CME

Physician, heal thyself

Developing a hospital-based physician well-being committee

NICOLE BAIRD, MD
JUDITH S. FISH, DPS
MICHAEL DWORKIND, MD
YVONNE STEINERT, PHD

SUMMARY

This article describes the development of a physician well-being committee at the Sir Mortimer B. Davis-Jewish General Hospital. It discusses the issue of physician stress, outlines the committee's mandate, and describes the various activities and services that were implemented.

RÉSUMÉ

Cet article décrit la formation d'un comité préoccupé du bien-être des médecins à l'Hôpital général juif Sir Mortimer B. Davis. On y présente une discussion sur le stress vécu par les médecins, une description du mandat du comité et les diverses activités et services mis sur pied.

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THE MEDICAL PROFESSION IS A privileged profession. We care about people. We are honored by their confidence. We are permitted to share and participate in basic moments of life. Paradoxically, however, although physicians care about the physical and emotional health of patients, they take notoriously poor care of themselves.[1]

In the fall of 1986, a physician member of our Department of Family Medicine committed suicide. The shock and disbelief caused by this tragedy prompted the department to ask itself some difficult questions. How could we, physicians in a caring profession, not see a colleague's distress? Why was he not helped? Do physicians not see their own distress? How can we help physicians take care of themselves?

These questions, and the numerous discussions that followed, prompted the Department of Family Medicine to create a Physician Well-Being Committee (PWBC). The initial mandate of this committee was to examine physician distress and to develop strategies to promote the physical and emotional well-being of physicians in our hospital Department of Family Medicine.

This article describes the activities of the PWBC and highlights its successes and limitations. We hope that this description will encourage other physicians to explore new ways of dealing with physician distress and to address the question: Who heals the healer? Who helps the helper?

Dr Baird *is a member of the Department of Family Medicine of the Sir Mortimer B. Davis-Jewish General Hospital (SMBD-JGH) and is part-time faculty lecturer in the Department of Family Medicine at McGill University in Montreal.* **Dr Fish** *is Co-director of the Physician Referral Service at SMBD-JGH and was Assistant Professor of Family Medicine at McGill University at the time of writing.*
Dr Dworkind *is Chairman of the Physician Well-Being Committee of the Department of Family Medicine of SMBD-JGH and is Associate Professor of Family Medicine at McGill University.*
Dr Steinert *is Director of Behavioural Sciences at the Herzl Family Practice Centre at SMBD-JGH, is Co-director of the Physician Referral Service, and is Associate Professor of Family Medicine at McGill University.*

Physician stress and coping

Medicine is an inherently stressful profession. Long hours, "difficult" patients and their families, pressing clinical decisions, and conflicting demands of personal and professional goals are some of the causes of distress.[2-4] In addition, physicians report a high incidence of marital problems, depression,

and anxiety.[5-7] Their suicide risk is higher than that of the general population,[8,9] and the prevalence of addiction, both drug and alcohol, is alarming.[10-12]

Not only is the practice of medicine stressful, but doctors are also known to take poor care of themselves.[13,14] Few have their own personal physicians, and few go for annual checkups, often preferring to treat themselves or to ask a colleague to prescribe medication.[15-18] Some physicians are so accustomed to the role of helper that providing help and asking for help seem mutually exclusive.[12] Denial of physician distress is common, as is a reluctance to deal with emotional difficulties effectively.

In many ways, physicians' mechanisms for coping with stress are often maladaptive and unhealthy.[13,14,19] In fact, it has been suggested that some of the personality traits that get doctors into medicine in the first place, such as a strong sense of responsibility, delayed gratification, traits of obsessive-compulsiveness, and personal sacrifice, can lead to their downfall.[20,21] In addition, medical education does not generally prepare physicians to deal with the stress of a practice, a home, and a marriage. If anything, it reinforces the need to deny the human weaknesses that physicians readily accept in their patients.[11,22]

Well-being programs

Several programs that address the problem of physician distress have been established in North America and Europe.[11,23-28] Most of these programs fall under the auspices of medical associations and licensing boards, and are primarily focused on physicians with problems of drug and alcohol abuse. Impairment programs generally do not focus on prevention. Distressed physicians are usually identified late in the course of their distress or impairment, when professional competence has been affected. To our knowledge, hospital-based programs, developed by practising physicians to focus on *normal* as well as severe distress, are uncommon.

Medical schools have recently addressed the problem of physician distress by developing outreach programs for medical students and residents. These programs include support groups for residents and their spouses, individual and marital counseling, and stress management training.[29-35] Several universities have also set up well-being committees for students.[36] But what about after residency? It seems that, once the diploma is in hand, physicians are on their own. What does well-being mean for physicians in the community?

Developing the Physician Well-Being Committee

The PWBC consists of five physicians and two psychologists, working in the Department of Family Medicine. Initially, we met to discuss physician stress and coping, our role in helping physicians in distress, the difficulty of reaching physicians at high risk, and ways of alleviating and reducing physician distress. Although we were concerned about the lack of priority physicians generally give to this topic, and the possible lack of interest in the projects we would develop, we nonetheless decided to focus on prevention and alleviation of physician distress.

Objectives of the PWBC were:

- to increase physician awareness through continuing medical education;
- to alleviate physician distress through specific prevention programs; and
- to develop an outreach service to physicians in distress.

Education. In an attempt to increase physician awareness of stress-related issues, the PWBC developed a series of lectures and workshops on physician burnout, stress management, working with "difficult" patients, and time management. We sponsored these lectures in order to recognize the importance of these topics in physicians' lives.[34] Although attendance at these sessions was low, feedback from the physicians who did attend was positive. In fact, several physicians asked for more detailed, written information on these topics, and this request led to the development of a resource lending

library, with information on stress and burnout, time management, substance abuse, and treatment centres available in Canada and the United States.

Prevention. To diminish physician stress and to enhance communication between the members of the department, the committee organized a number of different activities: a Balint group; a locum service; a monthly newsletter; and an in-house aerobics class.

Balint group: A Balint group was set up in 1987 to provide physicians with a forum in which to discuss their difficulties in working with patients. Led by a psychiatrist, this group was designed to help physicians examine their interactions with patients and to discuss their own anxieties, doubts, and concerns. The initial group of four physicians met weekly for 1 hour in the hospital. A second group of four physicians was launched in 1989 led by a family physician who was doing a psychiatry residency at the time. Although the feedback from the participating physicians was excellent, it was difficult to recruit new physicians from within the hospital community.

As a result, the members of the Balint group made several recommendations. They suggested that participation should be open to all family physicians within the Department of Family Medicine at McGill, that the meetings should be held outside the hospital, and that the time should be more convenient for everyone concerned.

Locum service: A locum service was established to enable physicians to take short periods (1 to 3 months) off from their work without having to abandon their patients. Community physicians could phone the PWBC and give the details of their practice and their planned leave. We would then contact a second-year resident or recent graduate who had not yet settled into a fixed workplace. The number of requests received, as well as the feedback from the physicians who used this service, emphasized the benefit of this activity. Anticipating the need, and finding an available physician willing to take on a locum, was the key challenge to this program.

Departmental newsletter: A newsletter, entitled *The Colleague*, was developed to enhance communication among community family physicians and to promote a sense of departmental well-being. This newsletter provided a forum for presenting stress-related articles, conference announcements, and humorous anecdotes about medical life. Building a sense of community was an important objective of the newsletter, and physicians were encouraged to send in their own contributions.

Exercise classes: Aerobic exercise is a common component of stress management programs.[20,37,38] To help members of our Department "burn off" their daily stress, an exercise class was scheduled in the hospital at the end of the day. Unfortunately, few physicians attended, and the group had to disband after several months. We found that accommodating physicians' busy schedules was difficult, if not impossible, and we decided to concentrate our efforts on encouraging physicians to organize their own regular exercise programs.

Physician Referral Service

One of the Committee's main activities has been developing a Physician Referral Service (PRS), an outreach program for distressed physicians modeled on employee assistance programs.[39,40] The PRS provides help to any member of the Department of Family Medicine or family members experiencing personal or professional distress. This service is described in greater detail by Fish and Steinert (page 249).

Help is offered in the form of a confidential assessment and referral to an appropriate community resource. Assessment is carried out by a team consisting of a family physician and a clinical psychologist. Referral is made to an appropriate resource, such as a psychologist, a psychiatrist, a financial adviser, a substance abuse centre, a physician, or a social worker. We opted to create our own referral service, as committee members believed that

physicians would be reluctant to use the hospital employee assistance service.

The PRS was created in 1987. We predicted a user rate of two assessments yearly, as approximately 2.15% of employees avail themselves of employee services.[41] To date 32 physicians have used this service, for a variety of problems including anxiety and depression, marital and family problems, child behaviour problems, and stress and burnout. This response exceeded our initial expectation and impressed upon us (and other physicians) the usefulness of such a service.

Conclusion

The impact of programs set up by the PWBC to prevent and alleviate physician distress is difficult to assess. Does the assessment of each activity accurately reflect the Committee's work as a whole? Is the success of a project linked to the rate of participation, to the interest of the involved participants, or to the setting up of similar projects elsewhere?

In our opinion, one of our committee's most important accomplishments has been an increased awareness of physician stress among the members of the department. By demonstrating its commitment to the well-being of its members, the department has encouraged the development of a sense of community and support among the hospital-based and community physicians. The department's continued interest and support for the committee's existence has also been a measure of its success, despite the fact that participation in most programs has been low.

Although poor participation could have been due to practical factors, such as inadequate marketing or scheduling conflicts, we think it partly reflects the fact that physicians are not used to taking care of themselves and frequently deny their own needs. In fact, this denial could explain the greater success of the PRS compared with other programs we developed, because the PRS service responds to the needs of physicians in distress, when the problem can no longer be denied. It could also be that physicians respond better to a one-to-one approach than to programs that require group participation.

We believe acceptance of physicians' vulnerabilities must start much earlier in doctors' medical careers, as must education around these issues. Committees, too, might be more effective if they worked to modify institutions where physicians are trained and maladaptive patterns are developed.[36] It is important that physicians not bear the inherent stresses of their lives in isolation, that doctors see their colleagues as caring, and that they perceive a "safety net" in moments of distress. Research is now needed to determine the most effective way of reaching out to physicians at risk in a nonthreatening and accepting way. ■

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Correspondence to: *Dr Nicole Baird, Department of Family Medicine, Sir Mortimer B. Davis-Jewish General Hospital, 5757 Legare St, Montreal, QC H3T 1Z6; fax: (514) 340-8298*

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