

# Health Habits and Coping Behaviors Among Practicing Physicians

LAWRENCE S. LINN, PhD; JOEL YAGER, MD; DENNIS COPE, MD, and BARBARA LEAKE, PhD, Los Angeles

*Practicing physicians on the full-time academic and clinical (volunteer) faculty of an urban university department of medicine (N = 211) completed questionnaires that examined their coping behaviors, health habits, life satisfaction, job stress, conflict between work and home life, health status and moods. Attempts to organize and restructure work activities were more frequently practiced by physicians who were more satisfied with work. Socializing, exercising and discussing feelings with others were not associated with any measures of physician health status, job stress, conflict or satisfaction. Those with higher scores on a health habits index tended to be less anxious, experienced less job stress, less conflict between work and home life and were more satisfied with their lives in general. Full-time academic faculty engaged in fewer positive or negative coping behaviors than clinical faculty. There were few strong intercorrelations among the various positive and negative coping behaviors or health habits; physicians often simultaneously engaged in both positive and negative activities, indicating complex patterns of coping behaviors that were not dramatically associated with life or work satisfaction.*

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In recent years, many segments of the medical establishment, including the American Medical Association (AMA), the American Medical Students Association and the Association for Academic Psychiatry, have become increasingly concerned about physician impairment.<sup>1-3</sup> An "impaired physician" has been defined by the AMA as "one who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or lack of motor skill, or excessive use or abuse of drugs including alcohol."<sup>1</sup> Studies of physician impairment have focused on defined cases of alcoholism, drug abuse, suicide, mental illness and marital discord based on data from psychiatric admissions, studies of psychiatric office practice, obituaries, disciplinary actions of state boards of medical examiners and surveys of medical students or house-staff populations.<sup>4</sup> Underlying most of these studies and discussions of physician impairment are some often-unstated and undocumented assumptions: that physicians compared with others (or other professionals) experience higher stress and frustration, are in poorer health, engage less frequently in positive health and coping behaviors and engage more frequently in inappropriate illness behaviors

such as self-medication, delay in seeking care or excessive use of denial.

There have been, however, surprisingly few published studies presenting recent data on the health habits and coping behaviors of normative samples of practicing physicians. Without such data, erroneous conclusions can easily be drawn about the state of the profession and the prevalence of impairment in the 1980s.

The few recently published studies of physician-coping behaviors and health habits do not seem to indicate that physicians are leading less healthy lives than other comparable socioeconomic groups in our society. Glanz and co-workers<sup>5</sup> in their 1980 study of physicians affiliated with Temple University (Philadelphia) looked at the prevalence of seven preventive health behaviors identified by Breslow and Enstrom in an Alameda County (California) study.<sup>6</sup> They found that 63% of their physician sample exercised vigorously two or more hours per week, only 19% smoked cigarettes, 13% drank alcoholic beverages daily and 75% slept seven to nine hours per night on a regular basis. Only half ate breakfast daily and a third ate snacks frequently. When the authors compared their findings with available national data on US

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From the Departments of Medicine (Drs Linn, Cope and Leake) and Psychiatry (Dr Yager), University of California, Los Angeles, School of Medicine, and UCLA School of Public Health (Dr Linn).

Reprint requests to Lawrence S. Linn, PhD, Research Sociologist, Department of Medicine, UCLA Center for the Health Sciences, Los Angeles, CA 90024.

adults, the Temple physicians were less likely to smoke, said they felt better than the general population, drank alcohol and snacked at about the same level, but were less likely to eat breakfast daily and reported getting slightly less sleep.

Wells and colleagues<sup>7</sup> in their 1978 study of Fresno, California, physicians found only 15% were current smokers. However, 59% thought they weighed too much, 73% reported one hour or less per week of strenuous exercise and 24% drank alcohol daily. Wyshak and co-workers<sup>8</sup> in their 1979 study of physicians and lawyers in Massachusetts reported that 75% of both groups engaged in some vigorous physical activity each week and that 86% of physicians and 80% of lawyers did not smoke cigarettes. Drinking alcohol was more frequent and prevalent among lawyers than doctors, but 90% in both groups drank at least once a month. Regarding other health habits, 3% of the doctors and lawyers they studied reported using antidepressants. Physicians were found to be slightly more likely to use tranquilizers and significantly more likely to use sleeping pills than lawyers, but the authors present no percentage data on these behaviors. Based on their findings, the authors concluded that, as a whole, physicians seemed more concerned than lawyers with personal health-promoting behaviors.

Although these studies provide interesting descriptive data, each focused on slightly different and often narrowly defined habits or behaviors and measured them in different ways. Because of these limitations, we decided to expand our definition of coping to include any behavior in which people engage to maintain or improve their physical, mental or social health and well-being. Therefore, our primary aim was to cover a wide range of physician behaviors, at the risk of not having detailed information about any single one. A second but closely related purpose was to determine the degree to which various positive and negative health and coping behaviors are interrelated with each other. Finally, we explored the relationships among the prevalence of different coping behaviors and physicians' perceived mental and physical health status, level of conflict between work and personal life and job and life satisfaction. The following hypotheses were tested:

- Physicians who more frequently used positive health habits and coping behaviors were less anxious, less depressed, had fewer symptoms or episodes of chronic disease, were more satisfied with work, experienced less conflict between work and private life and were more satisfied with all aspects of their life.

- Physicians who more frequently used negative health habits and coping behaviors were more likely to exhibit attitudes and behavior patterns opposite of the patterns listed above.

Because this research was cross-sectional, these hypotheses are not to be interpreted as causal: They merely postulate associations. We also recognize that our use of the terms "positive" and "negative" in classifying coping behaviors and health habits represents an overly simplistic and somewhat controversial set of value judgments. Similar judgments are frequently made by health professionals and people interested in coping, however. They are not necessarily thought to reflect the state of the scientific knowledge of the effects of each behavior. The classification scheme is used to facilitate analyzing and presenting the data.

## Methods

### *Sample and Design*

The present study comprised a 50% random sample of full-time academic faculty and all practicing volunteer clinical faculty affiliated with a department of medicine in an urban teaching hospital in the West.\* During the summer of 1984, respondents were sent a questionnaire accompanied by a letter from the department chair encouraging participation and guaranteeing confidentiality. After two mailings and telephone calls, completed and usable questionnaires were returned by 79% of the academic faculty (N = 56) and 64% of the clinical (volunteer) faculty (N = 155), constituting an overall response rate of 67% (N = 211).

Our final sample had the following characteristics: 91% were male; 77% were married; 76% had children, with the average number being two; 75% were clinical faculty; 8% were Catholic, 22% Protestant, 59% Jewish, 3% other and 9% had no religion, and their average age was 45 years. All physicians considered themselves as having an area of specialization. The largest groups represented were internal medicine (18%), dermatology (19%), hematology/oncology (12%), family medicine (15%), gastroenterology (6%), cardiology (6%), emergency medicine (4%) and pulmonary medicine (4%); 13 other specialties and subspecialties were listed with frequencies ranging from 1% to 3%.

### *Measurements*

Physicians completed a 13-item Job Satisfaction Scale ( $\alpha$  reliability = .85),<sup>9</sup> a widely used 9-item Life Satisfaction Scale ( $\alpha$  reliability = .89),<sup>10</sup> the 20-item Zung Depression Scale ( $\alpha$  reliability = .80)<sup>11</sup> and the 10-item Rand Anxiety Scale ( $\alpha$  reliability = .93).<sup>12</sup> Respondents also completed a 24-item multidimensional Job Stress Scale ( $\alpha$  reliability = .80), and they answered a 9-item Work/Social Conflict Scale ( $\alpha$  reliability = .74), which measured the frequency of conflict they experienced between work and personal responsibilities. These scales have been described in greater detail elsewhere.<sup>9</sup>

Physical health status was measured by a checklist of 16 chronic symptoms or diseases. Physicians were asked to check those that they had experienced over the previous six months. Finally, physicians were asked to indicate on a six-point scale from daily to never how often they engaged in each of 29 activities to make themselves feel better (health habits and coping behaviors).

## Results

As we mentioned, we chose to measure a variety of health habits and coping behaviors rather than asking detailed questions about any single one. For example, we asked how often our sample of physicians drank alcohol, not how much or what kind they drank. We asked how often they ate three meals a day, not the degree to which the food they ate was nutritionally sound. Thus, although this research will not provide an in-depth understanding of the health habits and coping styles of physicians, it will provide an overall picture not available elsewhere in the published empirical literature on the life-styles of physicians.

Table 1 describes the frequency with which physicians

\*Ken Shine, MD, provided valuable assistance with the data collection effort.

engaged in each of 29 behaviors. The most frequent behaviors were eating three meals a day, getting adequate sleep, engaging in strenuous exercise, reading non-work-related materials and engaging in sexual activity. Although most physicians engaged in these behaviors more than once a week, eating three meals a day was the only behavior practiced *daily* by a majority (51%). Of note, however, 27% reported eating three meals a day once a week or less. With regard to strenuous exercise, only 10% of physicians never engaged in such activity; 60% ran, swam or golfed several times a week or more.

Table 1 also shows that within the past six months, 20% of the physicians had used self-relaxing techniques such as meditation, progressive relaxation or breathing exercises, and 16% had sought some counseling or psychotherapy. This latter finding seems considerably higher than the use of mental health services among the general population.<sup>13</sup> Also, 91% did not smoke cigarettes and 84% had not used any mood-altering drugs for pharmaceutical or recreational reasons. Only 11%, however, of the physician sample did not drink alcoholic beverages: 32% drank several times a week and an additional 9% drank daily.

With regard to social activities, going out to dinner was the most popular, followed by talking on the telephone with friends, visiting friends or family in their homes and attending plays, movies or concerts. Only a minority of physicians engaged in such social behaviors more than once a week, however. The average frequency of these behaviors was between once a week and several times a month. In all, 51% never attended a religious service or activity and an additional 33% had done so once a month or less during the six-month time frame.

Physicians were also asked to report on how often they discussed their personal feelings with friends or family and how often they talked with them about the stressful nature of their work. As Table 1 shows, physicians varied widely in how frequently they vented their feelings. A sizable percentage discussed their feelings often, but a sizable percentage rarely or never discussed them. Although arguing with or emotionally withdrawing from others in their household was not reported as frequently as more positive types of social interactions, nevertheless, 24% reported arguing once a week or more and 14% reported withdrawing emotionally from friends and family at least once a week.

TABLE 1.—Frequency Distributions (in Percent) and Mean Scores\* (Scale of 1 to 6) of Typical Behavior in Which Physicians Engaged in the Past 6 Months to Make Themselves Feel Better (N = 211)

| Behavior   | Frequency (%) |                                   |                       |                                    |                                   |              | Mean Scores |
|--|---------------|-----------------------------------|-----------------------|------------------------------------|-----------------------------------|--------------|-------------|
|  | (6)<br>Daily  | (5)<br>Several<br>Times<br>a Week | (4)<br>Once<br>a Week | (3)<br>Several<br>Times<br>a Month | (2)<br>Once<br>or Less<br>a Month | (1)<br>Never |             |
| Eating 3 meals a day . . . . .   | 51            | 22                                | 7                     | 6                                  | 8                                 | 6            | 4.85        |
| Getting an adequate amount of sleep at night . . . . .   | 42            | 43                                | 5                     | 8                                  | 2                                 | 1            | 5.15        |
| Use of alcoholic beverages (beer, wine or liquor) . . . . .  | 9             | 32                                | 17                    | 14                                 | 17                                | 11           | 3.70        |
| Jogging, running, swimming, golfing or other strenuous exercise for 15 minutes or more . . . . .   | 14            | 46                                | 14                    | 9                                  | 8                                 | 10           | 4.21        |
| Use of meditation, progressive relaxation, biofeedback or breathing exercises . . . . .  | 1             | 5                                 | 2                     | 3                                  | 9                                 | 80           | 1.47        |
| Use of mood-altering drugs, either pharmaceutical (tranquilizers, sedatives, antidepressants) or organic (marijuana, cocaine, etc) . . . . . | 2             | 2                                 | 2                     | 1                                  | 9                                 | 84           | 1.34        |
| Attending a health club or gym . . . . .   | 1             | 12                                | 3                     | 4                                  | 8                                 | 72           | 1.79        |
| Counseling or psychotherapy . . . . .  | 1             | 2                                 | 5                     | 2                                  | 5                                 | 84           | 1.40        |
| Walking or driving for the exclusive purpose of relaxation and enjoyment . . . . .   | 2             | 14                                | 8                     | 21                                 | 24                                | 30           | 2.60        |
| Using special calendars, making lists or using other devices to become better organized† . . . . .   | 26            | 22                                | 8                     | 11                                 | 11                                | 22           | 3.75        |
| Attending religious services or activities . . . . .   | 1             | 1                                 | 8                     | 6                                  | 33                                | 51           | 1.76        |
| Reading non-work-related books and magazines other than daily newspapers . . . . .   | 23            | 42                                | 8                     | 16                                 | 9                                 | 2            | 4.49        |
| Attending plays, movies or concerts‡ . . . . .   | 0             | 4                                 | 21                    | 42                                 | 31                                | 1            | 2.98        |
| Going out to dinner in a restaurant with friends or family‡ . . . . .  | 1             | 25                                | 34                    | 31                                 | 9                                 | 0            | 3.77        |
| Visiting friends or family in their homes‡ . . . . .   | 0             | 7                                 | 21                    | 41                                 | 29                                | 1            | 3.03        |
| Talking on the telephone with friends about non-work-related activities‡ . . . . .   | 6             | 26                                | 12                    | 35                                 | 16                                | 5            | 3.55        |
| Engaging in pleasurable sexual activity . . . . .  | 4             | 51                                | 23                    | 17                                 | 4                                 | 1            | 4.27        |
| Smoking cigarettes . . . . .   | 4             | 1                                 | 0                     | 1                                  | 3                                 | 91           | 1.30        |
| Arguing with people in my household   . . . . .  | 2             | 11                                | 10                    | 20                                 | 43                                | 14           | 2.66        |
| Withdrawing emotionally from family members or friends upon coming home at night   . . . . .   | 0             | 6                                 | 8                     | 18                                 | 34                                | 34           | 2.17        |
| Discussing personal feelings with friends or family¶ . . . . .   | 13            | 25                                | 9                     | 24                                 | 20                                | 10           | 3.58        |
| Discussing the stressful nature of medical work with friends and family¶ . . . . .   | 5             | 17                                | 7                     | 23                                 | 32                                | 16           | 2.93        |
| Eating frequent snacks during the day or in the evening . . . . .  | 8             | 23                                | 7                     | 17                                 | 18                                | 27           | 3.06        |
| Blocking out time for making or returning phone calls† . . . . .   | 19            | 20                                | 5                     | 9                                  | 13                                | 34           | 3.22        |
| Organizing and scheduling work activities so that I will not be rushed or run late† . . . . .  | 37            | 26                                | 11                    | 10                                 | 7                                 | 9            | 4.48        |
| Reducing my expectations of what I can accomplish in a single day† . . . . .   | 14            | 24                                | 10                    | 10                                 | 21                                | 21           | 3.39        |
| Adding to, reorganizing or diversifying my practice of medicine§ . . . . .   | 8             | 7                                 | 6                     | 16                                 | 40                                | 23           | 2.59        |
| Delegating more responsibility to others to perform work-related tasks§ . . . . .  | 14            | 20                                | 8                     | 26                                 | 25                                | 7            | 3.51        |
| Cutting down on the number of patients I see§ . . . . .  | 5             | 4                                 | 5                     | 8                                  | 24                                | 54           | 1.97        |

\*Higher scores indicate more frequent behavior.  
† = Subscale: organizing (α = .62)  
‡ = Subscale: socializing (α = .72)  
§ = Subscale: restructuring (α = .60)  
|| = Subscale: arguing/withdrawing (α = .49)  
¶ = Subscale: venting feelings (α = .81)

PHYSICIAN HEALTH HABITS AND COPING

TABLE 2.—Pearson Correlation Coefficients Between Coping Scales and Scales Measuring Physicians' Health Status, Stress, Conflict and Satisfaction

| Health, Stress and Satisfaction Measures | Coping Behaviors |            |            |               |         |                     |                 |                 |               |
|--|------------------|------------|------------|---------------|---------|---------------------|-----------------|-----------------|---------------|
|  | Socializing      | Exercising | Organizing | Restructuring | Arguing | Discussing Feelings | Positive Coping | Negative Coping | Health Habits |
| Anxiety scores                           | .032             | .022       | -.073      | .095          | .259*   | .056                | .015            | .204†           | -.138‡        |
| Depression scores                        | -.028            | -.010      | -.087      | -.022         | .166‡   | -.009               | -.076           | .125            | -.114         |
| Number of chronic symptoms               | -.019            | .007       | .024       | .060          | .064    | .068                | .068            | .104            | -.064         |
| Job stress                               | -.018            | -.030      | .062       | .090          | .156‡   | .085                | .061            | .068            | -.138‡        |
| Job satisfaction                         | .118             | .063       | .203†      | .192†         | -.120   | -.026               | .194†           | -.114           | -.054         |
| Work or personal conflict                | .033             | -.067      | -.056      | .013          | .313*   | .110                | -.003           | .156‡           | -.164‡        |
| Life satisfaction                        | .063             | .109       | .121       | -.011         | -.234*  | .019                | .111            | -.138‡          | .182†         |

\*P < .001  
 †P < .01  
 ‡P < .05

Physicians varied in their use of time management techniques and behaviors that helped them to become more organized. For example, 26% used special calendars or made lists daily and an additional 22% did so several times a week, but 22% never used these techniques. Similarly, 39% blocked out time for making phone calls several times a week or daily, but 34% never did so. A majority (63%) reported organizing and scheduling their work so that they would not be rushed or run late, but 26% did so only several times a month or less. Additionally, 14% reduced their expectations of what they could accomplish on a daily basis and an additional 24% did so several times a week. But 21% never reduced their expectations of themselves and 21% did so once a month or less.

With regard to how often the physicians made attempts to restructure their practice of medicine to make their life easier, 15% said that they added to, reorganized or diversified their practice several times a week or more; 63% said they did so once or less a month or never. In all, 14% reported delegating responsibility to others daily and 20% did so several times a week, but 25% delegated work to others once or less a month and 7% never did so. Finally, only 14% of physicians said they cut down on the number of patients they saw once a week or more, and 54% reported never cutting down on their patient volume.

To see whether our 29 behavioral measures would cluster into dimensions, we did correlational and principal components factor analyses. The four items measuring socializing (items marked with ‡ on Table 1) factored into a scale ( $\alpha = .72, \bar{x} = 3.33$ ), as did the four behaviors reflecting attempts to become better organized (items marked with †,  $\alpha = .62, \bar{x} = 3.69$ ). The three items concerned with attempts to restructure one's medical practice (items marked with §) also factored into a scale ( $\alpha = .60, \bar{x} = 2.70$ ), as did the two items on discussing feelings (items marked with ¶,  $\alpha = .81, \bar{x} = 3.25$ ) and arguing and withdrawing (items marked with ||,  $\alpha = .49, \bar{x} = 2.42$ ).

Pearson correlations among these scales and other individual activities in Table 1 thought to be beneficial to overall health and well-being were used to construct a reliable 16-item scale ( $\alpha = .75$ ), which we call the Positive Coping Scale. These behaviors included exercising, belonging to a health club, sexual activity, socializing, attempting to organize and to restructure work-related activities and venting feelings. Negative coping behaviors generally thought to inhibit overall health and well-being, such as drinking alcohol, using mood-

altering drugs, smoking cigarettes, arguing or emotionally withdrawing from friends and family and frequent snacking, did not form a reliable scale. We constructed an index, however, by averaging the frequencies of these behaviors and will refer to it as the Negative Coping Index. Other behaviors thought to be therapeutic, such as meditating, the use of psychotherapy or attending religious activities, were statistically unrelated to all other behaviors.

Finally, we constructed a six-item Health Habit Index that consisted of six of the seven health behaviors found by Breslow and Enstrom in the Alameda County studies to be positively related to health status (eating regularly, sleeping adequately, exercising, not smoking, not drinking and not snacking).<sup>6</sup> Respondents were given a score of 1 for each positive behavior they engaged in several times a week or more and a score of 1 for each negative behavior they engaged in once a week or less. When scored in this way, 13% of our physician sample had a total score of 6, 37% a score of 5, 31% a 4, 16% a 3 and 4% a score of 1 or 2.

Table 2 shows Pearson correlation coefficients (and P values) between our nine coping scales and scores measuring physicians' anxiety, depression, symptoms of chronic disease, job stress, job satisfaction, work or personal conflict and life satisfaction. The findings can be summarized in the following way:

- More frequent efforts by physicians to organize and restructure their work by using time and other people more efficiently were associated with greater job satisfaction.
- Arguing more frequently with people at home or emotionally withdrawing from them (or both) were significantly associated with being more anxious and depressed, experiencing greater conflict between work demands and personal responsibilities, experiencing greater job stress and having less life satisfaction.
- Positive coping, as reflected by our scale of 16 behaviors, was more frequently practiced by physicians who were more satisfied with their work.
- Socializing, exercising and discussing feelings with others were not correlated with any measure of physician perceptions of health status, job stress, conflict or job or life satisfaction.
- Negative coping behaviors were used more frequently by physicians who were more anxious, experienced more conflict between their work and personal life and who were less satisfied with their life in general.

• On the Health Habits Index, which consisted of three positive and three negative health behaviors, physicians with higher scores were less anxious, experienced less stress on the job and less conflict between work and their home life and were more satisfied with their life in general.

We also examined the relationship between physician coping behaviors and selected demographic and work characteristics. None of the nine coping scales shown in Table 2 were related to physicians' age, race, sex or volume of inpatients or outpatients seen in the previous two weeks. Unmarried physicians, however, were significantly more likely than married physicians to socialize ( $P < .001$ ), exercise ( $P < .05$ ) and attempt to restructure their practice ( $P < .05$ ). Unmarried physicians were less likely to argue with people at home ( $P < .05$ ) but were more likely to use positive coping behaviors ( $P < .01$ ) and negative coping behaviors ( $P < .05$ ). Physicians with more children were less likely to restructure their practice, to vent their feelings or to use positive or negative coping behaviors (all  $P < .05$ ).

Physicians who had taken more vacation time in the previous year socialized more frequently ( $P < .01$ ) and engaged more frequently in positive coping behaviors ( $P < .05$ ). Similarly, physicians who worked more hours in an average work week socialized less ( $P < .001$ ) and engaged in positive and negative coping behaviors less frequently ( $P < .05$ ). Finally, clinical faculty, as compared with full-time academic faculty, were more likely to socialize ( $P < .01$ ), more likely to discuss their feelings with others ( $P < .05$ ) and more likely to engage in positive coping behaviors ( $P < .01$ ).

## Discussion

In the present study, we developed and tested a series of questions about the health habits and coping behaviors of practicing physicians. As we have shown, physicians varied widely in their habits and practices. Although we were able to develop a reliable scale consisting of 16 of the 29 coping activities we measured, many physician behaviors were unrelated to each other. Similar to what Glanz and her associates found in their Temple University sample, the Breslow Health Habits were not significantly intercorrelated with each other in our physician population. Similarly, the negative coping behaviors we measured also were not significantly intercorrelated with each other, nor were they routinely negatively correlated with positive coping behaviors. What this means is that our physician sample does not lead consistently healthy or unhealthy life-styles but engages in often random, unique and complex patterns of coping behaviors.

Because of the lack of comparable data on ways of measuring coping in other populations, it is difficult to know how satisfactory or healthy a life-style our population was leading relative to others. We have studied only internists affiliated with a single teaching hospital in southern California. Our results may not be generalizable to physicians in other specialties, to our nonrespondents or to those practicing in other parts of the country. Compared with other physician populations described in our introduction, however, the practices reported by our sample appear to be as healthy or healthier. Similarly, compared with what is known about the general adult population, physicians in our study probably exercise vigorously and use counseling or psychotherapy more frequently, but are less likely to attend religious activities, lead

active social lives, eat three meals a day on a regular basis or get adequate sleep. Alcohol consumption seems comparable to the adult male general population, but physicians use drugs significantly less frequently and are significantly less likely to smoke cigarettes.<sup>14</sup>

Our results suggest that the frequency of coping strategies of all kinds is significantly related to certain social circumstances. Unmarried physicians and those working fewer hours per week were more likely to engage in both positive and negative kinds of activities, probably because they had more time to do so. Physicians working longer hours and those with more children were less active in the behavioral coping strategies we measured.

With regard to the relationship between coping strategies and physicians' perceived health, stress, conflict and satisfaction, only a few of our initial hypotheses could be confirmed. Positive coping was significantly related only to increased job satisfaction. Physicians who expressed greater satisfaction with their work have somehow learned to manage their time more efficiently, are better organized, are more realistic regarding what they can accomplish, are able to delegate responsibility and are able to arrange and reorganize their work load frequently. Such positive coping, however, was not found to be related to stress, mental or physical health or overall life satisfaction.

On the other hand, physicians who engaged in negative coping behaviors more frequently experienced greater anxiety, greater conflict between work and home life and less life satisfaction. Arguing with others at home and emotionally withdrawing from friends or family were particularly associated with experiencing more anxiety, depression, stress and conflict and less life satisfaction. Of course, these negative coping behaviors are themselves often symptoms of anxiety and depression. They may simply be other indicators of distress or the failure of positive coping, or both. In spite of these associations, most of even the significant correlations were small.

Although in a cross-sectional study such as this, directions of associations cannot be determined, the absence of strong relationships between individual positive coping behaviors and positive mood, health status and perceptions about life are still somewhat surprising. This finding raises questions about the therapeutic value of many cherished behavioral interventions thought to be correlated with reduced anxiety, depression, stress and dissatisfaction. It is also possible, however, that positive coping behaviors are actually beneficial, but that our measures were inadequate to assess this properly.

The present study does confirm, although not dramatically, the additive value of Breslow's Health Habits. Physicians who reported healthier habits related to eating, sleeping, exercising, drinking, smoking and snacking actually expressed less anxiety, less job stress, less conflict and greater life satisfaction. These relationships and the role of health, stress and satisfaction will be explored in future reports.

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## Medical Practice Question

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EDITOR'S NOTE: *From time to time medical practice questions from organizations with a legitimate interest in the information are referred to the Scientific Board by the Quality Care Review Commission of the California Medical Association. The opinions offered are based on training, experience and literature reviewed by specialists. These opinions are, however, informational only and should not be interpreted as directives, instructions or policy statements.*

### Arthroscopic Stapling of an Unstable Shoulder

**QUESTION:**

*Is arthroscopic stapling of an unstable shoulder considered accepted medical practice?*

**OPINION:**

In the opinion of the Scientific Advisory Panel on Orthopedics, arthroscopic stapling of an unstable shoulder is considered investigational. Though preliminary reports indicate that this promising technique may approximate the effectiveness of current operative methods, it is still in the early stages of development and its long-term results are unknown. Until published studies document its efficacy over time, therefore, arthroscopic stapling to correct an unstable shoulder is not considered established medical practice.