly being recognized as aspects that physicians must develop in their working lives [166].

In an article exploring the concept of resilience, Howe summarizes its key elements and underscores the relevance of applying this concept to both medical training and professional practice. The author defines resilience as the ability of individuals to survive in and thrive on adversity [166]. More specifically, she pinpoints its characteristics, including

self-efficacy, persistence, ability to manage one's emotions and engage support, learning from difficulties, and finding meaning in challenges. Resilient individuals thus succeed in overcoming obstacles and meeting challenges without imperilling their mental equilibrium. It is increasingly widely acknowledged that resilience is more than an appealing quality or characteristic; it also plays a key role in preventing mental distress and acts as a preventive mechanism against the numerous stressors inherent to medical practice. Howe also points out that, unlike other less changeable psychological characteristics such as temperament, resilience is a dynamic trait that can be developed and nurtured over time.

Epstein defines resilience as the ability to respond to stress in a healthy way at minimal psychological and physical cost [153]. Resilient individuals can thus "bounce back" after challenges while also growing stronger. But while the concept is clearly defined, methods of fostering resilience in the medical context need to be better pinpointed.

We will look at some recommendations made by different authors who have explored these concepts, and distinguish examples of individual strategies from those that can be applied across the medical community.

## Individual strategies

Authors who have studied resilience point primarily to the importance of developing a healthier attitude toward work. In a study conducted on Canadian family doctors, Jensen and her co-authors selected subjects who seemed to show qualities associated with resilience, with a view to better understanding their characteristics and what sets them apart from their colleagues [150]. The authors found that healthy attitudes toward work, developing self-awareness, recognizing and accepting personal limitations, nurturing interests outside of work, maintaining healthy personal and professional relationships and balancing work and family life are all key to resilience.

Shanafelt and his colleagues reach similar conclusions and report, in addition, that physicians who find meaning in their work and who define their personal and professional values and priorities are at a lower risk of burnout [151]. They emphasize the importance for residents of reflecting on these matters, taking the time to identify their personal and professional goals, and keeping them in mind when choosing their careers as future physicians [167]. Their research shows that physicians who spent more of their time on the aspect of work that they found most meaningful had a lower

*Having an arsenal of formal or informal adaptation strategies, along with realistic expectations and good self-knowledge, can pave the way to a sustainable practice.*

risk of burning out; indeed, those who devoted between 10% and 20% of their time to activities that gave them the most satisfaction appeared to be more resistant to burnout [168].

Zwack explains that regardless of the stressors, a well-diversified pool of social resources and fields of interest, along with realistic expectations and good self-knowledge, are assets to a sustainable practice. This, in turn, creates feelings of self-efficacy that motivate individuals to continue along this positive path [160].

But even before suggesting ways for physicians to increase their resilience, Epstein points out that physicians must first recognize how and when they are adversely affected by stress at work and be able to distinguish adaptation strategies that are effective for them from others that are less useful [153]. Too often, he notes, physicians tend to ignore early warning signs such as fatigue or irritability in the hope that the situation will resolve itself; however, denial or avoidance frequently exacerbate the problem and make it more complex and difficult to manage. Worse yet, the individual has missed a learning opportunity and is no better equipped to cope should a similar situation arise; hence the importance for physicians of developing their self-awareness.

Various approaches have proven effective for enhancing self-awareness. For example, Balint groups, based on the method developed by Hungarian psychoanalyst Michael Balint, are well known by family doctors. These groups have proven their effectiveness in helping physicians reflect on their relationships with their patients, especially as concerns their own transference or counter-transference reactions, and in helping them understand how these reactions can impact on their clinical behaviour [153, 169]. Other well-documented approaches also lead to improved self-awareness, such as narrative medicine, where physicians gather in small groups to share stories describing a real-life experience from their practice [170]. Sands showed, through a study carried out on an interdisciplinary team of pediatric oncology workers, that six consecutive weekly sessions of narrative training improved participants' teamwork and resilience [171].

More recent studies suggest that the Mindfulness-Based Stress Reduction (MBSR) approach can also increase self-knowledge and help physicians more accurately identify their values and reconnect with what is most meaningful for them [172-174]. In addition to benefiting physicians

personally, this approach also improves certain aspects of medical practice. A mix of several methods also appears promising; Krasner reports that group training combining mindfulness and narrative medicine improved participants' well-being, as well as their attitude and empathy toward patients. The benefits lasted even after completion of the training program [175]. Participants reported having developed better listening skills, enhanced mindfulness and greater authenticity, which favourably influenced their relationships with their patients. They especially appreciated being able to share their clinical experiences with colleagues, especially since, as Epstein points out, physicians are more and more isolated and overworked, and have little time to interact among themselves. And yet, even though participants acknowledged that this program was beneficial to them, they also reported having found it difficult to give themselves permission to set aside time for self-help activities [153].

As helpful as workshops and the other structured approaches described above might be, Epstein posits that physicians should also find a way of integrating resilience-promoting activities into their daily practice [153]. The author suggests using informal practices that promote self-awareness and mindfulness during patient care; they help practitioners "take stock and clear their minds." In his study of surgeons, Moulton describes how they succeed in developing a tacit awareness so that they can "slow down when they should," particularly at crucial moments, allowing them to respond to the situation more deliberately [176]. Kearney lists other ways of fostering mindfulness, for example by taking a brief pause after having seen a patient and clearing one's mind before seeing the next, or by calling on a colleague when confronted with a difficult event [170].

Thus, despite demanding patients, excessive workload, time constraints and other stressors inherent to medical practice, having an arsenal of formal or informal adaptation strategies, along with realistic expectations and good self-knowledge, can pave the way to a sustainable practice [160].

## Beyond self-care

Many physicians manage their stress through relaxation or the practice of leisure activities or sports. But although these activities may be beneficial, Kearney points out that they may not measure up to the challenges of medicine in a global perspective of resilience [170]. Thus, it is increasingly recognized that self-care must be accompanied by other strategies, including the ability to consider professional challenges as opportunities for learning and growth [153]. Longenecker reports that flexibility or the ability to adapt to situations through creativity and the quest for new solutions, as opposed to endurance, is another

important component of resilience [177]. Thus, instead of adopting survival strategies, physicians should aim for resilience-promoting strategies, by overcoming difficulties rather than avoiding them.

*People must learn to receive support from others, a concept that is still foreign to the medical culture, which tends to advocate self-sufficiency.*

## Community and organizational strategies

Longenecker explains that resilience stems both from the individual and the community: in order to grow, people must learn to receive support from others, a concept that is still foreign to the medical culture, which tends to advocate self-sufficiency. To achieve this goal, physicians must learn to communicate effectively and respectfully and to solve problems as a team, skills the author hopes to see incorporated into the curriculum of future physicians [177].

A number of other studies posit that approaches to preventing burnout and promoting satisfaction and wellness should be part of a broader vision, so as to include measures targeting the work environment. Findings show that the concepts of resilience and wellness should be applied to teams and organizations, and not just to individuals [165, 166, 178, 179]. Howe describes how resilience can develop among members of a team through mutual trust and the strong ties they forge, enabling them to cope with difficulties and adversity together [166].

A Dutch study conducted on 29 hematology-oncology teams assessed the effects of a team-based burnout intervention program [180], which combined a staff support group with the Participatory Action Research (PAR) approach, based on the principle that an organization must have the capacity to identify and solve its own problems. Upon completion of the study, researchers observed a decrease in emotional exhaustion and cynicism (depersonalization), two components of burnout, in groups having participated in the program, as compared to the control groups. These effects lasted several months beyond the end of the program. Their findings also showed that this is a relatively easy and low-cost approach in proportion to the benefits it affords.

In the United States, Dunn and Arnetz set up a multicentric intervention within a group of primary care clinics. Based on the assumption that physician well-being is just as important as care quality and financial viability of the organization, the researchers developed a strategy founded on

values such as autonomy, personal efficacy and the meaningfulness of work, twinned with reflection and ongoing evaluation of the process, as well as indicators as a gauge for well-being. After four years, the authors concluded that the indicators of professional satisfaction had improved and that factors related to burnout had decreased [181].

Sinsky and her co-authors report similar outcomes for a program of the same type applied to 23 primary care practices. According to their conclusions, it is possible to increase satisfaction and even joy in practice using innovative approaches involving more cooperation among professionals, support for physicians and forums for exchange and discussion [182].

Here in Canada, the Foundation for Medical Practice Education, under the aegis of McMaster University, launched practice-based small group (PBSG) learning programs, an opportunity for family physicians across the country to apply some of these principles [183]. Through continuing education activities, small groups of a dozen physicians meet regularly to develop and discuss a module on a theme of the group's choosing. This allows physicians not only to remain up to date on new developments but, through exchanges with their colleagues, to identify their own shortcomings and how to correct them. These meetings also provide the opportunity to discuss how guides to best practices can be applied in their work context. The PBSG approach is more than just training; it adds value by placing participants in an environment of trust and non-judgment. Thus, over time, these groups become a source of invaluable support by allowing physicians to experiment with reflection and develop genuine communities of practice [184, 185].

## Teaching resilience

Many studies confirm the relevance of applying the concepts of wellness and resilience as soon as students begin their medical training [162, 186-190]. More in-depth research is being done and several academic institutions, both in the United States and here in Canada, have begun teaching these concepts to future physicians. In Canada, physician health and resilience are now part of the CanMeds framework of competencies of the Royal College of Physicians and Surgeons of Canada and of the College of Family Physicians of Canada [191, 192].

*It is possible to increase satisfaction and even joy in practice using innovative approaches.*

In this regard, a recent publication outlines the efforts made by a group of professors in a rural medical school in the United States to develop a curriculum for the teaching of this competency. Preferred approaches included discussions in small groups about difficulties inherent to the profession, problem-solving exercises, and the development of different scales to evaluate the degree of resilience of both individuals and their medical community [177].

## A doctor for every physician

It would be remiss of us to conclude this section on preventive approaches without mentioning the strategy most often advocated by researchers and experts in the field, that is, that physicians must look after their own personal health and adopt better consultation habits [2, 3, 10, 14, 33, 38, 53, 193]. Given the individual and systemic barriers to consultation mentioned earlier, many experts recommend putting in place the conditions necessary for every physician to have their own personal doctor, and some of them even support the implementation of physician referral services [2, 14, 33, 53].

George and her co-authors report in their study that certain barriers to consultation can be overcome. To address concerns about confidentiality, the authors proposed, among other solutions, that physicians obtain care at other institutions [35].

Because of specific issues linked to treating colleagues and the challenges that this physician-patient relationship can pose, many experts suggest that customized training programs should be set up to educate physicians about the particular aspects of this relationship. Such training programs, according to many, should even be offered in medical school, so that future health-care professionals can expand their knowledge on physician health and thus feel more competent in this regard [3].

# CONCLUSION



## CONCLUSION

Physician health and wellness appears to be arousing more and more interest in Canada, the United States and most industrialized countries. Physicians are in better physical health than the general population, even though they do not always benefit from regular medical consultation and do not always practise what they preach, but they have their own vulnerabilities and are as or more likely to experience mental health problems than the non-physician population. Whether this is due to personal predisposition or current practice conditions is still a topic of debate, but the answer likely lies in a combination of the two.

In industrialized countries, health-care systems are undergoing profound change because of the explosion in medical knowledge and the reorganization of care. Never have so many physicians been so dissatisfied with their career choice, a phenomenon that more and more studies are highlighting and that translates, in the medical environment, into cases of burnout, impairment, transition to non-clinical tasks, early retirement and even quitting the profession.

This distress takes a heavy toll and has considerable repercussions not only on the health of our physicians, but also on the quality of the care delivered to patients and how health care is organized in general.

### Given the distress experienced by so many of its members, how should the profession respond?

We need to better understand the factors that contribute to the health and well-being of caregivers in order to educate both students and physicians. Recognizing the symptoms of burnout means being able to identify a sufferer in the early stages, and preventing it depends on being better able to pinpoint both risk and protective factors.

In 2010, the Canadian Medical Association published *Physician Health Matters*, a mental health strategy for physicians in Canada, which sets out a number of recommendations based on a review of the literature and expert opinions gleaned from across the country. The authors emphasized the deficiencies that need to be addressed in terms of prevention and the importance of taking action both with individuals and across the health-care system [53].

The disparity between the stress and mental health problems being experienced by physicians and the services

*The paradox of medical culture is that a bio-psycho-social approach is advocated for patients, while physicians are left to fend for themselves.*

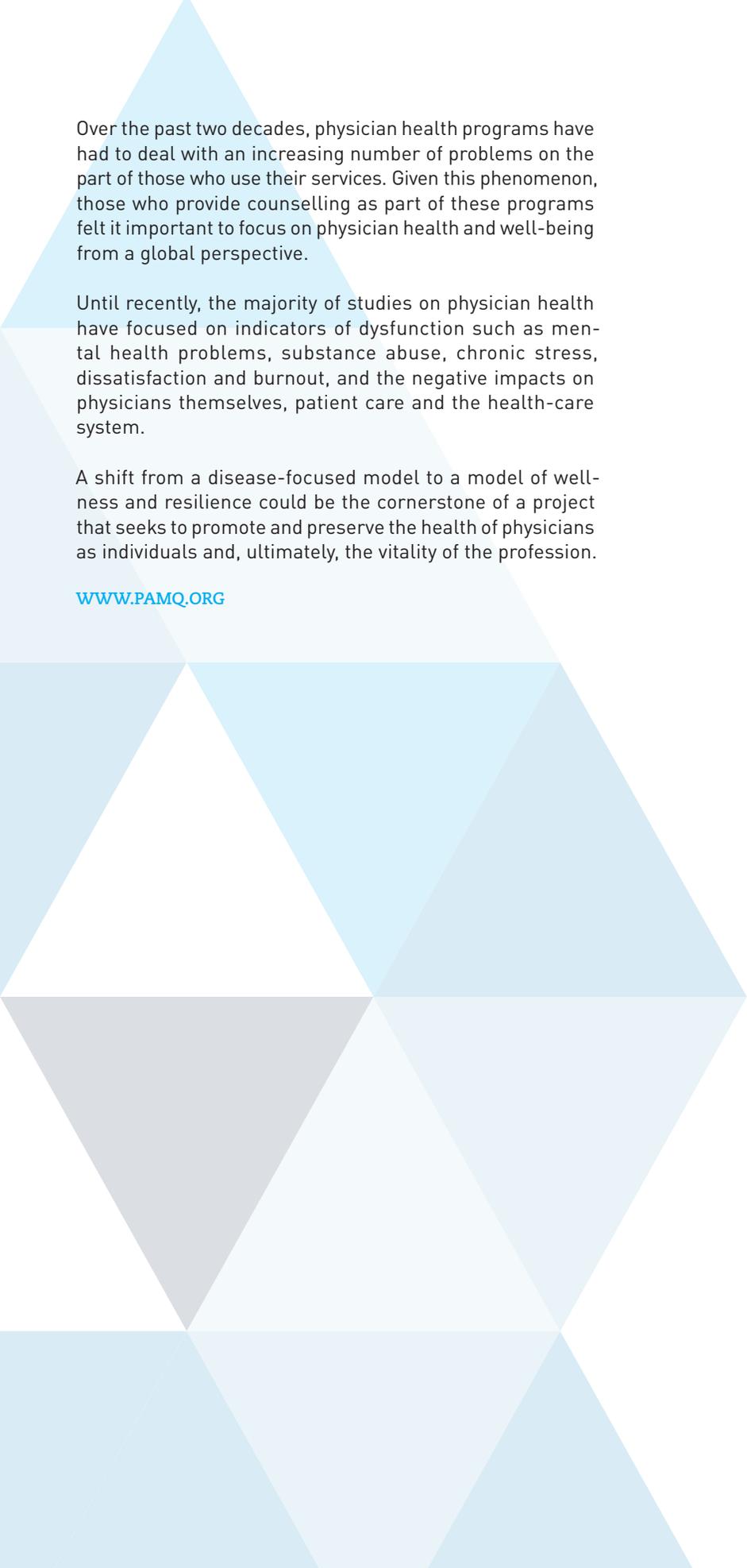
available to treat them is extremely troubling. Although well-structured programs to help physicians in difficulty exist, there is no overarching vision of the problem. Much remains to be done in order to promote holistic wellness for physicians, implement prevention strategies to facilitate their access to primary health care, boost their stress management skills and improve their work environment.

The paradox of medical culture is that a bio-psycho-social approach is advocated for patients, while physicians are left to fend for themselves.

*Physician wellness is essential to maintaining professional commitment, compassion, and long-term competencies.*

The findings of this review of literature on physician health should be interpreted by medical organizations as a call to action. It is crucial that the profession understand and accept that physicians are first and foremost human beings coping with the same challenges and issues as their patients, in addition to dealing with an array of stressors inherent to the health-care system. It is time to implement measures to give them the support they need so that they can maintain a healthy work-life balance.

Even now, medical culture encourages physicians to prioritize their work to the detriment of their needs. This sustains the myth that looking after oneself is the opposite of altruism, and yet physician wellness is essential to maintaining professional commitment, compassion, and long-term competencies. Self-sacrifice is a short-sighted notion doomed to failure. It must be recognized instead that looking after one's health is essential to being a physician. Caregivers must be encouraged to maintain personal and professional connections in order to develop an effective support network capable of meeting the challenges of medical practice.



Over the past two decades, physician health programs have had to deal with an increasing number of problems on the part of those who use their services. Given this phenomenon, those who provide counselling as part of these programs felt it important to focus on physician health and well-being from a global perspective.

Until recently, the majority of studies on physician health have focused on indicators of dysfunction such as mental health problems, substance abuse, chronic stress, dissatisfaction and burnout, and the negative impacts on physicians themselves, patient care and the health-care system.

A shift from a disease-focused model to a model of wellness and resilience could be the cornerstone of a project that seeks to promote and preserve the health of physicians as individuals and, ultimately, the vitality of the profession.

[WWW.PAMQ.ORG](http://WWW.PAMQ.ORG)

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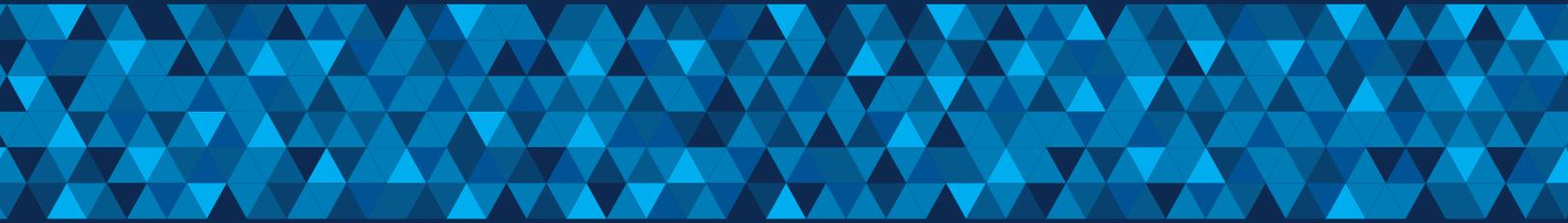
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