

# Stress Is Occupational Hazard for Physicians

**W**ANTED: Men and women high-school graduates who are willing to spend eight years in a university and an additional two to 10 years doing post-graduate work. Must work at least 60 hours each week at a declining pay scale and be willing to sacrifice personal and family time. Other desirable traits and skills: flexibility; a friendly disposition at all times;

excellent business, management and research skills; the ability to work under extreme stress, withstand constant lawsuit threats and accept that every decision you make could be scrutinized by a third party.

**Despite the long hours and overwhelming stress, many physicians believe that practicing medicine is still the best job anywhere on the planet. But others fall prey to the profession's downside—they struggle to achieve a balance between work and the rest of their lives and end up with serious disorders ranging from depression to addiction.**

How many people in the U.S. would actually want this job? In 2003, precisely 871,535 people did, according to the latest data available from the American Medical Association.

As you probably know, the job description is for a physician. Despite the long hours, overwhelming stress and challenging environment, many physicians believe that practicing medicine is still the best job anywhere on the planet. But others fall prey to the profession's downside—they struggle to achieve a balance between work and the rest of their lives and end up with serious disorders ranging from depression to addiction.

Perhaps no other profession—with the possible exception of air-traffic controller—offers so many challenges and pitfalls for those who practice it. Indeed, the culture of medicine places a

low priority on physician mental health despite evidence of untreated mood disorders and an increased burden of suicide, according to an article entitled *Confronting Depression and Suicide in Physicians: A Consensus Statement*, published in the June 18, 2003, issue of the *Journal of the American Medical Association*. “Barriers to physicians’ seeking help are often punitive, including discrimination in medical licensing, hospital privileges and professional advancement,” the article states.

The JAMA article reveals the following:

- A systematic review of articles published between 1963 and 1991 that focused on 14 international studies of suicide in physicians found higher rates of suicide in doctors compared with those of the general population.
- Thirty-five percent of physicians have no regular source of personal healthcare.
- Physicians often neglect to seek help for their own depression, which is the leading cause of disability and key risk factor for coronary artery disease in male physicians.
- Only 22 percent of medical students who screened positive for depression actually used mental-health services, while 42 percent with thoughts of suicide received treatment. Reasons included lack of time (48 percent), lack of confidentiality (37 percent), stigma (30 percent), cost (28 percent) and fear of documentation on academic record (24 percent).
- The largest U.S. study of white, male physician deaths in 28 states between 1984 and 1995 revealed that compared with white, male professionals, physicians’ proportionate mortality ratio was higher for suicide than for all other leading causes of death.

The AMA estimates that between 8 percent and 12 percent of physicians suffer from emotional problems or substance abuse. Likewise, state medical boards say that between one-third and one-half of complaints against physicians involve substance abuse.

Over the past decade, Dr. Jack McIntyre has noticed an increase in the number of physicians nationwide who are experiencing difficulty in coping with their jobs. Dr. McIntyre, a psychiatrist, chairs the department of psychiatry and behavioral health for Unity Health System in Rochester, N.Y., and also two committees that involve physician health and wellness for the Medical Society of the State of New York and the Monroe County

Medical Society. He says that some of the reasons for this trend include the demand for increased productivity and documentation, the intrusion into patient care by managed-care organizations and the need for physicians to practice defensive medicine as a result of the rising number of malpractice suits.

To make matters worse, Dr. McIntyre says, the support structure for physicians also has deteriorated. “The practice of medicine has become somewhat more isolating,” he says. “A couple of decades ago, physicians would spend a fair amount of time in the doctor’s lounge talking to one another. There was mutual support and sharing about how things were going. Now that kind of mutual support has greatly diminished so that folks are operating on a much more individual mode.” Even in group practices, he says, the fast pace has prevented physicians from talking to and supporting each other as they did in the past.

There are other factors that can lead to trouble. For example, many physicians are highly driven and competitive, observe demanding work schedules, typically neglect their own health-care needs and don’t carve out time for leisure activities or family life. Dr. McIntyre says that this all adds up to an increase in stress and vulnerability for depression, anxiety and substance-abuse problems.

### **Common Stressors in Physicians**

1. Excessively high patient-to-caregiver ratio.
2. Lack of time outs for a temporary breather.
3. Excessive continuous direct contact with patients.
4. No system for caregivers to “cover” for each other.
5. Limited access to a social-professional support system.
6. Limited time and place to share personal feelings with colleagues.
7. Inadequate training for working with people.
8. Tendency in the work setting to blame people rather than the situation when care or service deteriorates.
9. Repetitive single tasks.
10. Problems without solutions.
11. Time pressures and demands.
12. Indispensable syndrome.

*Source: Texas Medical Association Committee on Physician Health and Rehabilitation.*

Dr. McIntyre says that there is a strong need for physicians to return to the old days by providing a setting where doctors can reach out to colleagues for help. “There’s a real need for that kind of opportunity,” he says. “The major thing is to urge physicians to take care of themselves. It’s a little bit of the reverse golden rule—do unto you as you would for others. They need to listen to themselves as they would tell patients to do.”

Tom Erney, Ph.D., a licensed marriage and family therapist at Alternatives Counseling and Consultation Center in Gainesville, Fla., has counseled many stressed-out physicians. Unfortunately, he says, the need for

**The need for counseling** is still seen as a weakness by some doctors—especially male physicians—and threatens their identity, says Tom Erney, Ph.D., a licensed marriage and family therapist in Gainesville, Fla. But, he says, after one or two counseling sessions, they’re always appreciative for the opportunity to reflect on their own lives.

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“They’ve really mechanized their life, and part of counseling is personalizing their own life,” he says, adding that many doctors lack self-awareness. “They’re amazingly aware of other people and the dynamics of disease, illness, health and wellness but are amazingly unaware of their own inner experience.”

When helping physicians balance their work with home life, Dr. Erney suggests the following four tips:

■ **Wake up to your own life.** If you’re not self-aware, you are going to make choices that will create more conflict and confusion. No matter how busy you are, keep a journal to record your inner thoughts and experiences. The issue here is not time but setting your priorities and perspective. “Knowing what is true north matters most,” he says. “If you’re willing to be self-aware enough to say, ‘I don’t matter in my own life,’ that is your choice. But it needs to be a self-aware or conscious choice.”

■ **Open yourself to feedback from those who love you.** Becoming accepting of their ideas, opinions and alternative perspectives can be very helpful. “It takes two to see one—I need you to help

me see me,” he explains. Dr. Erney also compares this step to the process of cutting and polishing a gem. If there’s too little friction, the stone remains dull and lifeless. If there’s too much friction, the stone will shatter. “You need mindful and thoughtful cutting and polishing with and by the people who love you and whom you love,” he says.

■ **Be aware that every time you say “yes” to something, you’re saying “no” to something else.** How important is attending your son’s football game or sister’s birthday party? Be very clear about what matters to you. Begin with the end in mind. What do you want to be pleased with and proud of?

■ **Create a safe place or sanctuary**, whether it’s through prayer, meditation or therapy sessions, where you can begin to discard your defenses and reflect on how you’re living your life. “Most doctors have very few places where they ever feel safe,” he says. “They feel so vulnerable in their medical practices because of managed care, the threat of lawsuits, hospital management efficiency or money matters.”

Most physicians also suffer from the “never enough” syndrome, says Dr. Erney, explaining that there’s never enough of anything—ranging from enough understanding of an illness to time or energy. While that may have been the driving force behind their professional achievements, it also causes physicians to ignore their own lives or personal development.

## Generational Shift

Besides the emotional distress that can stem from making life-and-death decisions and coping with dying patients, doctors also face another challenge that’s unique to their profession: a generational shift that continues accelerating.

Consider physicians who belonged to the World War II generation. “When you were a doctor, that was your life,” says Dr. Richard Sheff, chairman and executive director of The Greeley Company, a division of HCPro, a national healthcare consulting and educational firm in Marblehead, Mass. “The common comment was, ‘Medicine is a jealous mistress.’”

But through the decades that perception has been slowly changing. He remembers when he entered clinical practice in the early 1980s. He joined a family physician who was a “salt-of-

the-earth guy—everybody loved him,” he says, adding that besides performing minor surgery, this doctor practiced in the same city for 30 years and delivered many of the town’s children.

When Dr. Sheff came on board, his wife at the time was pregnant with their first child. After their son was born, he announced that he was going to take three weeks off for paternity leave.

“He looked at me as if I was nuts,” he says, referring to his partner. When Dr. Sheff returned from paternity leave, he told the doctor that he planned to take off every Tuesday and Thursday afternoon in order to spend time with his newborn son.

“He [thought] I had gone off my rocker,” says Dr. Sheff. “He said to me, ‘Rick, why on God’s green earth would you want to spend any time with a kid under the age of two? He can’t even talk yet.’”

At that moment, the generation gap between the two physicians couldn’t be wider. Still, Dr. Sheff was determined to participate actively in both his marriage and the raising of his children. It wasn’t easy. Despite his good intentions, he consistently received the same message from his family: you’re not spending enough time at home.

When baby boomers became physicians, they came one step closer toward balancing the demands from work and family. They were on call every fourth, fifth or sixth night, believing that was a big burden. Now Generation X, which produced the latest batch of doctors, is the first group to experience night coverage, where a float physician covers the night shift.

“They can go to sleep, hand their patients off to someone else,” Dr. Sheff says. “They’re no longer their responsibility, which is a real shift in how physicians have seen their patients and their relationship with the care of patients.”

Another major difference is that residents are now required to limit their work schedule to 80 hours a week. In the past, work-weeks of up to 110 hours were common. More than any other

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generation of doctors, these physicians have developed a greater sense of life outside of medicine and can sometimes clash with those from the old school, Dr. Sheff says.

Another major change came in what Dr. Sheff refers to as a physician's social contract. Years ago, he says, if medical students went through rigorous training during their twenties, worked hard and sacrificed personal and family time, in return they would earn a good income, have a professionally satisfying career and earn the respect of the community. But that contract has since unraveled with help from managed care, increased malpractice litigation and declining government reimbursements, leaving physicians wondering what happened to the deal they thought they had struck, he says.

"They're stretched just running a practice—the amount of paperwork, management responsibilities and dealing with third-party payers just to get their money," Dr. Sheff says, adding that medicine is now more stressful than it has ever been. "Now they're even angrier because they can't cut back in the office to balance work and home. They have to work harder and dance faster just to stay in place."

Dr. Sheff teaches workshops addressing the management of polarities to physicians. He begins the course by asking, "Which is more important—work or home?" While everyone agrees that both are equally important, he then teaches the group how to manage these two extremes. He explains that the fundamental dilemma is that if you overfocus on one pole, good things will happen on that side but bad things will occur on the other.

For instance, if you focus on work, you can grow professionally, have a satisfying career, earn a decent living and develop security. But the downside of overworking can lead to a broken marriage, strained relationships with children and other family members and a lack of personal development. He says that many workaholic physicians face a difficult transition to retirement because they never took the time to develop personal interests.

But if you overfocus on your family or home, you may not be able to afford your home, he says, adding that one physician in his class jokingly added that you would still get divorced because "you're around too much."

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constantly are pushed to the edge of and beyond what they think they can handle,” Dr. Sheff says. “Then they suck it in and move forward anyway, whether they’re exhausted or had a patient die.”

In order to move ahead, they internally isolate experiences and build up walls around them that no one—not even family members—can penetrate. That process exacts a high toll that physicians aren’t even aware of, he says, often acting as a hidden source of failed marriages, depression, suicide or other disorders.

Yet one of the most powerful tools that physicians can use to help avoid this scenario is often overlooked: setting income goals.

### Take CARE of Yourself

Dr. Michael G. Rayel, a Canadian psychiatrist, trained and worked in the U.S. for six years. He says that there is not a great deal of difference in the types of stresses physicians experience whether they’re practicing in Canada or the U.S. To help doctors identify red flags and better cope with the demands of their job, he developed the CARE approach:

**C: Check for signs of significant changes from your baseline.** Are there changes in your emotion, behavior, mood, relationships with colleagues or work style? If so, acknowledge this and accept that there is a problem.

**A: Anticipate complications.** If you’re feeling irritable, lack interest in your work or don’t have the same level of motivation, it may lead to depression if ignored or even addiction to alcohol or drugs. Examine the consequences of the changes in your behavior. You may lose your hospital privileges, or the medical board may place sanctions against you.

**R: Remedy with early intervention.** Ask for help right away when you first spot changes. Be proactive. Call a colleague or find ways to reduce your stress. Avoid any complications or consequences that could negatively impact your ability to practice medicine.

**E: Educate yourself.** If you’re drinking more or popping pills, learn more about addiction, dependency, the consequences of it and withdrawal signs.

“Then do everything to improve your coping skills,” adds Dr. Rayel, who is the author of *First Aid to Mental Illness: A Practical Guide for Patients and Caregivers* (Soar Dime Ltd, 2002). “Learn how to make decisions and improve your problem-solving skills.”

Instead of expecting that social contract to be honored, he suggests that physicians perform a cost-benefit analysis with their spouse, family or significant other. Identify what type of lifestyle you want, how much money you will need to earn to support that lifestyle, what sacrifices you'll have to make and whether the end result is worth the sacrifice.

“Then pursue personal opportunities for healing related to the stress and scars of the practice of medicine,” says Dr. Sheff, explaining that physicians can be compared to alcoholics in the sense that they need to talk to other physicians for a healing experience.

**“In the process of training and taking care of patients, physicians constantly are pushed to the edge of and beyond what they think they can handle,” says Dr. Richard Sheff, chairman and executive director of The Greeley Company. “Then they suck it in and move forward anyway, whether they’re exhausted or had a patient die.”**

In the 1980s, while in his residency, Dr. Sheff participated in a Balint group, a personal-awareness program in which physicians discuss their experiences with peers. Balint groups are based on the work of Michael and Enid

Balint, British psychoanalysts who helped physicians understand the psychology behind doctor-patient relationships; they are offered in many educational and training programs. Dr. Sheff says that the Balint group was a very powerful experience, whether the participants talked about their experiences with medicine, office problems or stress at home. He says that the group helped the physicians get in touch with that place inside themselves that has been wounded.

Dr. Sheff’s company works with hospitals to form similar types of physician groups. Its first step is to interview each participating doctor about the challenges they experience either on the job or at home. When explained in advance what the interview will focus on, many typically believe that it will take only five minutes. But after 45 minutes, Dr. Sheff says, many are still talking.

“We couldn’t shoo them out of the room,” he says. “Once they started opening up, they couldn’t stop talking. They began to find it very powerful in ways that were surprising to them. The process of sharing and articulating experiences—not venting them—with another person helps.”

## Learning New Ways

Finding ways to cope with the pressures of medicine can help prevent the more serious issue of physician impairment. Physicians who are mentally ill or substance abusers can get help through physician health programs sponsored by state medical societies or licensing boards. Often physicians are forced into treatment after colleagues present them with two options: either seek counseling or be removed from the practice.

Every year, the Physician Health Committee of the Maryland Physician Health Program actively monitors and advocates for roughly 100 different physicians throughout the state who may be impaired. So far, it is providing assistance to approximately 300 physicians, says Dr. Stanley Platman, a psychiatrist who chairs the committee and also works at EHP Behavioral Services in Baltimore. While most suffer from stress, anxiety and managed-care pressures, disruptive physicians have recently become a concern.

“Physicians can’t get away with being unpleasant,” Dr. Platman says. “When we get this referral, we work them up to make sure they don’t have a disorder. For many, it’s just basically the way it is for them. They’re working in an environment they don’t like very much, they don’t know how to maintain reasonable relationships with other people, and they don’t understand that the nature of physicians has changed.”

While dealing with matters of life and death is an inherent part of the profession, Dr. Platman says that society’s expectations of what medicine can accomplish are often unrealistic. Blame it on everything from direct-to-consumer pharmaceutical advertising to new technology that allows armchair doctors to conduct a Google search and then challenge a physician’s every move. Therefore, doctors who “let” their patients die are considered a failure. When this occurs, he says, many physicians believe they’ve done something wrong and feel that the whole world has judged them as a failure.

He believes that the answer lies at the beginning. Medical schools across the country must include courses that teach coping skills as part of their curricula instead of shielding medical students from the profession’s harsh realities. What’s more, Dr. Platman says, schools will have to identify what types of personalities do well in the profession and can successfully handle

the myriad of stresses and challenges that doctors face.

“[Medical schools] teach in a world that’s outdated,” Dr. Platman says. “Until they begin to change and understand what the real world of medicine is like out there and build that into their teaching so that physicians are more prepared to cope with situations, it’s going to be very difficult.”

Some of that is already occurring at the University of California San Francisco School of Medicine. “I consider it basic training to have the skills to nurture and set limits from within so you can nurture and set limits with patients in very difficult situations, keep that emotional pipeline open and become a healer,” says Laurel Mellin, M.A., R.D., associate clinical professor of family and community medicine and pediatrics at the university.

She says that a handful of medical students have been taught “The Solution,” which is a counseling program that was designed initially to help obese children. Later on, it was found beneficial for adults who were obese, then it was proven effective for other adults who engaged in a whole range of excesses or addictions.

To understand how the approach works, she says that it is necessary to first understand how the brain functions. She says the feeling brain, or limbic system, is the center of emotional balance, relationships, intimacy, spiritual connection and all of the red-hot drives that lead to excess. Unless people are able to cope with high stress levels, she says, it’s easy for them to go into allostasis where feel-good neurotransmitters drain stress hormones to the point that there is imbalance or a drive to excess.

In the case of physicians, many are analytical, a quality that is reinforced by their medical training, and their world rotates around excessive work and brutal stress. Because they experience tremendous demands—both cognitively and emotionally—

### Need Help?

If you think you may be suffering from depression, log on to The American Foundation for Suicide Prevention’s Website ([www.afsp.org/physician](http://www.afsp.org/physician)). It offers a Physician Depression Questionnaire, a nine-question quiz that helps physicians assess their condition, along with links, resources and contact information.

it's easy for them to get into the habit of thinking too much or obsessing, she says, which can render them emotionally numb. In order to turn off this drive to excessive behavior—whether it is overdrinking, overeating, overspending or any other common way of coping—physicians need to spend more time with their limbic system in homeostasis or balance. This is referred to as being above the line, rather than out of balance and in allostasis, or below the line.

**Medical schools should offer courses that teach coping skills instead of shielding medical students from the profession's harsh realities, says Dr. Stanley Platman, a Baltimore psychiatrist. What's more, schools should identify what types of personalities do well in the profession and can successfully handle the myriad of stresses and challenges that doctors face.**

“The objective for physicians should be able to spend more moments of the day with their limbic brain in homeostasis or above the line,” says Ms. Mellin. “If they have the skills to do that, they will essentially be able to turn off—other than what genetics presents

them with—those drives from going to excess, emotionally, behaviorally, relationally and spiritually.”

Consider two physicians—one who is depressed, maybe an alcoholic or drug abuser, and the other who is relatively stable and resilient. Other than genetics and early childhood experiences, Ms. Mellin says that what separates the pair is whether they have the skills to nurture and set internal limits.

She says that this ability comes from our parents. If they nurture us during our childhood and teach us to set limits, neuro networks in our feeling brain form so that they naturally nurture themselves. But at puberty, the thinking brain takes over and creates a major barrier to the feeling brain. If physicians didn't receive the skills to nurture themselves and set limits early on, neuro networks can still be changed but only through repeated practice. Until then, doctors are vulnerable to excesses and remain neurologically hard-wired to go below the line.

## Medicine Seen Devalued

There are still other reasons why some physicians have trouble coping with their jobs. In the past, people had respect for the

doctors in their communities. Not anymore, says Dr. Lee Fischer, who practices family medicine at Palm Beach Family Physicians in West Palm Beach, Fla.

“Doctors used to be looked up to as professionals,” he says. “We were the pinnacle, very well respected. In the past 15 to 20 years, that has eroded, the pinnacle is gone. We got tainted.”

He points to various groups like managed-care organizations that have devalued physicians, partly by referring to doctors as providers. He believes that has had a psychological affect on people’s values throughout the country and undermined the role of the physician.

Worse yet, he believes the justice system opened the floodgates for medical malpractice suits. Thirty to 40 years ago, Dr. Fischer says, if a physician made a mistake, patients would forgive and probably forget. Now they’re suing doctors for every reason imaginable.

He says that the practice of medicine has become so overwhelming that more doctors are leaving the profession—some in dramatic and tragic ways. More than 20 years ago, he remembers waking up to flashing lights and the sound of police sirens. He quickly learned that his neighbor across the street—a general internist—had shot and killed himself. He remembers how upset his neighbor would become about the direction medicine was going, which wasn’t nearly as strenuous then as it is now. He shudders to think how that man would cope or behave in today’s world.

“We hear the talk about defensive medicine,” Dr. Fischer says, explaining that in the back of every doctor’s mind is the threat of a lawsuit. “There’s no other job in America where each and every judgment you make throughout the day could be subject to somebody getting seriously harmed or sued. If an airline pilot messes up when he’s flying the plane, [people] will sue the airline. The pilot himself isn’t personally liable.”

For the past 20 years, Dr. Fischer has been reviewing malpractice complaints for the Florida Board of Medicine. He says that this role sensitizes him to what doctors do wrong and the types of actions that typically result in a malpractice case. Many involve patient miscommunication or insufficient notes in charts about patient encounters.

Until the burden of malpractice suits eases up, it will always

be a major source of physician stress. Doctors will continue looking over their shoulder thinking every patient is going to sue them. But Dr. Fischer believes the situation is not as bad as it was 10 years ago since many capitated HMOs have disappeared or transformed into fee-for-service. He believes that the managed-care pendulum is swinging back to the middle, creating a more equitable climate in which to practice medicine.

Another problem is that physicians may be treated really special at work but as ordinary people by their spouse and family. For some, it can be hard to make the switch, adds Dr. David Shlim, a semi-retired physician who practices travel medicine at Jackson Hole Travel and Tropical Medicine in Jackson Hole, Wyo.

“It’s probably one of the underlying causes of [failed] doctor marriages, which are at a higher risk than [marriages] in the general population,” he says. “They can get somebody at work who looks up to them as a doctor, admires them more, feeds their ego, whereas the person at home says you’re never home, you don’t do the dishes or you’re not helping out.”

Even residents are at risk. Dr. Shlim believes it’s easy for them to become overconfident, especially since somebody is standing beside them, helping them make decisions. He compares it to children whose mother or father is watching them on a playground. As soon as the parent leaves—or in this scenario, residents join a private practice—suddenly they’re on their own. Doctors must decide whether the patient’s chest pains require antacids or a stress test. He says that the transition from training to practice is rarely addressed and can cause a great deal of stress

### **What Do Physicians Consider Most Stressful?**

1. Government regulations.
2. Demands from insurance companies/managed care.
3. Increased paperwork.
4. Malpractice/defensive medicine.
5. Loss of control over practice.
6. Decreased income.
7. Lack of time with family and friends.

*Source: Texas Medical Association Committee on Physician Health and Rehabilitation.*

and anxiety for new physicians.

Dr. Shlim knows all too well what it's like to work independently. Because his father was a physician, he was expected to follow in his footsteps. But in the late 1970s, he became disenchanted with medicine. After four years of practicing emergency medicine, he says that it still didn't feel quite right, almost as if he were interchangeable. He explains that you could end up saving someone's life, but only because you switched shifts that day. Also, instead of receiving credit for helping people who were sick or injured, all you could do was "screw up."

As a mountain climber, he became interested in medical problems at high altitudes. On three separate occasions—in 1979, 1980 and 1982—he practiced medicine for three consecutive months each time in a stone house at 14,000 feet in the Himalayas. He was stationed at a rescue post near the base of Mt. Everest to help mountain climbers or trekkers who were stricken with altitude sickness.

"It taught me how much you could do without all the lab tests and backup," he says. "You learn how to be a better thinker, how to think thoughts through. There was no one to call, and it was very difficult to get a helicopter evacuation. When I came back, it really helped me think clearly when you can't just order everything."

In many healthcare settings, a physician's main job is to avoid getting into trouble, Dr. Shlim says. But on the mountaintop, it was very different, he says, adding that he was the last hope for many patients. He also practiced at a new clinic in Katmandu that delivered medical care to foreigners living in Nepal. He says that it was the world's first destination travel clinic run by foreigners.

"You really felt that you were making a huge difference for travelers [who were] scared, sick and lonely," he says. "I got the feeling that practicing up on the mountaintop and in Nepal was similar to what medical practice was like from the 1930s through the

**The devaluation of medicine by society is another factor increasing doctors' stress levels. "Doctors used to be held up to as professionals," says Dr. Lee Fischer, a family physician in West Palm Beach, Fla. "We were the pinnacle, very well respected. In the past 15 to 20 years, that has eroded, the pinnacle is gone. We got tainted."**

1950s, when doctors were respected, got to know their patients, were appreciated. They were forgiven. Then somehow it changed.”

But the profession actually began changing more than 80 years ago. In a classic graduation address to Harvard medical students, Francis Peabody, a famous medical educator in the 1920s, stated that as medicine became more scientific, doctors shifted their focus away from the patient and on to science, says Dr. Shlim. In other words, patients became people to study to confirm the science instead of individuals who were sick, suffering and in need of care. They were the raw material on which physicians practiced their art.

Dr. Shlim believes that the practice of medicine grew worse from that moment on. Over the last few years, he had the opportunity to spend time with residents at a major medical center in the U.S. He spent nine hours with residents and didn't see a single patient, he says, explaining that the residents saw patients in the morning but spent the rest of the day sitting around a table talking about their patients, going to conferences and checking with the lab and X-ray departments about test results.

“I realized what they had managed to do was strip away the messy parts of medicine, which is actually talking with patients and dealing with their feelings,” he says. “It becomes really interesting to take all the data, try to figure out the diagnosis and what therapy or next step would be. It's like a quiz show. There's this underlying thing where getting the right answer is the gratification rather than seeing the look in patients' eyes when you're actually able to comfort them. It's out of balance.”

He believes that physicians could dramatically improve the profession by developing and cultivating a truly compassionate attitude so that when they enter an exam room, they're being a real person.

At the medicine and compassion workshops offered by Dr. Shlim, he says, physicians typically complain about how many of their patients are angry, irritable, aggressive and resentful, which really wears them out. So how do physicians learn or train themselves that this type of patient is suffering in a different way and that they need to give him or her even more compassion? Many haven't considered this perspective.

Dr. Shlim says that doctors are stuck right now between expe-

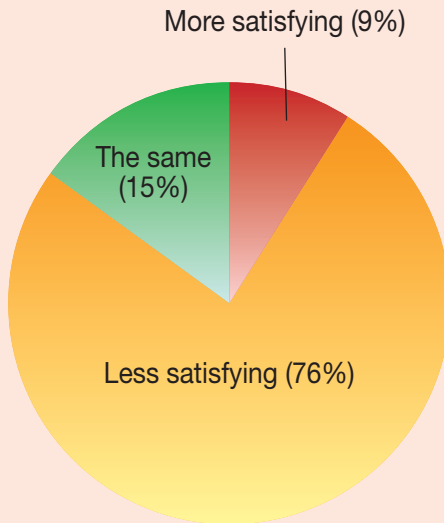
riencing their patient's emotions and processing those feelings internally. Many carry those emotions with them all day—even go to sleep with them—but there's a limit to how much they can carry. He says that medical training does not offer students a method for dealing with it.

Instead, medical students are encouraged to learn about their patients and experience empathy, but find they can't handle the emotional strain. Some shut it out or provide lip service about caring about patients, then enter a milieu where everybody distances themselves from their patients to protect themselves, he says.

Other times, life gets in the way. Before walking into a room to examine a patient, what happens if your car wouldn't start,

### Physician Satisfaction Declining

A survey of older physicians concluded that over three-quarters found the practice of medicine to be less satisfying over the past five years.



Source: Merritt, Hawkins & Associates, 2004 Survey of Physicians 50 to 65 Years Old.

your son didn't want to go school or your spouse was angry at you? "What's left to care about this patient?" he says, adding that physicians are often stuck with their thoughts and emotions but need to drop them or let them go in order to focus on what really matters at that moment—the patient.

## Grab the Reins

While some physicians point fingers at external organizations like managed-care companies for the profession's becoming out of whack, others blame the doctors themselves.

"Can you believe that doctors got talked into signing managed-care contracts?" says Dr. Tel Franklin, who practices family medicine at the Ryan Ranch Medical Group in Monterey, Calif. "Physicians as a group of people have failed to provide any real leadership. We've let business and insurance companies and national organizations that just aren't in touch with family and primary-care physicians take control."

At the very least, he believes that physicians must become more efficient at the business side of medicine, which will help them in their quest for work-life balance. But some think they're above all that, even refusing to spend money on converting their paper charts to electronic medical records, he says. Others aren't up-to-date on coding and new reimbursement procedures, or they

### Profile of a Physician at Risk for Suicide

Confronting Depression and Suicide in Physicians: A Consensus Statement, published in the June 18, 2003, issue of the *Journal of the American Medical Association*, listed the following suicide risk factors for physicians:

- Female aged 45 or over; male aged 50 or over.
- Divorced, separated, single or currently having marital disruption.
- Depression, alcohol or other drug abuse, workaholic, excessive risk taking (especially high-stakes gambling or thrill seeking).
- Psychiatric symptoms or history, especially depression and anxiety, physical symptoms such as chronic pain or chronic debilitating illness.
- Change in professional status, increased work demands, threats to autonomy, security, financial stability.
- Access to medications, access to firearms.

try to cut costs by paying low salaries to office staff and end up with low-quality employees.

Dr. Franklin also wonders how many physicians have developed a good business plan or business model or hired a practice-management consultant to review accounts receivable, scheduling, services they provide, codes they use, insurance contracts, reimbursements and sources of new patients or to help them introduce new services.

For example, Dr. Franklin added acupuncture to his list of medical services, hired a billing service at \$6,000 a month, spent \$92,000 so far on a leased electronic medical-record system, uses hospitalists and hired a registered nurse as an office manager.

Despite these added expenses, he says that he's bringing in an extra 20 percent to 25 percent in income. Better yet, he firmly believes these changes have improved his quality of life. He no longer receives calls at 3 or 4 a.m., has streamlined everything from prescriptions to phone calls and optimized patient care. Now he can devote several hours each day for leisure time, such as running, working out or spending time with his family.

"Understand that the bottom [line] is there's no way better way to spend your life than being a physician," he says. "There are so many people in different walks of life whom I would never meet, never get to know them or their families unless I was their doctor. At the end of the day when I'm driving home, I can say there are some people I helped."

**Dr. David Shlim**, who practices travel medicine in Jackson Hole, Wyo., says that the profession began changing more than 80 years ago, citing a classic Harvard graduation address by Francis Peabody, a famous medical educator in the 1920s. He stated that as medicine became more scientific, doctors shifted their focus away from the patient and on to science.